FINANCE COMMITTEE

Tuesday 2 September 2003
(*Morning*)

Session 2

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FINANCE COMMITTEE
4th Meeting 2003, Session 2

CONVENER

*Des McNulty (Clydebank and Milngavie) (Lab)

DEPUTY CONVENER

*Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP)

COMMITTEE MEMBERS

*Ms Wendy Alexander (Paisley North) (Lab)
*Mr Ted Brocklebank (Mid Scotland and Fife) (Con)
*Kate Maclean (Dundee West) (Lab)
*Mr Jim Mather (Highlands and Islands) (SNP)
*Dr Elaine Murray (Dumfries) (Lab)
*Jeremy Purvis (Tweeddale, Ettrick and Lauderdale) (LD)
*John Swinburne (Central Scotland) (SSCUP)

*attended

THE FOLLOWING ALSO ATTENDED:

Professor Arthur Midwinter (Adviser)

THE FOLLOWING GAVE EVIDENCE:

Dr Robin Balfour (Scottish General Practitioners Committee)
Lorna Clark (Scottish Executive Health Department)
Terry Findlay (Greater Glasgow Primary Care NHS Trust)
Douglas Griffin (Greater Glasgow Primary Care NHS Trust)
Dr David Love (Scottish General Practitioners Committee)
David Notman (Scottish Executive Health Department)
Ian Reid (Greater Glasgow Primary Care NHS Trust)
Dr Barbara West (Scottish General Practitioners Committee)
Dr Hugh Whyte (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

David McGill

SENIOR ASSISTANT CLERK

Jane Sutherland

ASSISTANT CLERK

Emma Berry

LOCATION

Committee Room 1

Scottish Parliament

Finance Committee

Tuesday 2 September 2003

(*Morning*)

[THE CONVENER *opened the meeting at 10:03*]

The Convener (Des McNulty): I welcome members to the fourth meeting of the Finance Committee in this session. I also welcome the press and the public, although I do not think that many members of the public are here.

I remind members to ensure that their mobile phones and pagers are switched off so that they do not go off during the meeting.

Fergus Ewing has sent his apologies. He has indicated that he will be late—I expect him to arrive at about 10:30.

Item in Private

The Convener: Agenda item 1 is to seek the committee's agreement to take item 5 in private. When the committee scrutinises draft legislation, it always seeks to report to the lead committee in advance of that committee taking evidence from the minister. As the Health Committee is due to take evidence from the Minister for Health and Community Care on the afternoon of Tuesday 9 September, the clerks will seek to issue a draft report on Thursday for our consideration at our meeting on Tuesday morning. Item 5 is designed to allow the committee to give the clerks a steer as to what our report should contain on the basis of the evidence that we take this morning, and to enable them to draft the report in a very short time. Do members agree to take item 5 in private?

Members *indicated agreement*.

Primary Medical Services (Scotland) Bill: Stage 1

10:05

The Convener: Agenda item 2 is consideration of the Primary Medical Services (Scotland) Bill, which was introduced on 23 June by the Minister for Health and Community Care. We have witnesses from the Scottish General Practitioners Committee to assist our consideration of the financial memorandum that accompanies the bill. I welcome Dr David Love, the chairman of the SGPC; Dr Robin Balfour, the vice-chairman; and Dr Barbara West, who is a member.

Witnesses from Greater Glasgow Primary Care NHS Trust are also here to assist our consideration of the financial memorandum. I welcome Ian Reid, the chief executive; Douglas Griffin, the director of finance; and Terry Findlay, the general manager with responsibility for primary care services.

The format of evidence sessions is that witnesses respond to questions from members. We will deal with the general practitioners first; after we have finished questioning them we will move on to the witnesses from the Greater Glasgow Primary Care NHS Trust.

I give Dr Love the opportunity to make some introductory comments.

Dr David Love (Scottish General Practitioners Committee): Thank you for inviting us to give evidence. We have submitted our written evidence to the committee. I do not want to say much at this stage other than that we support the bill's aim of implementing the new general practitioner contract from 1 April next year. We have expressed reservations about some items in the financial memorandum, but those reservations do not relate to the bill itself. I do not think that any of them should impede the progress of the bill, but I hope that they can be addressed during the stage at which regulations are laid. I am happy to answer questions about any of our reservations.

Mr Ted Brocklebank (Mid Scotland and Fife) (Con): Can you identify the results that GPs believe they will achieve with the additional expenditure that is committed for the next three years?

Dr Love: What GPs are looking for from the new contract is to be able to control the work load, to get more resources into their practices, to be able to spend more time with patients and to have the time and resources to deliver higher-quality care. The new contract should facilitate those aims and enable better care to be delivered to patients. At present there is a huge morale problem, as GPs

feel overburdened with bureaucracy and do not have enough time to deal with patients. We have great faith that the new contract will address that problem.

Mr Brocklebank: I understand that, but will the £8 million that is allocated to practices for preliminary assessment work be sufficient?

Dr Love: Members would not expect me to say that any amount of money is sufficient, but it will help practices to get started. We must recognise that practices have reached different stages of development in delivering quality services. The money will be helpful and will enable practices to get protected time. It may enable them to put extra staff in place to prepare for the new contracts and, in particular, the delivery of the quality framework.

Mr Brocklebank: Is there sufficient financial provision to compensate for time spent by practices on assessing themselves and providing the necessary information for quality payments?

Dr Love: The quality payments system will not start for real until the beginning of the new contract, when practices will indicate where they think they will be on the quality ladder by 1 April 2005. There is a fair amount of time for practices to prepare and recruit additional staff. Practices will be hugely dependent on information technology to measure quality, but I think that they will be able to meet the challenge.

Mr Brocklebank: As the prevalence adjustment for specific targets cannot be calculated until the overall prevalence for each target is known, will that cause practices particular financial hardship?

Dr Love: The concept of the aspiration payment should ease cash flow problems because practices will receive a third of their quality payments at the start of the year and the balance will be worked out towards the end of the year. We are not certain exactly when and how the balance of the payments will be worked out, but we anticipate that it will be paid at the end of the financial year. There may yet be agreements about feeding in the money over the course of the year to ease cash flow problems, but the matter is still under negotiation.

Mr Brocklebank: Is there a risk that practices may increase their prescribing and laboratory costs as they ensure that they meet the new quality indicators?

Dr Love: That is probably inevitable, but must be balanced against the fact that, if the new system works and if the evidence that the quality framework is based on is correct, practices will reduce the incidence of heart disease and stroke, which will have a huge financial benefit for the health service as a whole. There will be increased expenditure in one direction, but there should be considerable savings in another direction as we reduce the incidence of disease.

The Convener: Given your experience of how effectively general practitioners and practices adjust their procedures to maximise income, do you believe that the Scottish Executive has got its sums right in anticipating the way in which the system will work in practice?

Dr Love: The Scottish Executive is usually very careful with its money, and there is no exception with the GP contract. From the Executive's point of view, the assumptions that it has made about what practices will achieve through the quality framework are fairly conservative and safe. It assumes that 90 per cent of practices will achieve 90 per cent of the maximum amount of quality points. That is a fairly safe estimate and I guess that, despite their best efforts, practices will fall a bit short of that. The targets are really quite demanding and will require a huge amount of organisation and effort, so the assumptions made by the Executive are fairly safe.

The Convener: Can you see any holes or unanticipated mechanisms that would lead you to believe that practices might find income-generating mechanisms or ways round the assumptions that would make those assumptions inappropriate?

Dr Love: The only way round for practices to exceed the prediction is to achieve higher quality, even better care and even better outcomes. If 100 per cent of practices were to achieve 100 per cent of points, that would exceed the predicted spend, but the likelihood of that is fairly small. If that did happen, however, it would be a jolly good thing.

Jeremy Purvis (Tweeddale, Ettrick and Lauderdale) (LD): I want to ask about the allocation formula and about local needs, especially rurality. I start by asking Ian Reid and Dr Love whether the Scottish allocation formula will be fairer than the previous method.

Dr Love: The Scottish allocation formula is certainly better than the Carr-Hill formula, as it was originally conceived, in relation to targeting resources at rural practices in Scotland. The formula in general has limitations when applied to small numbers, and that is why the MPIG—the minimum practice income guarantee—is so important to practices, as it guarantees for rural practices the continuation of the payments that they had through the Scottish rural practice fund's mileage payments, which are known as the chapter 10.5 payments. Those payments are all guaranteed by the MPIG, so the existence of the MPIG is a huge help for rural practices. In fact, it is essential for them to maintain their viability, because in many instances the rural weighting in the allocation formula was not enough to deliver

even the existing rural payments. The MPIG guarantees that those payments are continued.

Jeremy Purvis: I shall touch on the rural aspect in a moment, but perhaps Ian Reid could comment first on how the formula will work in urban areas, and especially in deprived urban areas.

Ian Reid (Greater Glasgow Primary Care NHS Trust): As Dr Love said, we believe that the allocation formula is better than the existing system. Your point is well made, however, because the impact of certain elements of the formula will affect urban areas differently, depending on where one is in the country. In Glasgow, a key issue is the impact of the age aspect of the formula. The Glasgow population is not particularly aged in comparison with other areas, and we will be looking for a greater impact for the deprivation scores. It will be interesting to see just how the formula plays out in different geographical areas, and it is important to keep the formula under review in such circumstances.

10:15

Jeremy Purvis: On rurality, how effective do you think the mechanism will be in addressing specific issues in rural areas? The cost indications in the financial memorandum show £1 million in this financial year and the next, and then the costs will be transferred over to board administration funding. Is there an issue with regard to the costs going over to the boards, or is that not a problem at all?

Dr Love: Is the £1 million that you are referring to the money for recruitment and retention?

Jeremy Purvis: I am looking at the "Summary of costs" table in the financial memorandum, under "Expenditure Type".

Dr Love: I think that those are the packages for the golden hellos and special weighting to attract young doctors to take up posts in rural areas. It is a relatively small sum at the moment, and it will simply transfer into another funding stream.

Jeremy Purvis: Will the new mechanism affect the setting up or location of practices in rural or semi-urban areas? Will there be a financial incentive for practices to be located in areas where they can capitalise on the funding, rather than an incentive to maintain practices in rural areas? Are you are confident that the guarantee will be effective?

Dr Love: Yes. We are absolutely dependent on that minimum income guarantee, because it locks in existing subsidies to enable rural practices to be viable. That is why the MPIG is so important. As long as the MPIG continues, those practices will be viable. If it were to be withdrawn, we could face some fairly serious situations.

Jeremy Purvis: Do you think that the indicators that are used in rural areas—I am aware that there is a different approach in England and Wales—accurately reflect the different costs in rural areas? I know that car mileage is used as an indicator for deprivation, but car ownership is not. In urban areas, people might be considered not to be deprived if they own a car, but in rural areas a car is vital.

Dr Love: All the indicators in the rural weighting are perfectly valid, but I agree that we need to keep reviewing the formula. There are specific issues in rural areas, as the deprivation scores tend not to recognise rural deprivation, and we know that some rural deprivation is not picked up by existing measures of deprivation, which are largely based on urban measures.

Kate Maclean (Dundee West) (Lab): Could you say a little more about the effect that the formula could have in deprived areas? I wonder whether there is enough financial incentive for GP practices to set up in some of the peripheral housing estates in urban areas. The population in some of those deprived areas is quite young, so the only factor that could be taken into account would be the deprivation adjustment, and I wonder whether that offers enough of a financial incentive.

In the area that I represent, very few practices are prepared to set up in peripheral areas, although they may set up on bus routes leading out of those areas. Where access to a practice involves travelling some distance, people who live in rural areas have that factor taken into account. However, if someone in a deprived area does not have the money for the bus, they may be unable to get to a GP practice. Could you comment on that?

Dr Barbara West (Scottish General Practitioners Committee): I work in a deprived area—Drumchapel in Glasgow—and we certainly think that the new contract offers us opportunities to improve services for our patients. The Scottish allocation formula certainly has elements that incorporate indices of deprivation, but I echo my colleagues' views that it will need refinement over time, with robust practice-based data going into it. The MPIG is absolutely vital for maintaining practices in deprived areas. It incorporates the current payments for deprivation, which were a great boon to us when they were first set up, and we are absolutely dependent on retaining those in the MPIG.

Various aspects of the contract will benefit us. There is a known prevalence of increased morbidity in deprived areas. If one is basing the quality and outcomes payments on the incidence of morbidity, that should improve the cash flow situation for practices in deprived areas. The contract will make it easier to recruit in such areas.

In our practice, we have taken the bull by the horns and decided to introduce another doctor. We want to do this work well and believe that it will now be resourced adequately.

The Convener: You are suggesting that the new contract could assist some communities that do not have a GP at present or facilitate the improvement of the GP service that is provided in some deprived urban and, perhaps, rural communities.

Dr West: Absolutely. The cash flow system is designed to improve services. The way in which to improve services is to increase staff complement—the number of doctors, nurses and other health care professionals. Dr Love said that people wanted to get control of their work load. One way of doing that is to have a larger and better team providing services and giving proper time and care to patients. We hope that this financial incentive will enable us to do that.

The Convener: I want to ask a couple of specific questions about the MPIG, which—as the witnesses have emphasised several times—is crucial. The financial memorandum is slightly ambiguous about the future of the MPIG. Do you believe that it is necessary that the MPIG should be permanent? Do you expect MPIG funding to increase with inflation, or do you believe that it may gradually be devalued? What would be the consequences of its being devalued gradually?

Dr Love: It is essential that the MPIG continue for the foreseeable future. As the formula is refined and improved, the allocation that some practices receive may equal or exceed the equivalent funding for the core services that they provide. The MPIG would no longer be required for such practices.

We have great difficulty with the memorandum's suggestion that a practice that under the formula receives 70 per cent of its current resources for core work may make up the loss by providing a wider range of services of much higher quality, simply to stand still financially. That would be completely unacceptable. The MPIG had to be introduced because there was no chance that the profession would vote for the contract on the basis that GPs would have to do more work of higher quality simply to maintain current resources. The intention of the contract was to encourage GPs to offer more and higher-quality services, and to provide the additional resources to enable them to do so.

I do not know whether the MPIG will stand still or deflate gradually. That will be a matter for negotiation at the end of 2006. However, any suggestion that the MPIG could be withdrawn simply because practices had made up their losses by generating more income from enhanced and higher-quality services would cause a major upheaval.

The Convener: In other words, what happens to the MPIG is crucial in determining whether some practices are viable.

Dr Love: Absolutely.

Dr Elaine Murray (Dumfries) (Lab): I want to pursue the points that Kate Maclean made about practices that are subject to recruitment pressures. In my constituency, which is partially urban and partially rural, those pressures are often higher in urban practices, which have a heavier work load, than in rural practices.

Practices that have difficulties with recruitment also have difficulty recruiting locums to cover for GP absence. Are the bill's provisions sufficient to enable those practices to attract locums? Does the bill address that issue?

Dr Love: The bill cannot address it, because the supply of locums is dependent on their number and availability. That is beyond the control of the bill. In the past, when a practice had an unfilled vacancy, it lost the money associated with that vacancy. Such a practice was short not only of a doctor but of a substantial amount of money, so the position was even more difficult. The bill helps because now practices with unfilled vacancies will continue to receive their overall funding, so they may be better able to afford locums. However, locums are scarce and very expensive. I am afraid that that simply reflects market forces.

The Convener: Given the additional work load of high turnover lists in some urban areas with greater allocations of patients, will the new contract help to prevent GPs from putting patients off list and encourage retention of allocated patients?

Dr Love: The new contract should not influence GPs' decisions to accept or reject patients or to put them off list. Practices should look after patients who ask to be placed on list. We expect a practice to accept patients, regardless of the illnesses from which they suffer or any other consideration, unless it is completely overwhelmed.

The Convener: In practice, there have been instances of patients' being put off list.

Dr Love: There may be situations in which practices are overwhelmed with work or are a partner short. The new contract provides a mechanism that enables those practices to limit their work load by opting out temporarily from providing additional services, until the board can work with them to provide extra capacity. The new contract will help rather than hinder that process, because it will allow practices to keep their heads above water in very difficult circumstances.

The Convener: We may ask Ian Reid later how he handles such situations.

Jeremy Purvis: I would like to clarify the issue that I raised before on the £1 million for rural areas that appears in the "Summary of costs". Is that money that has been committed as an incentive to people to work in rural practices? When the new contract is introduced, will it be absorbed into health board funding, so that boards may use it as they wish?

Dr Love: Yes.

Jeremy Purvis: So that stream of funding will continue.

Dr Love: Yes.

Dr Murray: Some of the supporting functions of GPs—providing education in communities and supporting benefit payments—are quite time consuming. The bill creates three different levels of duties: essential duties, additional services and enhanced services. Are you concerned that some of the functions that GPs undertake, such as supporting benefit claims, will not be funded adequately, given the work load that they create?

Dr Love: The work involved in supporting benefit claims is statutory and is not funded separately. It is part of GPs' core work and will be included in core services. Funding for the various categories of service that GPs will provide is sufficient. All practices will provide essential and additional services; the only optional services will be enhanced services. Enhanced services will be under the control of health boards, which will commission and fund them. Provision of such services will be limited by the money that has been allocated to boards to pay for enhanced services. It will not be limited by the willingness of practices to provide them.

Dr Murray: Do you think that the changes in the way in which funding is provided will alter staff ratios—for example, the ratio of nurses to doctors—in GP practices, or will they affect the level of qualifications of those who are recruited?

Dr Love: In the long run, the changes will have a significant effect. It is difficult to imagine that a practice will be able to achieve very high quality levels without adequate practice nurse staffing. If GPs are to provide enhanced, more specialised services—services that were previously or are currently provided in hospitals—they may require increased training. The shape of general practice and the nature of the staffing within practices could change—indeed, they will probably have to change.

10:30

Dr Murray: The responsibility for providing an out-of-hours service will cease to be GPs' and will transfer to the health boards. Is the level of funding that GPs are to be offered sufficient for them to continue to provide that service?

Dr Love: The first thing to say is that the ability for GPs to opt out of providing an out-of-hours service is the ability to opt out of the responsibility for providing the service and to opt out of providing it. A large number of GPs will opt out of the responsibility for providing the service but will continue to provide it.

The money that is to be made available to practices that want to continue to provide their own out-of-hours service is probably not enough to be a huge incentive for them to provide it; practices will not provide such a service on the ground of money.

We have not finally settled on how much additional money will be provided to cover out-of-hours services for practices in the few areas of Scotland where it might be impossible for GPs to opt out of their responsibility, but it is clear that the additional money will have to be significant if doctors are to be recruited to those areas.

As Dr Murray knows, the main problem in recruiting GPs in rural areas is the commitment that they have to make to provide out-of-hours services. Young doctors are put off working in rural areas. We have to address that problem.

The Convener: It is a big problem.

I want to ask about services for people with drug and alcohol misuse problems. How will the contract affect the ways in which practices deal with multiple morbidity?

Dr West: Under the enhanced services heading, there is great potential in the contract to provide good and evidenced-based services to those categories of patients. We welcome that. We have a scheme for drug misusers in Glasgow. We hope to refine it and to encourage further practitioners to take it up.

The funding for the new contract makes such provision more attractive than is the case at the moment. Quite a number of the enhanced services that are contained in the contract fit very well with the problems of deprived communities. The convener has rightly identified the provision of drug and alcohol services, but I am thinking also of sexual health and mental health services, both of which are interesting areas in which we could make a great deal of difference to our patients if we had the funding to enable us to do so to a high level.

The Convener: In a sense, what you are saying is that the contract will allow GPs to target more accurately the needs of patients in some of those areas and will also allow them to provide a better service.

Dr West: Yes. We approve of the concept.

The Convener: In conclusion, your verdict seems fairly positive, although you have highlighted one or two issues of concern.

Dr Love: Yes. At the end of the day, GPs voted overwhelmingly in favour of the contract. Over the past couple of years, the future of general practice has been in the balance. The future is now totally dependent on getting the new contract implemented on 1 April 2004.

The Convener: As we have no further questions for the first group of witnesses, I thank you on behalf of the committee for coming to give evidence to us today.

Dr Love: Thank you.

The Convener: We will now take evidence from the Greater Glasgow Primary Care NHS Trust—that is not as great a mouthful as some of the other trusts in the Glasgow area. I will afford Ian Reid the same opportunity to make a couple of introductory remarks.

Ian Reid (Greater Glasgow Primary Care NHS Trust): We are pleased to have been asked to give evidence to the Finance Committee. In common with our colleagues who have just given evidence, we prepared written evidence to act as a commentary on the financial memorandum.

We welcome the bill and encourage the Executive to press ahead with it. The bill supports a lot of our work over the past two or three years in Glasgow on the development of our primary care strategy. Dr West, from whom the committee has just taken evidence, was part of that work. The contract and the way in which it is framed give us the basis on which to move forward.

John Swinburne (Central Scotland) (SSCUP): Good morning. The Scottish Executive is to provide £8 million to assist practices in assessing themselves in 2003-04. Given the demands of that exercise on information technology, training and time, is that money adequate?

Ian Reid: I will ask Terry Findlay to comment in a moment. Through the use of IT and—I have to say—by falling back on some manual systems, we have begun to work with practices to survey current activity. The feedback that we have received is that practices have the required level of information to hand. We were surprised by practices' ability to gather such information. At this stage, we feel that the money will be adequate.

We are slightly more concerned about the longer term, as general practice might wish to refine its IT provision. A responsibility is to be placed on the NHS board to assist practices in that respect and, as yet, we are not sure what the scale of need will be once IT becomes more prevalent. I am thinking in particular about the quality indicators.

Terry Findlay (Greater Glasgow Primary Care NHS Trust): Our current disease management programme has been running for more than 18 months. The preparation for that was much the same as is set out in the contract, which is to our benefit. I am very confident that we will be able to provide the kind of information that is required. However, as Ian Reid said, IT is a risk area.

John Swinburne: Do you foresee any additional costs arising from the implementation of the new contract? I am thinking of staff training, assessment and so forth. How will the health board address those additional financial demands?

Ian Reid: We are conscious of that issue. Much of the activity in primary care organisations has been focused around the processing of payments and on more administrative functions. The new contract takes a more managed approach to the delivery of primary care services and of general medical services in particular. That will lead to an internal issue for the NHS of reskilling the individuals who are involved in the administration of the existing arrangements to enable them to undertake roles that they have not undertaken to date.

We are fairly confident that we have sufficient resources to do that. As we develop the contract, it is to be hoped that people will learn from others. At this stage, we do not have any real concerns about that issue.

John Swinburne: In other words, you are quite happy with the £3.5 million of centrally resourced funds that the Executive is offering to cover that aspect.

Ian Reid: Yes.

Dr Murray: Will the Scottish allocation formula result in a fairer distribution among health boards? For example, will the SAF reflect the competing demands of remote rural areas and more pressurised urban areas?

Ian Reid: Yes. We are confident that the formula is more robust than is the case at present. As I said, we want the formula to be kept under review until some of the issues are played out. We will need to see the impact of the new arrangements on urban and rural situations. Provided that the review is sufficiently robust, and given that we support the general direction in which the new arrangements are moving, we do not have concerns at this stage. Douglas Griffin might like to comment on that.

Douglas Griffin (Greater Glasgow Primary Care NHS Trust): No, but I would like to make the point that the population in Glasgow is slightly younger than that in the rest of Scotland. We are concerned about the impact that the lower

proportion of elderly residents in Glasgow might have on the distribution of resources in our area. On the other hand, the deprivation indices should provide some compensation. As Ian Reid said, we will have to wait and see how the arrangements unfold over time and we will need to keep the situation under review.

Dr Murray: Are you confident that sufficient funding has been allocated for the enhanced services that you will be required to buy in?

Douglas Griffin: The proof of the pudding will be in the eating. That is an area of some uncertainty. Although a sum of money is to be made available, we will have to work out with our GP colleagues exactly what services are to be provided and what will be paid for.

We will also have to bear it in mind that one of the key thrusts of the contract is alleviating the pressure on GP work load. We are moving into a situation in which GPs will come forward voluntarily to take on additional services. Considerable discussion will have to take place to work out the package of those additional services. Only once we have worked through that will we be in a position to know what can be provided within the available resources.

Jeremy Purvis: You have talked about perhaps redesigning services and trying to alleviate GPs' work load. We have been provided with the summary costs under which you will operate. Will the contract limit your scope if you want to redesign services around the patient, for example by increasing the number of practice nurses or extending the role of pharmacists, because the contract is quite prescriptive and costs are prescribed until 2006?

Ian Reid: The benefit of the contract is that it affords the ability to redesign services and allows a far broader range of professional staff to contribute to primary care. We wish to encourage that, but we are where we are and it is important that the existing arrangements are safeguarded as we go through the transition. It appears that the funding flows are relatively fixed, but we welcome safeguarding. That will give us the ability, through negotiation with general practice and others, to redesign services so that they are more effective. It is helpful that funding will change as we go, but we welcome the funding certainty at this stage.

Dr Murray: Do you have concerns about out-of-hours services? Under the changed arrangements, a duty will be placed on boards to offer such services. Is the funding adequate to enable you to do that?

Ian Reid: You probably saw in our written evidence that we were concerned that we might have difficulties in providing the existing arrangements in Glasgow, given the available funding flows, although I was somewhat reassured by Dr Love. One of our concerns was that as well as giving up responsibility for providing the out-of-hours service, GPs might wish to opt out of the whole service. That would definitely lead to a cost pressure, in that we would have to find some financial inducement to bring people back.

In fact, the conversation that we are having in Glasgow with the general practice community has been positive, and our initial indications are that people will wish to continue in some form, although we are working through the detail.

We would like the issue to be flagged up, because we are not yet wholly confident that the funding will provide the level of service that we currently offer.

The Convener: Could your ability to calculate accurately the amount to be funded be compromised by potential problems with accurate morbidity recording, which is a particular issue in Glasgow?

Ian Reid: I will hand that question over to Terry Findlay.

Terry Findlay: From the practices' point of view, the incentive to get the recording correct is big. As members are aware, this is a high-trust contract, in that while we are looking to ensure that we are not heavy handed in our approach, an audit process will be in place. In the past couple of years, we have improved morbidity coding as much as the current system allows. It is much improved, but it is not perfect. The contract provides an incentive to improve it even further. Overall, we are not compromised, but improving recording to make the contract work for all parties—patients as well as general practitioners—is a challenge.

The Convener: I know that there have been concerns about data collection and data management, especially given the fact that people work on different systems and the problems that there have been with the general practice assessment survey. In greater Glasgow, you have a lot of patients with multiple morbidity, for example people with mental health problems who may have drug-related problems and a number of other health difficulties. Are the payment and contractual systems between yourselves and GPs sufficiently robust to deal not only with data recording issues, but with unmet need and unidentified morbidity problems?

10:45

Ian Reid: I will ask Terry Findlay to comment further but, as he said, the work that we have done around chronic disease management in particular, by beginning to build up registers, is assisting us in gathering those particular data. The challenge for us will be to ensure that our IT systems can be

improved and modified. The longer term funding of IT will become an issue, because that will be critical in addressing your point about multiple issues affecting particular patients.

Terry Findlay: That issue exercises our minds greatly, because I do not think that anyone has worked out a formula that is sensitive to all those co-morbidities and multiple factors. We are running a couple of projects to try to assess the resource impact and to ask what needs to be done differently, because although we can take each disease at a time and work out best practice or the indicators and measures of good performance and good management, if we put them together, the picture changes dramatically. As a provider of services, the questions are: what do we need to do differently and what resources are required? I do not think that anybody has cracked the problem of producing a formula that is sensitive to that demand, which is so evident in Glasgow.

That is not a particularly confident answer, but you have identified one of the things that will continue to exercise us under the current arrangements and with the new contract.

The Convener: There was concern elsewhere in Scotland about the operation of the Arbuthnott formula which, if it had been introduced into primary care, would have led to a significant shift in resources in the direction of Glasgow. Given that we are moving from a non-cash-limited to a cash-limited approach, could Glasgow lose out again because of unrecorded morbidity?

Ian Reid: Unmet need has been exercising Greater Glasgow NHS Board for some time. The chair of the board—Sir John Arbuthnott himself—is, of course, remarkably familiar with the matter. One of the issues that we have in Glasgow is how we can redirect some of the existing resources towards local need, but the issue of unmet need is one to which we will need to return as the allocation formula is implemented.

The Convener: Do your discussions with the Scottish Executive convince you that there will be sufficient flexibility from the Executive in examining allocations to ensure that Glasgow, and perhaps other health boards with unrecorded morbidity, are not disadvantaged by the imposition of a cash-limited scheme?

Ian Reid: We have had relatively positive discussions with the Executive on the issue of unmet need. The matter has not been resolved, but the door is open to further discussions.

The Convener: I have a question on prescribing. When I was a member of the then Greater Glasgow Health Board, before I joined this place, prescribing levels were 30 to 40 per cent lower than they are now, which is a result of increased access to new drugs, particularly in cardiology and cancer. What will be the impact of the contract on prescribing practice? Is there a funding issue?

Ian Reid: In Glasgow, we feel to some extent that we have been victims of our own success, because through the chronic disease management programme we have been tackling some of the illnesses and diseases to which you referred, and that has put considerable pressure on our prescribing budget. We have introduced a medicines management regime, which looks to more effective prescribing. We have much better data on that now than we ever had in the past. However, given that the contract encourages further moves towards better management of particular diseases, that could put additional pressure on our prescribing budget. We would like to see how quality indicators and prevalence factors begin to play into that to see whether there is any way in which we can further incentivise prescribing practice. Douglas Griffin does most of our work in that area. He may wish to comment.

Douglas Griffin: The question pinpoints a key area where there is a risk of significant growth in expenditure. In a sense, it is impossible to predict the exact rate at which prescribing might grow, but we expect that the rate of growth will not exceed what we have experienced over the past few years. Prescribing has been a difficult issue for us to manage financially, and it will continue to be so. However, it is one of a number of on-going risks that we face. Because of its scale, prescribing is a significant area of risk, but we are aware of the issue and we will have to take it into account in our future planning.

The Convener: Will the change in the financial pressures on practices, in particular the need to try to meet the quality indicators, have an impact on the way in which prescribing operates? Might there also be an impact on some of the testing and laboratory work issues? Have you modelled that?

Douglas Griffin: No. It is difficult to do that and to look across the 218 different practices in Glasgow, which are all at different stages. We have a team of prescribing advisers who keep an eye on the rate of change in prescribing practice for individual practices and for groups of practices. The team engages with practices about where they are relative to the standards that we would expect, but we have not modelled a prediction of how the contract will impact on that. It is difficult to be precise about that.

Ian Reid: I do not know that the GMS contract will necessarily drive that. With the redesign of services and the moving of some diagnostics and so on into more community-based settings, we could see within the city some transfer of resource from what is currently invested in acute services. The contract will help in doing that, but I am not

sure that it will necessarily be the driver. The issue is more about where activity takes place.

Terry Findlay: I think that we will treat the contract like the introduction of a new guideline. In other words, we will make a prediction. What Douglas Griffin has described is the fact that predictions are often not that accurate because of the sometimes idiosyncratic nature of prescribing. However, many other factors will come into play in the increased cost, not least of which are the international issues and national issues. Although we can make a prediction on prescribing, I would not like to say that that will be the end of the story.

Douglas Griffin: I might add that, in areas such as heart disease and diabetes that are directly targeted by the GMS contract, we have a feel locally for what the rate of growth in expenditure is likely to be because we have tracked the expenditure for a number of years. Indeed, when we engage with our colleagues within greater Glasgow to seek an appropriate allocation of resources to cover that expenditure on a year-by-year basis, we build in those detailed projections. We will just have to be very sensitive to developments as they unfold. Following the introduction of the contract, we will need to see whether there is any further change in the trends that we have experienced to date. We will need to engage with our colleagues on the board to address those issues.

The Convener: There are two issues there: financial management and the spreading of best practice. In a sense, the board will need to do both those things.

We have heard from the general practitioners about the importance of the MPIG. What is the trust's point of view on that? Will the MPIG reduce with time, as practices make better use of funding streams to maintain their previous funding level? Will the MPIG safety net gradually be able to be withdrawn from urban areas, or will it be with us for a long time because it is needed?

Ian Reid: Obviously, the MPIG is important to general practice because it maintains existing income levels. When the allocation formula was first run in Glasgow, it was found that more than 80 per cent or 90 per cent of practices would require the MPIG. Like all such safety nets, we will be able to convince general practitioners that they no longer require the safety net only at the appropriate point in time. The MPIG enables us to engage in a much more constructive dialogue with practices in a way that we were not able to do in the past. My view is that we need to retain the MPIG for as long as it is necessary and, like the allocation formula, keep the issue under review.

The Convener: Do members have any other questions?

Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP): I am sorry that I was a wee bit late. I was at the Audit Committee to discuss the costs of the Holyrood Parliament building and to try to get some money back to pay for some of these things.

I want to follow up a specific point about the minimum practice income guarantee. It seems to me that the convener's question should be put in the converse form: would not any possibility that the minimum practice income guarantee might be withdrawn be a severe deterrent and have an adverse effect on the capacity to recruit and retain GPs in practices that rely on the guarantee? It is pretty important that we say that the MPIG must remain for the foreseeable future. That must be written in tablets of stone; otherwise, it might be difficult to recruit for some areas.

Ian Reid: We must remember that the recruitment and retention of general practitioners was one of the principles behind the contract, so it will be important that we do not do anything that could affect that in the longer term.

Douglas Griffin: My general view is that, when a major change is being introduced and some of the implications of that change are uncertain, it is crucial to have something such as the MPIG that provides comfort and stability. As the convener said, it will come down to a matter of timing. In time, GP practices will perhaps get greater clarity about matters such as their earning streams and work-load capacity. GP practices would need to be comfortable about taking ownership of the withdrawal of the MPIG. I do not think that we could withdraw it except in partnership. Both sides would need to reach the conclusion that that was the appropriate way to go. In the short term, the MPIG provides stability and reassurance and so is important in bringing the new contract into life.

The Convener: In conclusion, from the tone of what has been said, I think that the trust sees the contract as a positive development. Do you want to highlight anything that is particularly beneficial or that causes particular concern?

Ian Reid: Our general sense is that the contract is positive and will enhance our ability to deliver more services within primary care. The fact that the contract removes the incentive from being directly dependent on the general practitioner will enable us to work with general practice to enable primary care services to be provided by a wider group of professional staff. In the longer term, that will provide better services to patients. Our only caveat is—as you would expect—about the associated funding. As with all allocations to NHS boards, the funding requires to be kept under review.

The Convener: Thank you very much for

coming along this morning to give us your evidence.

I suggest that the committee takes a break for five minutes while the witnesses from the Greater Glasgow Primary Care NHS Trust leave and the Executive witnesses come forward.

10:58

Meeting suspended.

11:03

On resuming—

The Convener: We will now hear from witnesses from the Executive. Lorna Clark is the bill team manager, Dr Hugh Whyte is the senior medical officer and David Notman is an economic adviser.

Do the witnesses want to say anything before we start?

Lorna Clark (Scottish Executive Health Department): Thank you for inviting us. We thought that it might be useful to go through each of the five main funding streams in the contract and to explain to the committee how we arrived at the overall figures that are listed in the costs summary.

The global sum equates to almost half the overall resources of the new contract. The money is guaranteed to practices; it will flow through the health boards, but they will have no powers to alter it. To arrive at the Scottish total for the global sum, we took the relevant fees and allowances that were paid out in 2001-02—the most recent year for which we have full data—and we uprated them by 3.225 per cent for 2002-03 and by the same amount for 2003-04. We then uplifted that total by 1.47 per cent, which was the figure that was agreed at United Kingdom level, to arrive at the overall Scottish pot for the global sum for 2004-05. That is a fixed pot of money that we cannot overspend.

The money under the global sum is paid out to practices using the Scottish allocation formula and it pays for the essential and additional services that practices provide. The fact that that money is paid out under the Scottish allocation formula means that the money going into practices is based on assessment of the needs of patients and, therefore, the consequent likely work load for practices.

The pot of money for the quality framework accounts for about 18 per cent of the overall budget, but it accounts for about two thirds of the new investment. Most of the new investment will go towards the quality framework. As far as we are aware, this is the first time that a large health care system in any country has systematically and explicitly linked practice reward to the quality of care delivered to patients.

The funds allocated to quality start off reasonably low, at £8 million in the current year. That is part of the money that will help practices to prepare for the new framework and the new ways of working. The amount that will go into quality will increase quite quickly during the next two years, partly because the amount of money that a quality point is worth will increase from £75 in the first year to £120 in the second year, and partly because it will take time for practices to get used to the new ways of working and to start to make their way up the quality ladder.

The funds that we have put in for the quality line for 2004-05 and 2005-06 are based on an estimate that 90 per cent of practices will achieve 90 per cent of the number of points. Given that we are introducing a different system with new ways of working, our estimate is probably generous and we do not imagine that there is a huge risk that it will be exceeded. I note that the Scottish General Practitioners Committee agreed in its written evidence that that was a fair assessment of the risk.

The money that will go into the enhanced services makes up about 8 per cent of the overall income. The enhanced services are provided over and above standard services and take place around the interface between primary and secondary care. Unlike the global sum payments, the enhanced services payments go directly to NHS boards and it is up to them to decide how to spend that money.

In order to reach the amount of money for enhanced services, we took the money that is currently spent on services that will be recategorised as enhanced services—such as the influenza immunisation—and put in an additional substantial pot of money for new investment and to fund new services. That money is not guaranteed to practices; it is guaranteed to boards. Boards will have discretion as to how they want to spend the money. It might be that, for some enhanced services, boards will decide that they want to contract every practice in their area to provide those services. However, other enhanced services might require more specialised treatment or more specialised equipment or premises, or boards might decide that they want to contract a smaller number because they think that that is a better way to meet patient need.

In order to help bed down the new ways of working, we have set a minimum floor for enhanced services above which all boards must spend. If they wish to, they can spend more out of the unified budget, but they will not be allowed to spend less. The amount that each board receives under the enhanced services will be determined

by the Scottish allocation formula to reflect the overall patient need in the board's area and the accompanying work load for primary medical services.

Health-board administered funding accounts for about 21 per cent of the overall budget, most of which goes towards premises and IT. To arrive at the allocation for that line, we uprated the existing fees and allowances for other elements such as seniority, superannuation, paternity and maternity leave and we put in a substantial amount of new investment, most of which will go on premises and IT. The intention is that the board-administered funds will be allocated to boards using the Scottish allocation formula.

The final 4 per cent of the overall budget goes towards the minimum practice income guarantee—the MPIG. The financial and practice-based data that we have have allowed us to do detailed modelling on how practices in Scotland will fare in comparison between their existing fees and allowances and the new global sum. The detailed modelling work at practice level was built up to give us a Scottish figure that is robust and reliable.

There has been some discussion this morning about whether the MPIG is permanent: the principle of the MPIG is permanent. We agree with the SGPC that, although the new formula has redistributive effects, we need to protect the viability of existing practices. However, the formula will be reviewed and may be changed. When the formula is reviewed, practices that currently receive the MPIG will need to be reconsidered to see whether the revisions and improvements to the formula have increased their existing fees and allowances to the point at which they no longer need the MPIG. We agree with the SGPC that the MPIG is vital to maintaining the financial viability of practices.

The new contract is accompanied by an unprecedented 33 per cent increase in funding for primary medical services. The amount of money that goes into primary care will increase by £142 million by 2005-06. The additional resources for primary medical services are guaranteed and were given to us as part of the spending review. It is new money: it is not money that we have taken from anywhere else in the budget. The gross investment guarantee that we agreed as part of the contract negotiations guarantees that the new investment will go to primary medical services to help to fund the duties that are set out in the bill.

The Convener: Thank you—that is quite a lot of information to take on board. It would be useful if the committee could get some of the detail of it on paper to help us in preparing our report. We would need that information quickly, as we must soon complete our consideration of the bill.

Lorna Clark: I can send that information to you when I get back to my office. You will have it today or first thing tomorrow.

The Convener: That will be very useful.

How did you arrive at the figure of £8 million to be set aside for practices for assessment?

Lorna Clark: David Notman can provide the details. The figure was based on an average practice's receiving around £9,000. It is important to note that that is not the only money that is being allocated to practices this year to help them to prepare for the quality framework. We are introducing one of the directed enhanced services this year and practices will receive an additional amount of money as quality preparation payments. That money will help them to undertake work to ensure that their lists are clean and in a fit state to allow them to implement the quality framework. The £8 million is part of the package, but it is not the full package that is being provided to help practices.

The Convener: On the change from non-limited cash funding to limited cash funding, what consideration has been given to the impact on funding of potential flaws in the data, such as under-representation of practices that experience severe and multiple morbidity? That issue has concerned you for some time.

Lorna Clark: David Notman may want to speak about the formula.

David Notman (Scottish Executive Health Department): The formula will be subject to review. The basic principle is the use of an evidence base to inform relative patient need. The formula tries to inform not absolute resources, but relative resources. Where possible, we are using evidence that is available in Scotland; hence, there is a difference between the Carr-Hill formula and the Scottish formula, which is based principally on age, sex, deprivation and the remote rural areas adjustment. In the case of the remote rural areas adjustment, there is clearly a link between additional cost in remote rural areas and GP work load. We have, as far as possible, tried to use an evidence base for that adjustment. The expectation is that, in review, as epidemiological evidence comes on stream from the quality and outcomes framework, we will be able to fill in the gaps in later years.

The Convener: However, in the context of the roll out of the Arbuthnott review, you acknowledged that there were flaws in data availability—especially in relation to the extent throughout Scotland of the general practice assessment survey system, from which you are gathering information—and that there are issues about the broadly representative nature of practices in the sample. Might potential problems

in your financial planning arise from the data that are available to you?

11:15

David Notman: The formula is based on population registered lists. That information is complete and is collected through the fees and allowances payments system. We then make a series of adjustments. The age and sex adjustment is based on information from the continuous morbidity recording practices, of which there are between 70 and 80 in Scotland. That is a statistically representative sample of Scottish practices; therefore, we are quite confident about those data.

The Convener: I thought that there were concerns about whether those data were accurate and representative.

David Notman: When the Arbuthnott GMS formula was devised, a steering group was set up to investigate such issues. Some statistical work was carried out and it was found that the continuous morbidity recording practices were statistically representative of Scotland.

The deprivation adjustment uses independent evidence such as the unemployment rate, the level of income support claimed among the elderly, two or more indicators of household deprivation in the census and the standardised mortality rate for people below the age of 65. Those data are all collected independently by such organisations as the Office of National Statistics and the Department for Work and Pensions; therefore, we can be confident about them.

The adjustment for remote and rural areas is based on population density and sparsity as well as on rural practice payments. Those are extra data that go into the Scottish formula because we had difficulties in accommodating the rural practices in Scotland.

Other elements of the formula, such as new registrations, come straight from GP payments data. We are also hoping to collect information on nursing and residential home payments through the community health index, and market forces will provide fairly standard data on staff costs.

The Convener: The evidence that we took from the general practitioners revealed that the contract will allow improvements in services. One of our witnesses raised issues about increasing the quality of service in deprived areas where there is multiple morbidity: I would like to press you on that. If there has been under-recording of morbidity in the past, and if we are now moving to a system that is likely to facilitate better recording of multiple morbidity, will that affect the way in which your financial planning operates? Are you going to make sufficient resources available to deal with multiple morbidity in areas such as greater Glasgow?

David Notman: You are arguing that there should be an unmet need adjustment in the Scottish allocation formula.

The Convener: I am pressing you on that in the context of the move from unlimited cash funding to limited cash funding because I am anxious about the implications of that.

David Notman: The fundamental principle is that all allocation formulae should be based on evidence. At present, there is little evidence of unmet need in the data that we have. The Arbuthnott review of acute services and GP prescribing formulae has been investigating unmet need. Although I have not been privy to that, I understand that there is very little evidence of unmet need in the data. There is the possibility that there will be an unmet need adjustment, but we are not yet that far down the road on the GMS side. I am not disputing that there could be unmet need; I am just suggesting that, at present, there is in the data very little evidence of it.

Dr Hugh Whyte (Scottish Executive Health Department): We have to start from the principle that resource allocation was agreed at UK level regarding the way in which the contract was going to be developed. We felt that, although the system in Scotland was imperfect, we certainly had better and more comprehensive data that we could use in the distributive process. David Love of the SGPC correctly pointed out that if a practice suffers a vacancy, it loses a significant amount of revenue from which to provide services in its area. The global sum will ensure that the funding stays where the patients are and where the identified need is. We recognise that the data are not perfect; hence, we have made a commitment to review them continually. As better data become available, we will re-evaluate the formula. The quality and outcomes framework itself will be a rich source of data to inform the formula and resource distribution. At the moment, we are forced to use less-than-perfect data, but we are moving forward into a new era of data collection.

The Convener: David Notman's answer framed the problem. He said that there are insufficient data on unmet need. You seem to be saying that there probably is unmet need that has not been identified by the current systems of data capture. The way in which the contract works might throw up a considerable amount of unmet need, especially in the context of multiple morbidity. Has that been identified as potentially having an impact on the funding arrangements?

Dr Whyte: In terms of unmet need, in addition to the global sum, money will go into quality services

and there is also additional investment in wider NHS services to provide improved care to patients.

At the moment, unmet need is a difficult matter—we heard that from the Greater Glasgow Primary Care NHS Trust and David Notman. Only through collection of better information will we begin to get a handle on unmet need, bearing in mind that the resource allocation formula is a distributive formula for the resources that are made available through the Parliament, not a means of identifying how much resource should go into the system. The question is perhaps more to do with relative unmet need in Glasgow compared to the unmet need arising from rural deprivation. We do not know whether the distribution is correct, but we will become better informed. If we were to wait for perfect data, we would simply stick with what we have and do nothing about the problems that currently exist in areas such as recruitment and retention, morale and provision of general practice services throughout Scotland.

The Convener: I do not want to labour the point, but there is an issue about whether the work that has been done in the post-Arbuthnott period is sufficiently informing the way in which allocations are being arrived at.

John Swinburne: Are you quite comfortable that the checks and balances are sufficient to allow you to overcome problems that might arise in the future? Do you have confidence in the current system of data collection?

Dr Whyte: Yes. The data sources that we use for continuous morbidity recording, standardised mortality rates, census data, list sizes and so on are all externally validated and are robust. One of the limitations in relation to the driving principles of the formula is the requirement to find sources of evidence to inform the formula that are as comprehensive, accurate and robust as possible.

The Convener: Lorna Clark gave us a dense statement about the way in which you had arrived at the detail of the funding arrangements. Could you specify again what factors were considered in deciding where to allocate the additional funds in 2004-05 and 2005-06?

Lorna Clark: We considered what needed to be put into each of the elements. For example, on quality, we carried out an assessment of how much money we would need should 90 per cent of practices achieve 90 per cent of the points; we then assigned the required amount. We also examined existing funding sources, such as the money that goes into fees and allowances, and we uprated those.

We decided that substantial new investment was required as well. We put a lot of money into the quality framework and into premises and information technology. We considered what we had committed ourselves to doing within the terms of the contract, we examined the data that we had and we tried to estimate how much money would be needed adequately to fund what we are asking health boards and practices to do.

The Convener: You know that some things will change as a result of the system, which means that uncertainty is built into your data. Did you assess how much uncertainty there might be, or consider what might be the areas of major uncertainty as a result of the introduction of the system?

David Notman: On the global sum, we are identifying essential and additional services and using the fees and allowances as part of the global sum pot. The data set is comprehensive. As Lorna Clark suggested, the funding sources are uprated to take into account the future value of those fees and allowances. Some adjustments to that are part of the UK negotiations.

Other items, such as the associates allowance and assistance allowance, which fall within primary care trust board-administered funds, are much better managed from the centre. Unlike the global sum, which goes straight to a practice, PCT-administered funds go to health boards to be administered. Again, that money is taken from fees and allowances.

Some existing quality payments fall within the quality budget, but as Lorna Clark said, that is new money. We have also done a little bit of work on a risk matrix, to identify some of the related sensitivities. An awful lot of new money is going into enhanced services, but I remind the committee that an enhanced service floor applies. It is up to boards to decide whether to provide additional moneys.

The Convener: Why did you allocate the funding for seniority payments to boards, when it is arguable that such payments might be considered to be part of a GP's or GP practice's guaranteed income?

David Notman: We are trying to clarify that remuneration and allocation are different. The allocation formula takes a fixed pot and allocates to boards. How GPs are remunerated is another matter. Within the contract, different methods of remuneration, of which seniority is one, are available. That money is managed by the board. GP pay and patient needs assessment should be linked in some way. We are examining the PCT-administered line closely.

Fergus Ewing: I would like to discuss paragraphs 71 and 72 of the explanatory notes, which are on quality payments. I understand that

"The new contract will include an evidence-based quality and outcomes framework to reward practices on the basis of the quality of care delivered to patients."

That is the first sentence in paragraph 71. GPs will be paid in accordance with a regime of quality monitoring. We all want quality, which is welcome, and I notice that the British Medical Association welcomes the emphasis on quality. However, I would like to ask about points of principle that arise from using quality as a yardstick for assessing payment. How can any system, no matter how complicated and sophisticated it is, measure accurately the quality of care that GPs provide?

Dr Whyte: As Lorna Clark said, that measure is an innovative introduction into the contract. On the evidence about quality, we have been guided by a group of external experts. We have a range of indicators on the process of care; if the process of care is delivered, we know from research and published work that outcome improvements can be expected. The bulk of our monitoring and examination of quality indicators throughout the health service is aimed at ensuring that the process of care is as good as possible at delivering the care that we know should provide the expected clinical outcome. Often, the clinical outcome will occur two, three, four or five years down the track—for example, in the treatment of somebody who has high blood pressure, or if the cholesterol level of somebody who has heart disease is to be lowered. The indicators are not specifically of outcomes, but they have an evidence base in the process that delivers those outcomes.

Fergus Ewing: However, if GPs are to be paid in accordance with how good they are perceived to be—that is inevitably how the system will be seen to work, at least in some quarters—will that not introduce the possibility of a two-tier GP system, involving GPs who receive quality payments and those who do not? Might not that lead not me but some people or newspapers to conclude that there are good GPs, who receive quality payments, and bad GPs, who do not?

For what it is worth, my impression is that all the GPs in my constituency are widely respected, extremely hard working, overworked, often harassed, and doing an excellent job. It slightly sticks in my craw that GPs could be seen to be judged on the basis of an abstruse, arcane and sophisticated system of awarding them points up to a maximum of 1,050. Some people—I do not suggest that I am one of them—might see the Eurovision song contest as a comparison. However one might be able to justify that in theory, do we really want to go down that road?

11:30

Dr Whyte: Your question is fundamental to the working of the UK contract. Undoubtedly, the profession is keen to be involved in this area, as is the Executive. We see the delivery of high-quality primary care services as fundamental to the redesign of the NHS in Scotland.

Although the quality framework is not compulsory, I would be very surprised if any practices in Scotland do not participate in it. At present, we have extremely high levels of practice participation in areas such as practice accreditation and the quality practice awards. We do not expect practices to opt out of participation in the quality and outcomes framework. The nature of the change is that, because the contract is practice based, the local health board will want to have a dialogue with practices that do not participate in it about why they chose not to.

Fergus Ewing: What is the cost of administering the points system?

Dr Whyte: We have no information on that at the moment.

Fergus Ewing: If we are going to embark on this new future of rewarding quality, surely the Finance Committee should know how much the new regime will cost?

Dr Whyte: Substantial investment is already being made in processing payments through a rather large bureaucracy that administers the statement of fees and allowances—the red book, as it is called. I am referring to items such as service payments, deprivation payments and quality payments. Some of those systems will be modified and adapted. Although work is in hand to look at the resource implications of the new regime, at this stage we do not have information about what the new costs will be.

Fergus Ewing: What is the cost of the existing system? Will the new regime be more or less expensive to administer? I do not expect an immediate answer to the latter question, but I assume that you can tell me the cost of the existing regime.

Dr Whyte: We do not have that information to hand, but we can find it out.

Fergus Ewing: Perhaps we could also have a stab or a best guess at what the new system might cost. That would allow us to know what the financial implications are.

Dr Whyte: Work is in hand to develop a specification for the new system that is to be put in place. Until the specification is developed, information on the new system will not be available.

Fergus Ewing: My final substantive point is taken directly from the BMA submission in which the quality and outcomes framework is addressed. The submission says:

"the BMA is disappointed that this principle has not been applied to the childhood immunisation programme, where the current target system remains, particularly given the current lack of public confidence in the MMR triple vaccine. GPs will therefore continue to be penalised for patients taking decisions on the principle of informed dissent."

What is your response to that statement?

Dr Whyte: That is very much a policy decision of the Scottish Executive. You would have to address that question to the minister.

Fergus Ewing: Can you tell us what the additional cost would be?

Dr Whyte: I am sorry. Could you repeat the question?

Fergus Ewing: The BMA proposes that the childhood immunisation programme should be part of the new system. If that happens in the way that the BMA wishes, what would the cost implications be?

The Convener: I suppose that the point is whether the Executive has asked that question and, if so, are you able to answer it?

Dr Whyte: It is not a simple read across. We have a target system that says, "You have to achieve 90 per cent or higher to get the highest level of target payment for the measles, mumps and rubella immunisation and other childhood immunisations." If we were to move to a system of informed dissent, the payments might not change substantially. If we allowed informed dissent to contribute towards the target, all practices would achieve the 90 per cent higher level. The additional cost would be made up of the difference between the current levels of uptake, which are over 90 per cent and the uptake of MMR. There would be an increase from about 84 to 90 per cent.

Fergus Ewing: I understand your point. If the BMA's proposal were to be incorporated into the contract, that would lead to more practices receiving a higher proportion of the total. However, that is a financial argument. The BMA is making the principled argument that if there is to be a system that rewards quality of care and outcomes and if patients decide through a process of informed dissent that, for example, they do not wish their children to have the MMR vaccine, that is no real fault of the GP. No doubt the GP will give appropriate advice, but why should a GP be penalised financially for something that quite demonstrably is not their fault?

Dr Whyte: The decision on MMR is one of public health policy. The question would have to be put to the minister.

Ms Wendy Alexander (Paisley North) (Lab): I want to pursue the issue of quality payments. My question was going to be a particularly obtuse one about the minutiae of the contract. I will get to that question, but Fergus Ewing, in his inimitable style, has quite rightly elevated the debate to one on an issue of principle.

Funding for GPs, along with so much else in the public services, was hitherto input, not outcome, based. The quality payment is an attempt in part to reflect outcomes. As is always the case, the challenge is how to raise performance without penalising patients.

On reading paragraph 72 and other parts of the explanatory notes, it is encouraging to see that the Executive has moved forward through the use of peer review or experts in the field. I understand that quality payments will be based on quality indicators that will intimately be linked to the prevalence factors of certain diseases, which GPs will have to record in disease registers. When assessing the prevalence factors, who will decide which medical conditions are to be used?

Dr Whyte: The clinical indicators were informed by national, UK-wide policies and by the expert advisers. The contract recognises that, in common with the allocation formula, the indicators will have to be maintained and reviewed in the light of the criteria on which they are based and in respect of new treatments, interventions or clinical conditions that might be introduced. Although the detail is not finalised, there is a recognition that some form of independent expert advisory forum will be required to keep the quality framework under review and updated.

Ms Alexander: Notwithstanding my commitment to measuring outcomes, I observe that that is a courageous step. However, it remains the case that telling me to lower my cholesterol levels might be more successful than would telling some of my constituents to do so. No doubt the Executive will want to review whether the quality indicators or disease registers, as distinct from other socio-economic factors, will reflect the capacity of GPs to influence those outcomes.

I return to the overall objectives. There are a lot of detailed papers that give us the minutiae of how, because Scottish statistics are better, our data differ from those in the rest of the UK. I want to ask a more fundamental question about how the issue will be approached in Scotland and how that will differ from the rest of the UK.

It is clear from the contract, as it will be operationalised in Scotland, that 49 or 50 per cent of the funding will go on the global sum payments, just under 20 per cent will go on quality payments, 20 per cent will be retained by the health board, and the residual 10 per cent will go on the other

two elements. In other words, 50 per cent is the patient allocation, 20 per cent is held on to by the health board, and 20 per cent goes on quality. Does that differ from the rest of the UK? Is the contract so tightly drawn that it will be broadly the same across the UK?

Dr Whyte: Yes.

Kate Maclean: I would like to ask a couple of questions about the mechanisms for ensuring that services are delivered in all areas. If practices had to opt out, for some reason, from providing additional services, or if they chose not to offer enhanced services such as contraceptive advice, how would those services be delivered? Would trusts and boards be able to enter into service level agreements with other providers that provide those services, such as local government or other organisations? If no organisations provide those services in an area, how will you be able to ensure that they are provided?

Lorna Clark: Proposed new section 2C places an overarching duty on health boards to provide primary medical services. It is expected that GP practices will provide essential services and the vast majority of additional services. However, as you said, GPs are able to opt out of providing additional services, and to opt into—or not to opt into—providing enhanced services.

The overarching duty to make sure that those services are available rests with the health board. For example, where practices in an area decide that they do not want to provide contraceptive services, the board would have a number of choices. It could examine whether other practices in the area want to provide the service, it could determine whether it wants to provide the service itself by employing staff directly to provide it, or it could examine whether other agencies or bodies in the area are interested in providing the service. If GPs say that they do not want to provide additional services, the health board has a range of options for providing them, but the overall responsibility for ensuring that the services are available to patients rests with the health board.

Kate Maclean: I suppose that I am trying to get an answer to the following question. If a couple of GP practices in an area decide that they are not going to provide a certain service for which other facilities in the area already exist, will the health board make a conscious effort to ensure that funding follows patients who use the service? For example, a contraceptive advisory clinic that is run by a charity or voluntary organisation might suddenly get lots more people going to it because GP practices have stopped providing that service. Will that clinic be able to ask for the money or will it just be the clinic's tough luck because the situation is hard to measure or monitor?

Lorna Clark: If practices opt out of additional services, they have to give back part of the global sum. The health board then has a pot of money that it can use to decide how it will reprovision its services. To use the example that you gave, if an agency in an area already provides contraceptive services, the health board could say to it, "We would like you to provide care for these patients. Here is an additional pot of money with which to do it."

Jeremy Purvis: I have a question about risk, which follows up on the quality payments. If one takes the view that making quality payments direct to the practices will affect the quality of the care or services that they deliver—given that there is an opt-in for those services—and the board's funding for enhanced services will shape the delivery of those services in the board area, we will see finance being used to shape the services that patients receive. There is an inherent risk, which you say is minimal.

On the associated risk, both the BMA and Greater Glasgow Primary Care NHS Trust in their submissions raised questions about whether your estimates for the quality payments will be reached. The BMA does not think that they will be reached, and Greater Glasgow Primary Care NHS Trust wants to know what contingencies exist should the payments be exceeded. Given that you stressed that the overall total will remain the same, what possible impact will there be and which areas in the summary of costs will be affected if the payments are exceeded or if there is an underspend? That question also applies to the MPIG. We heard earlier that there is a feeling that it will carry on for the foreseeable future, but you have just told us that it will be reviewed. That will have an implication for the costs, but what impact will it have on your risk analysis?

11:45

Lorna Clark: I will deal with the MPIG question and let one of my colleagues deal with your other question. The amount of money in the MPIG is set for the financial period listed. The idea is that we will review the formula from October next year. When we get to the end of the period of the negotiated agreement, we will need to reconsider which practices still need the MPIG once the formula has been changed. There should not be any change in the three years of the contract covered by the financial memorandum. What happens after that will be the subject of further negotiations with the SGPC.

Dr Whyte: In the unlikely event of more than 90 per cent of practices gaining more than 90 per cent of the available quality points, as part of the overall part 1 funding to boards, there would be an issue around how boards would manage risk

locally. We have not envisaged that scenario, but given the nature of the new funding streams, it would come within what we know as the unified budget and therefore would be contingent on that. The only caveat is that given the introduction of the prevalence adjustment, which we can make only late in the financial year, we will be looking to manage centrally the overall distribution and outcomes of framework payments. In that sense, we will be considering national risk rather than individual local risk. The prevalence adjustment is predicated on our knowing the national prevalence, which we can know only after collecting all the data.

Jeremy Purvis: Am I right to assume that you will have the data after the end of the agreed contract?

Dr Whyte: Discussions are taking place about exactly how and when the data for the first year's prevalence adjustment will be captured, collated, analysed and used to inform the final payments for the financial year 2004-05.

Dr Murray: How were the out-of-hours development fund totals calculated? Obviously, responsibility for providing those services has transferred from GPs to health boards. Greater Glasgow NHS Board has expressed concern that if GPs decide to opt out of that provision, it might have to offer other enhancements or arrangements for out-of-hours services. I would like reassurance about the sums of money that have been allocated.

David Notman: On the money front, the sums against an out-of-hours development fund for 2003-04 and 2004-05 will follow the uplifts for the cash limited spending review—GMS cash limited allocations. For 2005-06, the sum will be set at £3,000 per GP principal.

Dr Murray: Are you confident that that will be adequate, should boards have to make alternative arrangements? Does it reflect the variation in the use of out-of-hours services in different parts of the country?

Dr Whyte: There are two elements to the funding that is available. For practices that choose to transfer responsibility for out-of-hours services, there is a UK figure for a percentage of their global sum that they will forfeit, which will be roughly £7,000 per GP in Scotland. In addition, the money that is identified separately is a significant increase in the current levels of out-of-hours funding that goes into the system to support what we recognise as out-of-hours services. In some areas that includes co-operatives or extended rotas, and in other areas it includes commercial services. That totality of resource, in addition to what boards already contribute, will be subject to redeployment.

We will see a significant redesign of how some of those services are provided. A wider range of professionals will be deployed, but there will be recognition of the fact that a patient who needs to see a doctor must still be able to do so. Much of the work that has been done, such as the introduction of NHS 24 and the work of GP services throughout Scotland and the UK, has told us that only a relatively small proportion of patients who need advice, reassurance and help actually need to see a doctor. One of the challenges for local health systems will involve the deployment of GP services, accident and emergency services and ambulance services, which will be supported by other agencies, such as NHS 24.

Lorna Clark: I have a more general point about out-of-hours services. We acknowledge that the proposal represents a major change and a significant amount of work is going on around Scotland to help boards, trusts and GPs to come to terms with that change. A national working group, which brings together all interested parties, including the Scottish Executive, boards and trusts, the GP co-ops, the Scottish Ambulance Service and NHS 24, has been set up and has met a few times. A great deal of work is going on nationally to help to support boards to share best practice and to do some modelling work. The 15 individual health boards will not be left to sort out matters on their own. We are providing a lot of support to help them through the process.

The Convener: The cost of providing out-of-hours services will vary in different parts of the country, depending on the availability of someone to provide such services, if GPs in certain parts of Scotland do not provide them. If, for example, the practice on Islay decided that it would not provide an out-of-hours service, the cost to Argyll and Clyde NHS Board of providing such a service would be significantly higher than if a practice in central Glasgow opted out of providing the service. Have any mechanisms been built in for exceptional circumstances in rural areas, for example, where the cost to the relevant health board that might arise from a GP opt-out might be particularly high?

Dr Whyte: The existing distribution of fees and allowances in some of the out-of-hours development fund is weighted towards remote and rural factors. That element is already there.

In some cases, there might also be significant redeployment from other schemes, such as the assistance and associates scheme. For example, additional support doctors have often been supplied in fairly small practices in which three doctors would not be required by any stretch of the imagination. To help to alleviate the pressure on out-of-hours services, two or three doctors will provide that care to a population of 800 to 1,000.

There is scope for redeployment and redesign within the system. We will not have to look at the funding streams specifically. As Lorna Clark said,

we are considering the creation and development of models that boards will be able to fashion to suit local circumstances. A great deal of thinking is under way on what is a fundamental strand of the contract that relates not just to how patients will receive their services but to the maintenance of recruitment in remote and rural areas of Scotland and the continued provision of such services.

Mr Brocklebank: I share Wendy Alexander's concern that we might be in danger of being overwhelmed by the minutiae that the bill presents us with. I am sure that no member would deny GPs adequate remuneration or contest that the morale of GPs is at an all-time low. However, the morale of patients is also at an all-time low. Although, as I understand it, more money per capita is invested in health in Scotland than in any other country in Europe, we are discussing yet more public investment in health. The nature of health means that there is no end to the amount of money that can be thrown at it. How confident are you that the implementation of the bill will bring to health care in Scotland tangible and quantifiable benefits that we can all see?

Dr Whyte: I am confident that there will be a significant improvement in the quality of care provided through the measures that are being introduced in the quality and outcomes framework. All the measures are evidence based and in every case we know whether we can deliver the care, although we accept that patients will have a choice. That is one of the reasons why there is a range of exception reports in the quality and outcomes framework. Ours is not a dogmatic society and we must engage with the public and patients to encourage them to participate in their health care.

If we can achieve the level of care that is outlined in the quality and outcomes framework and in the additional services category, I have no doubt that there will be an improvement in the health of the patients of Scotland. In addition, for the first time patients will have a specific say in what their doctor is remunerated for through the patient experience survey that forms part of the quality and outcomes framework. To show that we are committed to engaging with patients, various patient representative groups are involved with the implementation programme for the out-of-hours and quality frameworks. That is a fundamental aspect of implementing the contract in a meaningful way that takes the public and patients with us as opposed to imposing something upon them.

Mr Brocklebank: Perhaps this is an unfair question, but can you indicate the time frame in which we, the public, can start to recognise the improvements that you claim to be confident we will achieve?

Dr Whyte: We know from work that is being done on the enhanced access initiative and from some of the work that, rather than wait for five years after making a change to the process, we have already done on practice accreditation that we should see some improvements in clinical outcomes within 18 months to two years, and certainly by the end of three years. I will not bore you with the progression of epidemiology to explain why that should be, but if we change a process today, it does not take five years before it kicks in for everybody. There is a lead-in phase during which patients benefit from day one. Usually it takes between two and three years for a programme of structured care to deliver measurable improvements in clinical outcomes.

Mr Brocklebank: If that does not happen, will you come back in two years and explain why?

The Convener: The matter will not return to us—it will be a matter for the Health Committee.

Mr Jim Mather (Highlands and Islands) (SNP): I am interested to know more about the consultation that took place at a macro level to put together the financial memorandum. What pockets of resistance and concerns were expressed in that process? Were views uniform throughout the country?

Lorna Clark: The bill is slightly unusual in that it is the result of a negotiated and balloted agreement between the profession and the Executive. Therefore, the consultation process has been different. We had two years of discussions between the four health departments, the SGPC and the NHS Confederation in Scotland. Those discussions led to the GPs being balloted twice on the acceptability and detail of the contract. As this is a negotiated agreement, the ballots formed the bulk of the consultation. Work is continuing to consult a wider range of people on the implementation of the contract, but the detail and the figures in the contract were negotiated between us and the SGPC.

Mr Mather: Have you identified any pattern in the ballot that highlights a geographical concern or other issues that should be addressed?

Lorna Clark: No. The SGPC took a firm decision that it was to be a UK contract and therefore the ballot yielded a UK result. You would have to speak to the SGPC for further details, but as far as I understand it, there is a UK result with no further geographical detail.

Mr Mather: Ted Brocklebank spoke earlier about targets. We have a massive list of criteria to follow when examining what is happening in GP practice. Given the greater spending that occurs now, is there a clear statement on macro-level targets, expressed in terms of outcomes such as life expectancy, impact on doctors and impact on

recruitment? Are there targets to measure performance in the years to come?

Dr Whyte: We might well measure performance at some future date by repeating the surveys on the profession that were undertaken before discussions on the contract began to find out whether there have been improvements in morale, recruitment to and retention in general practice. We have to consider the different components. That was a clear driver; after all, we will not know until the contract has been put in place and has been working for a few years whether it has delivered the success expected by all parties to the negotiations. I have already mentioned the quality and outcomes clinical components that we expect to receive from the clinical framework. The accountability and performance management processes will let us know just how well we are delivering enhanced services and the redesign of the service that forms part of the enhanced services component of the contract.

Mr Mather: Nevertheless, the Executive will be in the position of wanting feedback to be confident that you are on track and that such a complex operation is working well. Would it not make some sense to have tangible measurements that indicate whether implementation has been successful?

Dr Whyte: We will know in some detail which areas are improving clinically and boards' financial reports will tell us exactly where the money for enhanced services is going. At a macro level, we will need to monitor that we are paying in proportion to the costs outlined in the financial memorandum, such as global sum payments, quality payments, costs for enhanced primary care services and PCT administered funds. As a result, the contract should be monitored at quite a few levels.

Mr Mather: Will there be a mechanism to audit data from GP practices?

Dr Whyte: Yes.

Mr Mather: Will you give us a few words about how such a mechanism will work?

Dr Whyte: As the document points out, the mechanism will be high trust and low bureaucracy. Much of it will be driven by the IT system's requirements in terms of validated and auditable records of the clinical outcome areas that are being delivered and the number of points that have been achieved. Those records will then be subject to IT audit trails. There will also be a review system, because the contract requires that an annual review take place involving the practice and the board on quality aspirations and exactly which enhanced services will be provided. The system contains a mechanism that allows for some form of reporting on or review of individual practices that might become more frequent if there are areas of concern. However, if things are going well, the practice might move into more of a rolling-contract arrangement.

Mr Mather: Finally, is there any mechanism for imposing penalties on those who do not provide data or who provide lax, inaccurate or even false data?

Dr Whyte: There certainly is a mechanism as far as providing false data is concerned, because that is a criminal activity. However, any such mechanism that you are referring to will form part of in-year contract monitoring. Unlike the current arrangements, which take the form of an agreement between ministers and individual doctors, the contract document will be an active one that both parties will revisit year on year. The specific arrangements will be a mixture of audit processes such as sampling and visiting. However, the details are being discussed in one of the implementation groups that we have mentioned and which have been set up to examine the introduction and implementation of the financial arrangements that will be specific to Scotland.

Fergus Ewing: Although the bill has 16 pages of explanatory notes, only two parts mention remote and rural practices: paragraph 93 on page 15 and the table on page 15, which shows that the existing expenditure on that category is £1 million. That is £2 out of every £1,000, which is obviously a minute amount. However, that might be down to how the term "remote and rural" is defined.

I understand that the BMA has expressed concerns about how remote and rural practices will operate under the new MPIG arrangements. For example, it says that the degree to which the aims of high-quality services will be achieved will depend on

"the willingness of the Health Boards to offer attractive packages to their existing GPs to retain them and to recruit new applicants for unfilled vacancies."

Paragraph 81 of the explanatory notes, which is headed "Health Board administered funds", states:

"Health Boards will receive a further allocation from the Executive to cover the following: premises, IT, seniority payments, recruitment and retention"

and other things. Paragraph 82 provides a breakdown of expenditure on premises and information technology and so on. I may have misread the notes—in which case, mea culpa—but as far as I can see, there is no breakdown covering recruitment and retention. There has been a huge problem of recruitment and retention in the Highlands and Islands. Helmsdale is a cause, if not particularly célèbre. I believe that even in Laggan, which could be described as a central remote rural part, only one or two people

applied for a post that became vacant not so long ago, whereas 10 or 15 applicants would have been expected previously. It is a serious problem, to which there are no simple answers.

The Highland NHS Board is doing a great job—I hope we will get to hear about that at some stage—but there does not seem to be any ring-fenced element to the funding, which would help to address the problem. With reference to paragraph 81 of the explanatory notes, is there a specific calculation of the amount to be added for recruitment and retention?

12:00

Dr Whyte: No specific funding for recruitment and retention is identified within the allocation. The £1 million figure that members will notice is comprised largely of expenditure on recruitment and retention. That is weighted for remote and rural practices, so there is a greater incentive to recruit and retain in those areas.

The answer to Fergus Ewing's question is that the contract will have to deliver by improving recruitment and retention. A key element of that has to be the facility to transfer responsibility for out-of-hours care. We know from a large number of surveys that that is the single biggest determinant of the disincentive to work in remote and rural areas. The profession is changing, and the expectations of younger doctors are different now. We need to deliver on an ability to transfer responsibility, which I think is the crux of the question. The whole contract has been designed in such a way that working in areas where it is difficult to recruit—in remote and rural areas and in areas of urban deprivation—will become more attractive and those areas will become more amenable to improved recruitment and retention.

Fergus Ewing: I absolutely agree about the role of out-of-hours care, which is in effect the responsibility of a one-man band, 24 hours a day and 365 days a year. That is a huge responsibility, and perhaps a deterrent to recruitment and retention. Although I entirely accept that, I do not understand why, although you say in paragraph 81 that health boards will receive extra cash, you are unable to state what extra cash they will receive. Has there been no estimate or provision? How can you explain the fact that estimates have been made for IT and premises but not for recruitment and retention?

Dr Whyte: There is as yet unallocated funding that is part of the current support to inducement practices. We are in a dialogue with the SGPC and rural practice associations as to how we can most effectively deploy the resource in those areas where remoteness is the biggest problem. We have about 80 inducement practices, some of which are now quite large. We suspect that some of those practices will do well under the new contract arrangements. Others will require to be supported. We are in discussion with other groups as to how the resource that is available at the moment can be most effectively deployed. David Notman might have the figures.

David Notman: About £5 million that currently forms part of the inducement top-up falls within the PCT-administered line in 2004-05 and 2005-06. Our intention, on an allocation basis, would be that it would be £5 million less than the numbers that members have in front of them. That £5 million is in effect inducement practice money, which should be returned to the inducement practices. It is the method of doing that fairly that has been subject to discussion. It is work in progress.

Fergus Ewing: I am not sure that I entirely understand that answer, but let me move on.

You say that you are in further discussions. That is welcome. Will those discussions include discussions with the remote and rural GPs and the health boards in the areas in which those GPs practise?

Dr Whyte: Yes.

The Convener: Before concluding, I want to ask a question about paragraph 88, which states that £25 million has been set aside for MPIG both for 2004-05 and for 2005-06. Will inflation be taken into account in those two years and subsequently? Will an inflationary adjustment be built into MPIG?

David Notman: Essentially, the "Global sum payments" on line 3 and the "MPIG adjustment" should equate to the global financial sum for practices. In effect, that sum is being held constant for the period up to 2005-06. I do not think that any decision has been made on what should happen to global sum payments and the MPIG subsequently. The reason why the MPIG is fixed is that the global sum is fixed. That is because, in effect, the global sum equivalent is fixed at the end of financial year 2003-04.

The Convener: Will that sum be reviewed in the context of how the MPIG turns out? Can I take it that you have not set yourselves against the idea of inflationary adjustments once the need for such adjustments has been identified?

David Notman *indicated agreement*.

The Convener: On behalf of the committee, I thank you for responding to our questions. We have a tight time scale within which to turn round our report to the lead committee on the bill. I think that you will give evidence to that committee next week, so you will have to return to these issues. Thank you.

Children in Poverty

12:08

The Convener: Agenda item 4 is consideration of the Executive's response to our "Report on Cross-Cutting Expenditure in relation to Children in Poverty". As members will recall, the work on the report was carried out by our predecessor committee, which presented a draft report for us to adopt and publish. The Executive has now issued a response.

Arthur Midwinter, who was involved in the research that was associated with the review, has read the Executive's response and prepared a paper for us. When he has arranged his papers, perhaps he can speak briefly to us about that.

Professor Arthur Midwinter (Adviser): I was not the lead adviser on the report but became involved late in the day to strengthen the rigour of the arguments in the document—that was how it was put to me. I was involved very early on in doing some of the background work and in briefing the reporters group on the questions that they should ask of ministers—including Des McNulty, as he will remember. Therefore, when the response came in, it was passed to me to have a look at on behalf of the predecessor committee.

For those who are new to the committee, the first thing that I should say is that the Executive's approach to tackling the problem of children in poverty is ambitious. The definitions that are used are very wide. The aim is not just to tackle poverty in the absolute sense but to tackle poverty and inequality over a range of indicators, such as education and health.

I am content with most of the Executive's response. On the whole, I found that the dozen or so points in which the Executive responded were constructive and positive. The response has certainly taken time—it is now running late—but I want to thank publicly the corporate team that worked on the response for the effort that it has put in. However, I will concentrate my comments on the problems that I see in the responses. The committee can then decide whether it wishes to take the issue any further. I will make comments about recommendations 1, 2 and 4. If members have any other queries, they can raise them with me.

12:15

There is a particular problem with the response to recommendation 1, which I regard as a wholly inadequate response. That stems from my concerns about the poverty indicator. I was very surprised to see the Executive respond that the indicator used for measuring poverty is not robust—I do not know whether Wendy Alexander was involved in the selection of the indicators, but she could perhaps comment later—so I went back to the original source document. We told the Executive that we were happy that it was making progress in reducing poverty in absolute terms. However, the data that the Executive provided to us suggested that relative poverty, in terms of inequality, showed an initial improvement when the benefit system was changed but then stabilised. I quoted directly in my report what the Executive said in its report, which was that the poverty indicator

"has remained fairly constant since 1997-98."

Therefore, I found it surprising that the Executive said that the indicator is not robust and that we should not assume that it was correct. In my view, the same fact holds for probably five of the inequality milestones in the social justice document, which is that after initial progress there was a levelling out. Therefore, I was somewhat unhappy about that Executive response.

The Executive has set ambitious targets—for example, to eliminate poverty by 2020, or whenever. I suspect that we would all like that target to be achieved. However, my concern is that, given the current relative indicators, the Executive will not be able to do that. I think that the Executive ought to revisit the issue. Simply saying that the indicator is not statistically robust is not an adequate response.

My second comment is on the Executive's response to recommendation 2. The Executive's reworking of the relevant data will bring to the committee's attention some of the recurring problems with resource accounting and budgeting, of which members heard a glowing defence at the Dunkeld away day. I do not have an abstract mind and so have always found RAB problematic. I like to measure things that can be measured. In our exercise, we compared trends over two annual expenditure reviews. The first document that we considered was the "Investing in You" report. We discovered that there was a lengthy discussion of RAB in that report, but that RAB was not used until later in the same year, so the comparisons were invalid.

There have been four or five reports and I think that there are now four different accounting bases for RAB—from straight cash measurement to full RAB. That situation is about to change again, as the committee will hear next week when we discuss the draft budget. Such changes make it difficult to do any kind of time-series comparisons, which are fundamental to the kind of exercise in which we are involved. David McGill and I want to discuss with the Executive how we can get a time-series set of data that is consistent over four or five years.

The Executive has reworked the data in the light of the committee's particular concern about housing. We felt that the social justice budget was the one that was most central to the poverty agenda because almost all of it is targeted on low-income households. We were concerned about data in the annual reports that appeared to show that although there was an increase in housing expenditure in real terms, the increase was much lower than the average for the Scottish budget as a whole. However, I think that the committee should be reassured by the Executive's response. I would add only that, at the moment, there appears to be a fall in the expenditure in real terms in that it seems to be below the Scottish average for the next few years. However, the Executive's explanation is fine for the period about which we were concerned.

The problem is an accounting one that we keep coming up against. Neither David McGill nor I was involved when the first AERs came out. I spoke to the people who were involved at the time and they said that there was only one person in finance co-ordination who knew exactly what was happening with RAB. That is part of the problem.

Thirdly, I want to talk about the Executive's response to recommendation 4, which the committee touched on in the previous discussion. The issue is the Executive's notion that, when measuring outcomes, there is no need to know how the money arrived in the first place. Again, I feel that that is an inadequate response. What we said—which I think Des McNulty will remember from the question sessions when he was on the other side of the argument—was that the committee could not be sure that, in the major spending programmes, money was getting through to the targets for children in poverty.

The response that was provided to us is a kind of standard response that declares that inputs do not matter as long as outcomes are measured. That would be fine if the outcomes were at a stage of development that allowed us to have complete faith in them. However, they are at only an early stage of development. I plucked out a couple of Andy Kerr's statements just to recall what he said to us previously. He said:

"We will concentrate our efforts in making sure that Scotland's health, education and care services focus their resources on those children"

who are most in need.

Nothing in the documents that we considered could assure us that that was happening. I think that the response to recommendation 4 is inadequate.

In last year's end-year funding announcement, Andy Kerr said:

"the Executive has placed particular emphasis on ensuring effective use of the Scottish budget in line with its priorities."—[*Official Report*, 26 June 2002; c 13040.]

Again, the reporters group was unable to say, hand on heart, that the money was getting through. On those two particular items, we should encourage the Executive to think again.

The Convener: Thanks for giving us such a comprehensive overview and for preparing it in such a short time. As you said, there are some positive things in the response, which we should acknowledge and welcome, but there are one or two areas in which there are continuing concerns.

Ms Alexander: Professor Midwinter's excellent follow-up was an example of the kind of work that there should be more of. Too often, committees do not revisit a matter once the Executive has produced a response.

Arthur Midwinter raises two points, essentially. Recommendation 1 relates to inadequacy of data and the policy implications of that and recommendation 4 is about spending. Those two points go to the heart of what committees should be doing as they concern matters that are difficult to raise in the chamber. Therefore, we should follow up both those issues.

The first point deals with a critical issue. I will touch on it briefly just now and talk to Arthur about it offline. During the process by which the social justice framework was arrived at, there was a lively discussion about whether there should be both absolute and relative poverty measures. On the issue of absolute poverty measures, the question has to be whether there is a difference north and south of the border. Our understanding of that will be helped by the fact that the Executive will now be in possession of not only the data for the UK annual social justice report, which is usually published in September, but the provisional data for Scotland, which are usually published in November. Certainly, we expect the UK data this year to show evidence of a significant decline in absolute poverty.

On the second point, relative poverty, it is possible to control incomes at the bottom, through benefits, but it is impossible to control incomes at the top. During the past four years, the Department for Work and Pensions has changed its attitudes towards its own data and there has been a moving away from using those measures on a UK basis. Whether we do it through the joint ministerial committee or not, we need to have absolute clarity about whether the relative measures are still those that are used by the Department for Work and Pensions or whether there is now a difference between the Department for Work and Pensions and Scotland. In the past couple of years, there has been a long dialogue with the Department for Work and Pensions about

whether, because of changing European definitions of poverty, the UK should move in line with European definitions and that, therefore, Scotland should move away from the stake in the ground that was put in place in 1999. Absolute clarity on that point is important if the integrity of the social justice report is to be preserved. The issues that I have raised are best dealt with in correspondence.

On recommendation 4, which is about spending, we know the difficulties of disaggregating health and education spend but, given their significance in the Scottish budget, it is not possible to state that we know that we are closing the opportunity gap as we are incapable of specifying the amount of expenditure and the trend in that expenditure against that heading. We have to nail that some time in the second session of the Parliament. The sooner we start, the better.

Dr Murray: I agree with the thrust of what Arthur Midwinter says about returning to the Executive on some issues. It is a bit trite to say that the data are uncertain because the sample size is too small if those data are then going to be used. When one is confronted with criticism, it is not acceptable simply to say that the standard of sampling was incorrect.

With regard to recommendation 4, part of the problem relates to the fact that the moneys have been given to other bodies to disburse and that those bodies have local control of the spending, which means that it will be hard to secure data. However, it is important that the Executive gets some feedback from local government and the health boards on the issue of what they are doing to target funds on national priorities. I do not know how that can be done.

When we ask questions about that—particularly written questions—we quite often get the answer that the data are not held centrally. I wonder whether this is yet another example of data not being held centrally. There might be an argument for the Executive at least to ask the other authorities how the money is targeted. Although the minister is right to say that outcomes are extremely important, we do not really know whether our spending is appropriately targeted to produce outcomes unless we also know what the inputs are.

Professor Midwinter: That is a fundamental point, as 60 to 70 per cent of the budget is allocated in that way. The committee could spend all its time scrutinising 30 per cent of the budget while the other 70 per cent was handled as a block. That might have been okay 10 years ago, when hardly any scrutiny was taking place, but it is not okay today.

The Convener: I agree strongly with that point.

In your introduction, you did not mention in relation to recommendation 5 the issue of accounting for unmet need. There are definite issues of unmet need in relation to health and local government. Is that a matter that we can pursue more strategically than this narrow context allows?

Professor Midwinter: That relates to a previous discussion. I was one of the technical advisers to the first Arbuthnott report before ill health overtook me and I needed to lower my cholesterol level—I am now taking statins. Although colleagues from the department were talking about the formula needing to be evidence based, the evidence base was current usage. There were no data to show unmet need because all the information related to those people who used the service. Because of that, the chapter on unmet needs was written.

The two geographic areas of Scotland with unmet needs were identified as the remote and the rural. There are definitions of remote and rural areas—somebody asked about that. Particularly in small island communities, where there are problems of access, people use the service less than they ought to according to their health need. That was fairly widely accepted by health professionals in the discussions at the time of the writing of the first Arbuthnott report. The new model was introduced for hospital and community health services on the understanding that work on unmet need would go on.

Thereafter, it became complicated, as Sir John Arbuthnott was appointed the chairman of Greater Glasgow NHS Board. His report on unmet need was submitted prior to that but, to my knowledge, it has not seen the light of day, although, from discussions with those involved, I understand that there remain concerns about the degree of unmet need in remote and rural areas, in greater Glasgow and the urban parts of the West of Scotland, and in Dundee.

Recommendation 5 was based partly on the expectation that the Arbuthnott report on unmet need would be published. It was also expected that we would be able to see whether that report had implications for the local government formula, which is similarly based on current expenditure as opposed to current usage.

I am happy enough for you to put that back to the minister. It relates to recommendation 4 as well, because the defence for only a small proportion of the money's being allocated on the basis of poverty and deprivation was that only the relativities were being dealt with, not the whole package, and the assumption was that more of the money was actually being spent in those areas. Again, we had to say that we did not know.

We could draft a response that takes the

response to recommendation 5 into account, if that is agreeable.

The Convener: I think that we should take it into account in our response but, as you indicated, there is also the broader issue, which needs to come out.

Fergus Ewing: The committee adviser's work should be incorporated in our report to the Executive requesting a response to what are plainly a number of pertinent criticisms. I say that—as the convener said it—as one of all of us here who was not part of the original inquiry. It is sensible to say that it is difficult to comment in any substantive way as we did not hear the evidence directly. However, I would like to make one or two points that have emerged from the discussion.

First, paragraph 4 of Professor Midwinter's comments, which relates to recommendation 1 of the committee's report, raises a matter of great concern. The Executive states that it is proud to have achieved its target of raising 60,000 children out of poverty by 2002, but in fact the social justice report data show that the reduction was almost wholly achieved by 1997, prior to the establishment of the Parliament. Indeed, the proportion grew in the first year after the Parliament's establishment, which tends to suggest—unless I am missing something—that the Parliament has not achieved very much, if anything, in relation to child poverty. Without being party political, that comes as a bit of a shock and a surprise to me. Whatever party we are in, I hope that we all share the aim of reducing child poverty, and certainly of doing so before children are adults, which will not be the case with the current target of 2020. I hope that that point is put to the Executive. Have I understood that particular point correctly?

12:30

Professor Midwinter: I think you have. There is a difference between the progress on absolute poverty and that on relative poverty. Wendy Alexander raised questions about the measure. There is a report in *The Guardian* today about the same measure being used in England, and questions are being asked about whether the targets will be met. Performance on the relative measure is more uneven. That is quite central to the definition. You have fully understood the point.

Fergus Ewing: That said, as Wendy Alexander said, it is extremely difficult to measure the outcomes of Government policy. Anyone who aspires to be part of a Government must recognise that. Rural poverty is often hidden and is not identifiable. There is an element of pride, which I am sure applies everywhere, not just in rural Scotland; people are not keen to talk about how poor they are. It is extremely difficult to measure the outcome of the policy, but it is important.

As has been pointed out, if the Executive is asking for more money in "Closing the Opportunity Gap", it has to say, "This is the amount of money we want to spend. This is what we think it is going to achieve." We are due that, and if we are not getting that, there is a fundamental and principal flaw in the Executive's approach. It is not just about getting a reply for the next committee meeting at which we consider the matter; it is about getting a reply before the debate on Thursday. It is a reply to a simple but important point, which would inform the debate on Thursday.

I have a final general point, which arises from having studied—although, sadly for me, not having attended—the away day, and that is the general process of resource accounting, which seems to be even more arcane than the Schleswig-Holstein question, as far as I could understand it, which I could not. I am not surprised to hear that only one person understands the system. In fact, I am surprised that there is that single digit.

Professor Midwinter: He has gone on leave somewhere else.

Fergus Ewing: Well, there we are. It is a bit like the Schleswig-Holstein question after all.

I have a concern about the Finance Committee's approach and I do not know the answer, so now is the time to raise it. Outcomes are difficult to measure, but we try to measure them. How do we measure the efficacy of the expenditure, in other words whether the money could have been used more effectively to achieve the same outcome or whether we could have achieved a better outcome had the money been used more effectively?

From my understanding of the away-day papers, the advice from Professor Midwinter was that we are considering a pot of money that is for salaries and fixed costs and so we are considering only a small part of the expenditure. That is not necessarily a fruitful activity. I would like to examine the whole expenditure to find out whether money could be spent more effectively on social inclusion partnerships, to take a controversial example. Such consideration must be part of the committee's key role.

That argument must have been aired before, because we cannot possibly spend all our time examining 1 per cent of the expenditure.

The Convener: I think that Fergus Ewing is probably misinterpreting what Professor Midwinter said. Nobody is suggesting that we consider only a small part of the budget. It might be that, in terms of seismic shifts, it becomes difficult to shift more than a small percentage of the budget in any one

financial period, but that is not to say that we will not monitor and scrutinise the expenditure of the whole budget.

Fergus Ewing: I advocate only one policy that could be described as "seismic" in any way and that is the independence policy, although I would not use the word seismic. Other than that, I would not adopt a policy of implementing seismic changes.

I agree with the Liberals' argument at a UK level that quango budgets could be constrained—they argue that quango budgets are about 5 per cent too high. As part of our core function, I would like the committee to discover whether there is a case for constraining quango expenditure and whether that applies to the matter of poverty.

I will be interested in Professor Midwinter's response to those points about the general approach.

Professor Midwinter: I agree with most of what Fergus Ewing says. We have to distinguish between the role of scrutinising the budget, which is about managing the margins because of the limits on change in the short term, and exercises such as the cross-cutting reviews or inquiries that members wanted to have in which we could consider a big topic in depth and ask the kinds of questions that Fergus Ewing mentioned.

As the budget process takes place in such a short time, we have tried to ensure that we focus on the real choices rather than spending time examining money that could not be moved in the short term anyway. By carrying out that exercise, we can take the more in-depth approach that Fergus Ewing seeks. It will not necessarily be a cross-cutting review; the committee could conduct an inquiry into any field it likes. I am encouraging other committees to do the same thing when I am let loose before them.

Fergus Ewing: Such as Scottish Water's finances, for example.

Professor Midwinter: Yes. One committee considered Scottish Enterprise in some depth during the budget process. I would like committees to do that outside the budget process—to get to the point on the budget, but also to conduct those in-depth reviews that, of necessity, take longer than the rush in which the budget process takes place.

The Convener: We should focus on the report in front of us.

Mr Mather: The relativity of poverty is an important issue. There is no doubt that poor children today have a better diet, better clothing, live in warmer houses and have more entertainment and transport options than did middle-class kids 100 years ago. However, relativity is the issue. A lot of good work exists that demonstrates that that relativity affects children and their parents. Where the gap opens up, we find motivation, health and life-expectancy problems—the fundamental matters that brought me into politics.

It is reasonable to speak about the positive way in which the Executive responded to the majority of the recommendations.

On the other hand, Alison Davies of Save the Children Scotland, who was speaking on "Good Morning Scotland" this morning, made a pointed and poignant critique of the current situation. I would like us to pass muster with her on what she spoke about. I suggest that the committee get her to audit the recommendations that have been made and the responses to them. It would be good to get her up-to-date comments, which would help us move forward in a concrete way.

John Swinburne: My comments are just generalities, but when I read the document that is before us I see things that I would expect to see in the poor law of 1834. We are talking about children in poverty. We have learned gentlemen telling us about absolute poverty and relative poverty. If you are poor, you are poor, Professor Midwinter. It is immaterial whether people are relatively poor or absolutely poor: they are poor. To differentiate using terms like that is to dance on the head of a pin. It is the year 2003, but we have not yet moved on from the poor law of 1834. Absolute poverty? Children? Let us get our act together and get things rectified somehow. We should at least sort out the wording: we should use just one word: "poverty"—never mind "relative" or "absolute". Let us get down to cases.

Professor Midwinter: I am sorry, convener, but it is my job to respond to the documents that come from the Executive, which use the terms "absolute poverty" and "relative poverty", which the Parliament has agreed in the past. I am not going to carry the can for documents that use other peoples' words. I think, however, that there is an important issue around the notion of relative poverty—it is another expression for inequality.

The Convener: The seminal work on poverty is by Peter Townsend, who developed definitions of absolute and relative poverty. I do not think that anyone who knows his work would question his commitment to the cause of tackling poverty.

As for how we deal with the matter, Arthur Midwinter has provided us with the basis for how we might proceed with the Executive.

Jeremy Purvis: Before we discuss that, I would like to make a specific point about the Executive's response. I endorse everything that our adviser has said about the way forward and about how we respond to the Executive, but it might be useful to

ask the Executive to get back to us on the concerns that it is raising and how it is raising them with the Westminster Government. In particular, I refer to the statistics in paragraph 1 of the Executive response.

Professor Midwinter: I do not know how the mechanism that is used operates. It is the obvious formal mechanism, but there may be other ways in which things could be done. As I understand it, the Chancellor of the Exchequer is in charge of the exercise. Some of the concerns that have been raised are to do with the differences between people on benefits and people on rising incomes. Those differences provide some of the reasons for the lack of progress on relative poverty.

The Convener: I suggest that, notwithstanding Fergus Ewing's desire to get a response from the Executive in time for the debate this Thursday which, in my view, is unlikely—

Fergus Ewing: Why is that, convener? Why do not we just ask the Executive? It can do a lot in 24 hours, you know.

The Convener: It can, but I think that we would want a considered response to what is a considered piece of work by our adviser. It is obviously open to Fergus Ewing to ask the Executive about the matter if he so wishes. I suggest, based on the work that Arthur Midwinter has done and on members' comments, that we ask the clerks to prepare in conjunction with Arthur a paper to send to the Executive. We could seek clarity, taking on board in particular some of the points that were made by Wendy Alexander and Jim Mather on the comments by the director of Save the Children Scotland this morning. When we get a response to that letter, we can decide how we want to proceed with the issues. That seems to me to be a sensible way in which to proceed. Do members agree to that?

Fergus Ewing: I seek clarification. Professor Midwinter's note is marked "PRIVATE PAPER – FINANCE COMMITTEE ONLY". I presume that that does not apply to the forthcoming debate on Thursday, and that we are quite open to refer to the paper, flourish it, quote from it, brandish it about and do whatever we want to do with it.

David McGill (Clerk): It is open to the committee to adopt the paper. It was written by Arthur Midwinter and reflects his opinion, but there is no reason why the committee should not adopt it.

Professor Midwinter: I have no objection to members quoting from the paper—I never write anything that I am not prepared to say publicly. I am happy for the paper to be used to inform the debate, if people wish to use it.

Jeremy Purvis: It may be worth while for us to establish whether we are setting a precedent for papers. Will all advisers' papers be published and referred to ad hoc in the chamber? Are there private papers that will remain private or will private papers be private only for specific meetings?

The Convener: The convention is that we should consider papers line by line and paragraph by paragraph before we adopt them. We are not being asked to do that at this point. The adviser has given us a paper that sets out his analysis of the situation and that is intended to inform our judgment. We are not being asked to adopt or to publish the paper as a report.

Ms Alexander: I take the point that Jeremy Purvis makes—as the convener indicated, there are different types of private paper. It is proper for members to seek the advice of the committee in dealing with private papers, as Fergus Ewing has done. Of course he can report what an expert adviser has said to us. That is qualitatively different from a member quoting from a draft committee report before it is completed.

Fergus Ewing has observed all the proprieties and indicated that he wishes to draw on the factual information in Professor Midwinter's report. No doubt he will attribute that information to Professor Midwinter and state that the paper was submitted to the Finance Committee, without commenting further on the attitude of committee members. I hope that he will also make the point that we are seeking further clarification. It would be inappropriate to try to restrict the use of factual information that has been provided by a third party.

12:45

The Convener: Fergus Ewing may attribute advice to Arthur Midwinter if Arthur is willing for him to do so. Our adviser has indicated that he has no problem with that.

Professor Midwinter: Can I say something off the record?

The Convener: Not yet.

Professor Midwinter: Are there journalists present?

Fergus Ewing: The official report is still here.

Professor Midwinter: At an early meeting of the previous Finance Committee, I mentioned to the clerk that when one of my reports is debated in public there is a tendency for the media to see it as a case of "Arthur Midwinter versus Whomever". I would much prefer to discuss reports in private. If members want to use the arguments that appear there, that is fine. However, the emphasis should be on the committee's concerns, rather than on mine. I am happy for the paper to be used, but it

was submitted as a private paper because on one occasion in the early days of the Parliament it was reported that I had attacked the Executive—God forbid.

The Convener: That is a fair point. The committee must receive information from its advisers in private. Do we agree that we will adopt that procedure?

Fergus Ewing: To do what?

The Convener: When our adviser produces a private paper for us, it will be customary for us to discuss that advice in private and to consider whether to adopt it.

Fergus Ewing: No. We are not doing that at the moment.

The Convener: No.

Fergus Ewing: If we were to make such a revolutionary change in procedure, we would have to debate that properly. The proposal goes against the principle of openness and transparency, and against the desire that the Presiding Officer and others have expressed that fewer meetings be held in private. We should not debate the matter now, as it is nearly lunch time.

However, if we are to make the major change that has been suggested, the proposal should appear on the agenda of a future meeting. Before that, we should have the benefit of advice from the clerks on current practice. Let us not rush into something right now.

The Convener: We can certainly consider the issue.

Professor Midwinter: I am simply trying to account for the fact that the paper is submitted as a private paper, because of a decision that the previous Finance Committee took.

The Convener: We have agreed how to proceed.

Item 5 on the agenda will be taken in private.

12:49

Meeting continued in private until 12:59.

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