FINANCE COMMITTEE

Tuesday 7 October 2003
(*Morning*)

Session 2

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by The Stationery Office Ltd.

Her Majesty's Stationery Office is independent of and separate from the company now trading as The Stationery Office Ltd, which is responsible for printing and publishing Scottish Parliamentary Corporate Body publications.

CONTENTS

Tuesday 7 October 2003

FINANCE COMMITTEE
9th 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)
*Jim Mather (Highlands and Islands) (SNP)
*Dr Elaine Murray (Dumfries) (Lab)
*Jeremy Purvis (Tweeddale, Ettrick and Lauderdale) (LD)
*John Swinburne (Central Scotland) (SSCUP)

*attended

COMMITTEE SUBSTITUTES

Mr Adam Ingram (South of Scotland) (SNP)
Gordon Jackson (Glasgow Govan) (Lab)
Mary Scanlon (Highlands and Islands) (Con)
Iain Smith (North East Fife) (LD)

THE FOLLOWING ALSO ATTENDED:

Professor Arthur Midwinter (Adviser)

THE FOLLOWING GAVE EVIDENCE:

Alistair Brown (Scottish Executive Health Department)
Lorna Clark (Scottish Executive Health Department)
Dr Andrew Walker (University of Glasgow)
Dr Hamish Wilson (Scottish Executive Health Department)
Professor Kevin Woods (University of Glasgow)

CLERK TO THE COMMITTEE

Susan Duffy

SENIOR ASSISTANT CLERK

Jane Sutherland

ASSISTANT CLERK

Emma Berry

LOCATION

Chamber

Scottish Parliament

Finance Committee

Tuesday 7 October 2003

(*Morning*)

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

National Health Service Reform (Scotland) Bill: Financial Memorandum

The Convener (Des McNulty): I welcome people to the ninth meeting of the Finance Committee in the second session of the Parliament. I welcome the press and the public and remind members and anyone else that pagers and mobile phones should be switched off. We have received apologies from Ted Brocklebank, but I think that everyone else is present.

The first item on the agenda is further consideration of the National Health Service Reform (Scotland) Bill. I welcome witnesses from the Scottish Executive Health Department: Lorna Clark, the bill team manager; Dr Hamish Wilson, head of the primary care division; and Alistair Brown, head of the performance management division.

Members have a copy of various written submissions, including one from the Scottish Association of Health Councils, which gave evidence to the committee last week. We also received a submission from the Scottish Executive yesterday by e-mail—a paper copy of that submission is available to members.

I invite the Executive witnesses to make a brief opening statement.

Lorna Clark (Scottish Executive Health Department): As we know that time is limited this morning, we thought that it would be helpful if we made a brief statement and responded to some of the main points that have been raised by those who have provided written evidence on the bill and those who gave oral evidence to the committee last week.

I will start by setting the matter in context. This year, the Scottish Executive will spend £7.2 billion on health, most of which is allocated to the 15 health boards to manage and deliver health care services in their areas. That represents a rise of £1 billion since 2001-02 and the amount that we spend on health will increase still further to £8.5 billion by 2005-06. In the light of those resources, the Scottish Executive stands by the statement in the financial memorandum that there will be no additional expenditure associated with the bill.

We are aware that some witnesses have argued that there will be start-up costs associated with the establishment of community health partnerships. Funding is already provided for the management of a larger number of local health care co-operatives and some of that funding will be used to assist with the evolutionary development of CHPs. In addition, money is available through the change and innovation fund to assist with service redesign. We believe that health boards already have the capacity to manage the evolutionary change from LHCCs to CHPs within their existing management resources. That is supported by NHS Ayrshire and Arran, which said in its submission that what is required is a redistribution of resources and that there should be no overall cost increase.

On the powers of intervention, the financial memorandum states that the costs will depend on how the powers are used. We note from the evidence that the committee received last week that Argyll and Clyde NHS Board's experience of intervention cost about £300,000. We do not dispute that figure but we point out that that was a significant intervention that related to the departure of four staff at chief executive level. We suggest that any use of the intervention power following the bill is likely to be more targeted and therefore less expensive than was the case with NHS Argyll and Clyde. Of course, much depends on individual circumstances and it is difficult to indicate what an average intervention might cost, because each intervention is different and is costed according to the way in which it is run.

In practice, public involvement is already a core function of the national health service and, as such, is funded through the general financial allocation for the provision of health services. It is not a new or additional function; the bill simply makes the practice a statutory duty. The department is putting more money into public involvement nationally. Our patient focus and public involvement programme is investing some £4 million a year into national work to help the NHS, the voluntary sector, patients and the public to work together as equal partners and, by doing so, to improve the quality of the public consultation that is undertaken by the NHS. It is anticipated that the proposed Scottish health council will take over some of that responsibility and some of the central funding that supports that work.

The functions of the Scottish health council and its local advisory councils will be different from those of today's local health councils. Although it is true that the Scottish health council will have some functions that were not previously carried

out by local health councils, it will not do many of the things that are currently undertaken by local health councils. The Executive's view is that, on balance, the existing allocation to local health councils will be sufficient to set up and run the Scottish health council.

That was a brief summary and I look forward to discussing the issues further with the committee.

The Convener: Thank you for your statement and for giving us a copy in writing. By and large, the processes that are needed to abolish the trusts do not need legislation. What is required of the bill is a legislative tidy-up. However, there is an issue about the costs that are associated with the abolition of the trusts. Would it not be better to give us an outline balance sheet to show how the savings might be arrived at and how any additional costs might be met, rather than to assume that they will somehow be netted out of the process, which seems to be the substance of your comments?

Alistair Brown (Scottish Executive Health Department): The work that we have done and our discussions with the NHS suggest that the direct cost of abolishing trusts is very low and is entirely administrative. As you suggested, the abolition of trusts is already going ahead under the legislative provisions of the National Health Service (Scotland) Act 1978. It is clear to us from our conversations with those in the NHS that, as I said, the costs will be very low. Other witnesses have suggested to the committee that opportunities for savings will be presented through single-system working and, for example, developing joint human resources and finance functions that cover the former trusts and boards in a single area. We expect savings from that, but we expect board areas to redeploy those savings towards improving patient care.

The Convener: Would it not have been better to give us a true financial assessment of savings that can be clearly identified and of any additional costs, especially in the initial phases, rather than to assume that the overall effect on costs will be netted out?

Alistair Brown: Producing such a statement would be difficult for the Health Department because it would need to be accurate for each health board. In time, individual health boards may be able to describe costs that they have incurred and savings that they have realised, but we expect those figures to be small in comparison with the overall sums of money that are being discussed.

The Convener: My question relates to scrutiny and our function is to scrutinise. I might want to accept your assurances, but I have the reasonable expectation that you can provide some figures.

Alistair Brown: We cannot give the committee figures today. Dissolutions are already beginning so I repeat with confidence that the costs that are associated with dissolutions are not material. I will not say that they do not exist, because some staff must be deployed to draw up consultation measures and undertake consultation, but the costs are very small. We cannot yet indicate possible savings from single-system working, but we are beginning to observe its results in the Borders and in Dumfries and Galloway, where trusts were formally dissolved on 1 April this year.

Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP): It is obviously the duty of ministers to provide a clear financial memorandum, which means providing a clear estimate of how much a bill will cost. Paragraph 42 of the financial memorandum says:

"There will be no additional expenditure".

However, you just said that you cannot produce figures because they would need to be accurate and you do not know how much each health board's proposals will cost. How did you conclude that no costs would be incurred, given proposed new section 4A(5) of the 1978 act, which entitles ministers to produce regulations that stipulate the number of CHPs, the number of staff and how CHPs operate? How many CHPs will be created and how much will they cost in total?

Alistair Brown: Your last point took me from the costs and savings that are associated with the dissolution of trusts to community health partnerships. One of my colleagues will have to comment on the partnerships.

Your first point was about whether we really know the costs that are associated with the bill and in particular with section 1, which is on the dissolution of trusts. We stand absolutely by the financial memorandum's statement that no costs of any significance will be associated with dissolving trusts.

10:15

Dr Hamish Wilson (Scottish Executive Health Department): I will bring the committee up to date on community health partnerships. As was requested in the white paper "Partnership for Care", each area is considering its current configuration of local health care co-operatives and what that might mean for community health partnerships. That exercise has not concluded, so although some areas have a fairly clear idea of the appropriate number of community health partnerships to deliver what the white paper requires, others have not reached that stage. However, the information that we have suggests that we are heading for about 50 partnerships. I stress that that figure is provisional and is based on the best information that is available. There are

roughly 80 local health care co-operatives in Scotland, so the number of bodies will change.

Fergus Ewing: We discovered this morning that one of the few times that ministers made any attempt to predict in the financial memorandum how much the bill would cost relates to the powers of intervention, whose use is expected to cost about £85,000. However, the witnesses today appeared to accept the figure of £300,000, so that error is of a factor of nearly 400 per cent.

The almost total lack of figures in the financial memorandum contrasts markedly with the approach that ministers took in the financial memorandum for the Vulnerable Witnesses (Scotland) Bill, which contains a clear list of figures and costed measures. Dr Wilson admitted that the Executive does not know how many CHPs will be created so, by definition, we do not know how much the bill will cost. The financial memorandum contains about as much hard fact as the average astrological chart does. The prediction might well have been made by Mystic Meg. That is simply not good enough.

Such a bill should not be introduced until the Minister for Finance and Public Services and his deputy can tell the Parliament how much it will cost. If the Executive cannot do that—the witnesses have admitted that they cannot—a clear balance sheet should be produced that shows ranges of estimates and of costs, as the convener said. Without that, we are being asked to sign a blank cheque and we do not know whether that is a Scottish Natural Heritage relocation cheque of £30 million or a Holyrood cheque of £400 million. Are not the financial memorandum and the lack of detail in the witnesses' responses, which I presume that ministers support, unacceptable?

The Convener: I am not sure whether that was a political speech or a request for factual evidence, but I will allow the witnesses to respond on factual issues.

Alistair Brown: I will respond in a way that I hope is helpful on the costs of the powers of intervention. Mr Ewing is right to draw attention to the fact that the financial memorandum contains the figure of £85,000. The memorandum explains that that would be the cost of a task force that comprised six people and lasted 10 months.

In the Executive's opening statement, we said that we would not disagree with the figure of £300,000 that Neil Campbell of NHS Argyll and Clyde submitted to the committee. Both figures are correct, because they represent different interventions at different times. The figure of £85,000 is taken from a parliamentary answer of December 2000. The question related to a task force that ministers asked to go into Tayside NHS Board in February that year and which completed its work in autumn 2000. According to the parliamentary answer, the cost of that task force was £84,467. That is where our figure of £85,000 came from, so I assure the committee that it has a factual basis.

Ms Wendy Alexander (Paisley North) (Lab): I will pursue that point. The figure might have a factual basis, but that is not the issue that the financial memorandum deals with. The memorandum concerns estimated costs for the forthcoming four years. We all appreciate the difficulties of costing prospective interventions, but at least four examples can be found in the past of interventions that the Parliament would have sought if the new powers had been available.

In the Parliament's first year, the Ruddle inquiry was held and issues that were specific to Carstairs were considered. Those matters would be unlikely to fall under the bill's provisions, but that was an area-specific intervention. The Tayside intervention, which Alistair Brown mentioned, then took place. The important issue is not the cost of that intervention as it was carried out but what might be the cost given the powers of intervention that are laid out in the bill and where those costs would fall. The question is whether the cost would fall to the Executive or the health boards.

In the third year, we had the example of the Beatson in Glasgow. Because of the legislative power that we are about to create for ministers, there will probably be some central intervention in future in such cases. No doubt Greater Glasgow NHS Board would be able to provide some indication of the costs. Most recently, we had the example of NHS Argyll and Clyde. Again, the powers in the bill make it likely that costs will accrue to the Executive.

We have had one intervention a year and more interventions are now likely because of the wider scope of the bill. It would be helpful if officials could write to us about the costs of the interventions in Tayside, the Beatson and Argyll and Clyde. It is a little surprising that those interventions were not considered when the financial memorandum was drawn up, but these things happen. The costs of those interventions could be agreed with the three health boards involved and used as a benchmark.

It is arguable that the sums of money involved are trivial when compared with a £7 billion budget. Had the financial memorandum said that the costs would be residual in such a budget, that would be fine. However, the artificial precision of £85,000 creates a danger. I do not think that that figure bears any relation to what the Tayside, Beatson or Argyll and Clyde interventions would have cost under the powers that we are creating.

Will you comment in more detail on the Argyll and Clyde case? I am disturbed by the justification in your paper, which says that the intervention was very significant and related to the departure of four staff at chief executive level. It seems to me that we should be costing not the outcome but the input. The input was a relatively small number of people who went in for a relatively short time. In the intervention team of four members, one was a senior local government official and one was from the private sector. On average, those people would be on a salary of, say, £100,000. The team spent six months looking into systemic mismanagement in a health board with a budget of hundreds of millions of pounds. Six months is a short time but the salaries of the four people would come to £200,000—let alone any backfill associated with their previous employment.

Do you envisage having intervention teams of fewer than four people, for periods of less than six months? That does not seem commensurate with the provisions in the bill or the likelihood—given past experience—of where interventions will have to take place. The outcome is not really the issue; the issue is the input required to intervene in the management of a health board.

The Convener: I think that there were several questions there.

Alistair Brown: Ms Alexander asked that we write to the committee about the costs of the interventions that she listed. We would, of course, be happy to do that as soon as we can.

The Convener: That would be welcome.

Alistair Brown: It may take us a little while to look back at papers that are now up to three or four years old.

I make one general point about the proposed new power of intervention in the bill. The policy intention is clearly that it should be used as a power of last resort. The words "last resort" appear not in the white paper but in the Executive's partnership agreement. We believe that that policy intention is carried into the wording of the bill, through the necessity test. In section 4 of the bill, proposed new section 78A(2) of the 1978 act states that

"The Scottish Ministers may, where they consider it necessary for the purpose of ensuring the provision of the service",

direct certain things. The lawyers advise us that that carries into the bill the policy intention that intervention should be a last resort—when other means of turning round poor or failing performance have been tried and failed, or when ministers judge that there is no reasonable prospect of such means succeeding.

I make that point to set Ms Alexander's comments in context. One cannot assume that, had the proposed new powers been in effect back in 1999, ministers would have decided to use them in the Ruddle, Tayside, Beatson and Argyll and Clyde cases. The intervention in each of those four cases was based on agreement between the Scottish Executive Health Department and the health body concerned.

That observation may not be relevant to the cost of an intervention, once a decision to intervene has been taken, but it may help the committee to judge how frequently ministers expect the intervention powers to be used. The answer is that they will not be used frequently. They will be used as a last resort only after a range of other interventions and actions has been attempted.

I accept Ms Alexander's comment about the artificial precision of the £85,000. We were trying to be helpful and I have made it clear where that number came from. It may help the committee if I explain why that figure seems small. The Tayside task force had a number of members and was in Tayside for nine or 10 months. At least one of the members was a recently retired senior chief executive in the health service. The cost of deploying him in Tayside was, in fact, remarkably low. I cannot give the committee the figures right now, but the additional cost to the public was very low. Other members of the Tayside task force had other jobs and were deployed for only one or two days a week.

Dr Elaine Murray (Dumfries) (Lab): Wendy Alexander raised a number of the points that concerned me. You have just suggested that the Tayside example may have been an exception because you had available to you a recently retired chief executive whose cost was relatively low. That would not be the case in every intervention. We have been considering Tayside and Argyll and Clyde but it is difficult to say which is the exception and which is the rule. It could be that Argyll and Clyde is more typical than Tayside. My genuine concern about the level of costs remains and, in its submission to the committee, the British Medical Association expressed a similar concern.

The financial memorandum seems to say that the cost burden would fall on the health board rather than on the Scottish Executive. Can you explain that to me? It would be surely be easier for the Executive to absorb the cost of an intervention than it would be for the health board, which might be in significant financial difficulties at the time of the intervention. Even £300,000 is a small sum when compared with the Health Department's budget or with the end-year flexibility figures that we have been discussing recently.

Alistair Brown: We have been giving thought to the very question that Dr Murray raises. The question of who would bear any additional cost of

such an intervention would be for discussion between ministers and the department on one hand and the health board in difficulty on the other. The conclusion reached would depend on the circumstances. The financial memorandum certainly states that costs would be

"contained within existing NHS financial allocations."

That would be our starting point. If an NHS board argued that the costs would damage service provision, for example, ministers would listen very carefully to that argument.

10:30

The Convener: Has that discussion taken place in the specific context of NHS Argyll and Clyde?

Alistair Brown: I cannot provide a factual answer to that question now. I will have to write to the committee with the information.

John Swinburne (Central Scotland) (SSCUP): The public regard this exercise as rather meaningless. They believe that the structure of the NHS is top heavy. There are not enough people at the sharp end—the delivery end—doing the good work that nurses, surgeons, doctors and so on do, and there are too many systems analysts and people counting the number of patients who are bedblocking. Although the bill will not save any money, will it make the system more efficient?

Lorna Clark: We have figures for management costs in the NHS, which show them to be quite small.

Dr Wilson: For a number of years, management costs in the NHS have run at around 5 per cent of total revenue. As the financial memorandum makes clear, it is expected that that figure will not be exceeded as a result of the measures that are being taken and that management costs will be contained at 5 per cent of total revenue.

As Alistair Brown mentioned, the abolition of trusts and the reunification of NHS boards offer us an opportunity to make savings by ensuring that support services are provided in a more efficient manner than they have been in recent years. Alistair Brown gave some examples of that. One of the fundamental aims of the white paper and the partnership agreement is to ensure that clinicians in the front line are empowered to get on with delivering the services that they believe local communities need. The white paper makes it clear that one reason for creating community health partnerships, which have evolved from local health care co-operatives, is to continue enabling clinicians in the front line to feel that they are in the driving seat when delivering care with the resources that they require to respond to local communities' needs.

Kate Maclean (Dundee West) (Lab): Like other members, I am concerned about the lack of financial clarity surrounding the bill. In response to Fergus Ewing's question about the cost of intervention, Alastair Brown cited the cost of the Tayside task force as an example. However, in response to Wendy Alexander's question he referred to various factors that kept the costs so low in Tayside. That leads one to believe that the figure that the financial memorandum provides for the cost of using the powers of intervention is inadequate.

Can you say more about the costs of dissolving trusts? In response to a number of questions, you said that those costs would be minimal. My experience is that with any kind of reorganisation there are often initial, non-recurring costs, which lead to savings a year or two down the road. If there are to be reforms and trusts are to be dissolved, leading to savings further down the road, it is difficult to believe that there will not be initial, non-recurring costs. I am concerned that we are being asked to agree to something with no idea of what costs and potential savings will be.

Alistair Brown: Kate Maclean suggests that the £85,000 is inadequate. The financial memorandum makes it clear that costs would be incurred only if the new powers were used and that the amount spent would depend on how the powers were used. That is an obvious statement, but it is worth my putting it on the record.

The cost estimate that I gave for the Tayside task force was the department's final reckoning at the end of 2000; I regard it as accurate. We should not lose sight of the fact that powers of intervention may be used in future to pinpoint a particular service that has gone wrong. In those circumstances intervention would be limited and sharply targeted, so it might cost only £10,000 or £20,000.

Neil Campbell gave the committee the example of the intervention that took place in Argyll and Clyde NHS Board. I accept fully that, because of the nature of the difficulties there, that intervention has had to be quite wide ranging and costs have been higher.

Kate Maclean's second question was about the costs of dissolution of trusts and the savings that might arise from that. The most helpful thing that I can do is to point to the experience of Borders NHS Board and Dumfries and Galloway NHS Board, where trusts were dissolved with effect from 1 April. I have had conversations with the chief executives in both of those NHS systems on the abolition of trusts and in neither case were costs an issue. Both chief executives are working to rationalise administrative support in the NHS in their areas, especially in finance, human resources and information technology. Any

savings that can be made will be available for the boards to invest in patient care, if they so choose. I hope that that answer is helpful.

Kate Maclean: If the savings are in personnel, are there no initial redundancy or early retirement costs?

Alistair Brown: Since the publication in December 2000 of the white paper "Our National Health: A plan for action, a plan for change", which indicated that the policy direction was to move towards unified NHS systems, the NHS has been preparing for what we describe as single-system working. Although the final policy decision to wind up all the trusts was made explicit only in the white paper that was published in February this year, boards have been planning prudently for that. Many of them have appointed chief executives of trusts on an acting or interim basis, so that the question of redundancy does not arise.

Because of the natural rate of turnover of staff, at any point in time boards will have vacancies to fill. They have used that naturally occurring facility to ensure that the changes associated with moving to single-system working cost either nothing or very little in severance. I am not aware of any severance payments' having been paid in the two boards that have moved to dissolve trusts.

Dr Murray: One reason why costs in Dumfries and Galloway NHS Board were not high was that a number of senior staff, including two chief executives of the board and the two trusts, had left and people were employed in those positions on an acting basis. It was relatively straightforward for people to be redeployed in the board. I do not know that we can be absolutely certain that it will be as easy for every board in Scotland to accommodate its personnel as it was for Dumfries and Galloway NHS Board.

Alistair Brown: I accept Dr Murray's point. However, like Dumfries and Galloway NHS Board, other boards have been planning with single-system working in view and have made what preparations they can.

Jeremy Purvis (Tweeddale, Ettrick and Lauderdale) (LD): I touch on the same issue in the context of Borders NHS Board, where there were previously three chief executives and where there is now one. In Borders NHS Board, redundancies and substantial costs were associated with the dissolution of trusts. Will a more co-ordinated approach to staffing reorganisation be taken throughout Scotland? When boards reorganise one by one, it is hard to relocate staff or to offer senior staff other opportunities in the NHS. Is it correct to say that if it were expected that the reorganisation would be carried out throughout Scotland, there would be more such opportunities for relocation and the burden of costs will not be that acute?

Alistair Brown: A co-ordinated approach to relocating senior staff would reduce severance or other costs. Each NHS board is legally a separate employer and must fulfil its contract with its employees, including its senior staff. We must be careful not to interfere with that situation, because it is governed by employment law and the private contracts between the parties.

The NHS in Scotland is not so big that people are unaware of any vacancies that might arise or of senior staff who might be available to fill them. As a result, there is already an informal exchange of information of the kind that you suggest. As I said, the Health Department would have to be careful about intervening formally in that process, given the existing private and contractual relationships between the individuals concerned and their separate NHS employers.

Jeremy Purvis: Substantial management time was taken up and consultancy costs incurred in the reorganisation in the Borders. Am I right in saying that those costs were met by the Executive?

Alistair Brown: Are you referring to consultancy costs?

Jeremy Purvis: Yes. I am referring in particular to management consultant costs.

Alistair Brown: Do you mean in advising the NHS board on the move to single-system working?

Jeremy Purvis: Yes.

Alistair Brown: As far as I am aware—and subject to checking—those costs were met by Borders NHS Board. However, if I find that I am wrong, I will write to the committee.

Jeremy Purvis: Substantial management time will be taken up if each board wishes to move to single-system working. After all, a board might have to hire management consultants to advise it on such a major reorganisation. As a follow-up to Kate Maclean's question, are you confident that those costs will be met by efficiency savings that will result from single-system working? If so, have you received any indication from the boards that have reorganised about what they expect those greater efficiency savings to be?

Alistair Brown: We have received a general indication from the boards that have reorganised and from those that are planning to do so that they expect to realise efficiency savings from bringing together functions that are currently being repeated in the health board and each of the trusts. However, that is not the driving force behind the policy of moving to single-system working. The policy intention remains to make care more patient-centred, and to make the transition between primary and secondary care

more seamless. That is reflected in some of the written submissions that the committee has received, such as that from the British Medical Association's Scottish office.

Jeremy Purvis: In the bill as drafted, there is a danger that, if a large board simply redesignates trusts into divisions, rebadges them, maintains the current management levels and in effect does not move towards single-system working, there would be increased costs without greater efficiency savings. Are you alive to that possibility?

Alistair Brown: One has to draw a distinction between what might happen in the very short term and the opportunity that will thereafter open up for NHS systems to rationalise, for example, their support services. I certainly do not want to say to the committee that in some cases existing trusts will not be more or less substituted by new operating divisions after the trusts are dissolved. However, where that happens, I would not expect the NHS systems to stop there; I would expect that in time they would use such a step as a basis for further rationalisation. Although we are not pressing boards specifically to do that, we and many other stakeholders would encourage them to run their operations as efficiently as possible to ensure that as large a proportion as possible of their total income from the Health Department is devoted to patient care and front-line services.

10:45

Jim Mather (Highlands and Islands) (SNP): I want to build on that comment. In any other setting and in most other areas of endeavour, we would expect any reform to have measurable returns on investment, which would be laid out and carefully measured from the start and come with a firm cost ceiling. Surely that must also be the case in an area of expenditure that amounts to a third of the Scottish budget. Do you envisage establishing reporting mechanisms to monitor performance and to encourage adequate performance along the lines that you described a moment ago in terms of there being more resources for front-line services, bureaucracy that will decrease over time, higher staff morale, reduced staff turnover, shorter waiting times, better outcomes, increased throughput and cost savings from streamlining and rationalisation? Such firm measures could be taken then segmented to provide an appropriate bill of materials and to ensure that performance can be monitored at individual levels.

Alistair Brown: Mr Mather has provided a very full run-down of the aspects of NHS performance that we measure or that, in some cases—I want to make this clear to the committee—we would like to measure better than we do.

We should see the bill as the legislative implication of the policy that the Executive set out in "Partnership for Care: Scotland's Health white Paper", which was published at the end of February 2003. That white paper emphasises the importance of reform in the NHS to ensure that the additional resources that are being put in have maximum impact on the quality of patient care. We believe that the bill's measures are necessary to give legislative effect to that policy.

The performance of each NHS area is measured in a variety of ways and at different levels of detail. For the committee, perhaps the most useful gathering of those measures is in what is referred to as the performance assessment framework, which contains something like 90 quantitative measures of performance and other qualitative assessments. The framework certainly covers issues such as waiting times, patient experience, outcomes from surgery and so on. However, we would like to develop better measures of, for example, patient experience and similar softer issues for which it is not always possible to find a reliable numeric measure. The department continues to work on that with the NHS and others who advise us on such matters. As a result, I think that I can answer "Yes" to Mr Mather's question.

The Convener: I want to move on to a slightly more technical issue. The primary care trusts that have already brought in LHCCs with extended involvement of the public and local authorities are probably not going to incur huge additional costs from the bill's proposed measures. However, I am concerned about less well-developed areas and locality structures in areas that will be overtaken by the new form of LHCCs. Given that the whole system depends on general practitioners' buying into it, are you concerned about moving from about 80 LHCCs to about 50 CHPs, and about sustaining locality structures where there is no correspondence between the existing LHCC and the proposed CHP? After all, such structures need to be sustained in some form.

Dr Wilson: One of the fundamental aims is to build on the best of the LHCCs, as you have described. Each area has to strike a balance between representing, and being responsive to, a community and having the capacity to deliver the functions that the white paper, "Partnership for Care", outlines for community health partnerships.

On commitment from primary care contractors, one of the issues that we face is that we rely heavily on clinical involvement, not just from general practitioners but from other primary care professionals, to ensure that LHCCs are responsive. One of the major development areas that we expect boards to address in examining CHPs is clinical leadership. We will continue to work with local areas on that to ensure that community health partnerships are both responsive to the community and have the clinical

leadership with buy-in from local clinical staff. We are trying to get the best from the LHCC model and work that into the new community health partnerships.

Given that LHCCs were voluntary initially, it is inevitable that there has been variable progress on them throughout Scotland. That is why it was felt that it was important to give community health partnerships a more formal place in the NHS so that they could be seen as an important part of what happens in the NHS locally and thereby gain credibility with the partners with which they work—local authorities are key to that.

All those factors put together seek to reinforce the principles behind "Partnership for Care", which is about communities, clinical buy-in and improving relationships with local authorities, the voluntary sector and so on.

The Convener: The two core questions are whether the smaller locality structures will continue to be supported under the new model and whether funds are available to ensure that the needs of enlarged representation will be met. I am not sure what your answer was to either question.

Dr Wilson: One has to consider each area to answer that question. We have already heard from a number of areas that wish to maintain within their community health partnerships' local identity—not necessarily a formal management structure, but something that maintains a locality's identity. That already exists within LHCCs. It is expected that there will be a shift of management effort from the LHCCs and other bits of the system, such as existing trusts or NHS boards, into community health partnerships. Equally, we will try to ensure that communication and other systems that exist are not lost in this new endeavour.

The Convener: I move on to interventions and projected costs, on which we have had lengthy discussion. One thing that concerns me is the looseness of how the bill is drafted in relation to the possibility of interventions. It is clear that if there were a relatively limited number of major interventions, the costs could be contained by either the health board or NHS Scotland. What concerns me is that if NHS Quality Improvement Scotland finds many examples of inferior services, ministers could be obliged to intervene more than they have until now, for example in the four cases that Wendy Alexander mentioned. Would that have a substantial projected cost?

Alistair Brown: The section of the bill that deals with powers of intervention grants a power to ministers rather than imposes a duty on them. The simple answer to your question is that ministers would use the power only where they felt it was justified and they chose to do so. It is relevant to repeat what I said earlier: the power of intervention is clearly intended to be used only as a last resort. The necessity test to which we refer conveys the policy intention through into the wording of the bill. I hope that that will help to reassure you. All the same, it is important that the power of intervention is available where it is necessary. We have therefore not constrained the power heavily in the drafting of the bill.

Jim Mather: I want to go back to measurement. It is clear that 90 measures are too many for external reporting. What smaller number of measurements should the Parliament use to judge future performance?

Alistair Brown: That is an interesting question. I will attempt briefly to justify why we have as many as 90 measures. We use the measures internally, although all 90 are reported publicly and are on the "Scottish health on the web" website. We use the measures to inform the discussions on performance that we have annually with NHS boards; it is important that we can look right across the range of their operations.

You asked which of the 90 measures and the qualitative assessments the Parliament and the Finance Committee would want to concentrate on. You have your own source of advice and expertise on such matters, so it is difficult for the Executive to give you a view on that. A lot depends on what is taking up the committee's attention at any given time. The indicators are designed deliberately to give a broad spectrum of measures. They relate to access, which is about how easy it is for people to receive health care and how long they have to wait for it; to quality, which is about how good the clinical outcomes are; to efficiency and to finance. Although there are not many indicators on the finance side, there are enough to enable us to monitor accurately how boards are performing. There are also indicators relating to patients' experience. We examine the incidence of health-care associated infection and boards' performance in relation to patient focus and public involvement. The committee would be able to choose from a broad spectrum of measures at any given time, depending on where its interests and investigations were leading it.

Jim Mather: I believe that it would be helpful if there were three or four key indicators that all parties knew were being measured at the macro level and that would be reported on consistently on a long-term basis. Do you agree with that?

Alistair Brown: Relative priorities and importance is a matter for ministers rather than for me. Mr Chisholm has recently agreed the 12 NHS priorities for 2004-05—the planning year that we are looking forward to—and they are the same 12 that he agreed for 2003-04.

The Convener: I am anxious that we are drifting a wee bit from the bill.

Jeremy Purvis: I have two quick questions on CHPs. We heard from the Scottish Association of Health Councils—this is supported by what Dr Wilson said this morning—that the nature of LHCCs' evolution from their initial voluntary basis meant that they received considerable funding in kind, which might not be available under a more structured system when they become CHPs. Do you share that view?

Dr Wilson: I wonder whether there is confusion between LHCCs and local health councils. Perhaps the comment that you referred to was made in relation to local health councils rather than to local health care co-operatives. LHCCs receive funding directly from the NHS boards or primary care trusts.

11:00

Jeremy Purvis: Is it anticipated that the new CHPs will incur more management costs because of the kind of work in which they may be involved. For example, their role in joint commissioning means that they will have a greater responsibility than their predecessors. Will not that increase the costs?

Dr Wilson: The creation of community health partnerships will not, in itself, require additional management to support joint working between the health service and local authorities in social care, children's services and so on. The CHPs will give local authorities a specific focus at the individual community level. That is why there is a wish for greater coterminosity between community health partnerships and local authorities.

The whole joint future agenda is a practical example of joint commissioning that is already in place for NHS boards and local authorities. That effort would continue whether or not community health partnerships existed, although community health partnerships provide a clear focus for such activity in the NHS and there may be a practical advantage in their being coterminous with their local authorities. We do not see CHPs creating any additional financial pressures. The joint future agenda is a parallel agenda, which we wish to bring into the whole equation; it is not an extra.

The Convener: There is an issue that I am still slightly unconvinced about. You are placing additional duties on CHPs with regard to public participation. I suspect that you will have to consider staffing issues and get more skilled staff into some positions, and other issues might arise in relation to liaison with local authorities that will incur other costs. The financial memorandum suggests that those additional costs can be met out of the existing funds for the LHCCs. Can you give us any further information about how you went about making that estimation?

Dr Wilson: The financial memorandum makes reference to a reallocation of existing resources within each board, including the funding that is allocated to LHCCs; it does not refer only to the funding that currently supports LHCCs. As Alistair Brown said, as NHS trusts change and operating divisions or their successors come into place—and as NHS boards themselves change—they have the opportunity to enhance the support that is given to community health partnerships for specific functions that may be devolved from NHS boards or from what are currently NHS trusts. It is about not just the money that is used to support LHCCs, but the whole management infrastructure that exists in the NHS.

The Convener: That gives rise to a further issue. The LHCC money is at least identified. Now you are talking about other money that might be reallocated, which you have not been able to quantify for us. You are saying that health boards might be able to contribute other money to the process of establishing the CHPs. To make your argument convincing, you must be able to say how much more than the LHCCs the CHPs will cost and how funding to meet that additional cost will be derived.

Dr Wilson: Yes. That takes us back to our earlier discussion about the timing of events. At present, because local NHS board areas are considering how best they can configure their services for the future, it has not been possible for us to do what you have described.

The Convener: I want to press you on another issue. One of the specific requirements of the bill is more systematic public consultation. Last week, we had some difficulty in getting from the health boards a sense of what that additional consultation would cost. Your assumption seems to be that health boards can meet the cost of the additional consultation from their current allocation. The same assumption is made in relation to the new Scottish health council being able to absorb the money that goes to the local health councils. It seems quite convenient that we can get more for less. Can you say more to convince us of that?

Lorna Clark: Public involvement is not a new duty; it is something that NHS boards ensure routinely. The extent to which there is public involvement will depend on what sort of service change is being considered. For example, if a health board or a GP practice is considering a small change in how it operates, it will undertake a reasonably small consultation exercise on that. If a major service change is being considered, one would expect the consultation to incur a bit of a cost. Boards have been consulting in that way for years; it is not something new.

By introducing a statutory duty for public involvement, the bill recognises the increased priority that public involvement is being given. Some of the evidence that the committee took from NHS boards such as Ayrshire and Arran NHS Board reiterated our point that boards expect to have to involve the public. Involving the public in determining how services operate is a fundamental part of what the NHS does; the bill simply makes that statutory. We are not changing the way in which NHS boards go about their consultation; we are putting more money in from the centre to assist public consultation and to help to build capacity at a local level.

Boards are already involving the public in service redesign and consideration of how they can do things differently. The duty simply puts that on a statutory footing. We are not placing any additional responsibility on NHS boards; we are just formalising what they do at the moment.

The Convener: Yes, but there is an issue about how ministers are expressing the policy intention of the bill. They are presenting the change in the volume of public consultation that people can expect as a major step change, yet the financial memorandum seems to suggest that that can be achieved at no additional cost. I wonder whether those two expressions of intent can be reconciled.

Lorna Clark: The Executive is investing something like an additional £4 million a year, as part of our patient focus and public involvement programme, to help with capacity planning, to ensure that NHS staff are better equipped for the commitments that are required of them, and to ensure that patients and the public are better equipped to be equal partners with the NHS in being consulted and in reacting to consultations. Additional central money is being allocated over and above what NHS boards receive at the moment. That commitment is on-going and is not a direct consequence of the bill. For some time, we have been working on increasing capacity and NHS boards' ability to undertake public involvement. The bill formalises that; it does not do anything particularly new.

The Convener: The general lesson to draw from that response—which perhaps came out of the earlier questions about the abolition of NHS trusts—is that, to get a better assessment of what is going on, we require more information than we are being given. If the information that we receive focuses narrowly on the specific impact of the legislative process, we will not get the full perspective that we require. If significant resources are already going into public consultation and participation, which the bill formalises, we need to get the whole financial picture of that.

Fergus Ewing: I want to return to our core function and the prediction that the minister has made, which is supported in paragraph 42 of the financial memorandum, which states:

"There will be no additional expenditure associated with this Bill."

We have heard from the witnesses today that there will be some savings, but they do not know how much those will be, so they cannot say. We have heard that there will be extra costs, but they do not know how much those will be, so they cannot say. On the other hand, page 9 of the explanatory notes makes claims about the dissolution of NHS trusts, CHPs, health boards and powers of intervention, all of which have been either contradicted or seriously questioned in several of the written submissions that we have received.

For example, Highland NHS Board says:

"CHPs may increase costs if central economies of scale are lost."

Argyll and Clyde NHS Board points out that CHPs are significantly more expensive than LHCCs. The witnesses have been unable to say how many CHPs there will be; they do not know. They do not know how many staff there will be. They have said that people are planning for single-system working, but Highland NHS Board says that there may be additional "unfunded" costs in relation to the dissolution of trusts and redundancy costs. I presume that it is not being suggested that any health board has set aside redundancy costs in future budgets, because I would have thought that they could not legally do that.

I wanted to bring all that together and put it to the witnesses that the financial memorandum is the Denis Norden of financial memorandums, in that it is hoped that it will be all right on the night. If that is felt to be too facetious, perhaps they will answer these two questions for me. First, to what percentage are they still confident that paragraph 42 is correct, when it states

"There will be no additional expenditure"?

Secondly, how confident are they—in percentage terms—that there will not be additional expenditure in the first year of operation?

Lorna Clark: We are confident that no additional costs will be attached to the bill. My colleagues and I have gone through the different sections of the bill and tried to explain how we have come to believe that. A lot of what the bill seeks to do is evolutionary—it builds on things that we are already doing. Boards have been working towards single-system working for some time and have been planning what they need to do.

We are confident that what we have said in the financial memorandum is correct.

Fergus Ewing: So there is no chance that you could be wrong.

Alistair Brown: It is important that we understand that the financial memorandum expresses the Executive's and ministers' expectation that there will be no additional expenditure; we are not providing an absolute guarantee. Within the world of the NHS, an NHS board could decide to use the occasion of the dissolution of its trusts to do things better locally. It might decide—and it would be quite within its rights to do so—to put more money into some aspect of its administration and less into something else, or it might decide to allocate more of its annual increase to something flowing from the dissolution of trusts.

We are not saying that those will never happen, and there is nothing to prevent NHS boards from taking steps of that kind, but we are saying that we have a confident expectation that no additional expenditure will flow as a direct consequence of this piece of legislation. I believe that that is as far as we can reasonably go. I hope the committee agrees with that.

The Convener: I think the Finance Committee tends to be sceptical at all times.

I have one final question, on health promotion and the requirements in paragraphs 38, 39 and 40, which describe the statutory duty that will be placed on boards in relation to health improvement. If the statutory function is to be meaningful, how can it be carried out without additional expenditure? In addition, who will audit the boards' provision in meeting that statutory function, because there is a gap in terms of the reorganisation?

Lorna Clark: Health boards are given an annual allocation and it is up to them to determine within the sums that are available to them how they will manage and deliver local health care systems that meet the health care needs of their local population. A lot of boards have been doing work on health improvement. As with the duty on public involvement, we are building on and making more explicit what a lot of boards have been doing already.

The most recent figures that are available show NHS boards' planned expenditure on health promotion in 2002-03 as around £24 million. That funding is incorporated in the resources that they have and will continue to flow into the present time.

If my colleagues are unable to answer the question about how that expenditure will be monitored, we can find out and get back to you.

The Convener: That would be helpful. On behalf of the committee, I thank the witnesses for coming along this morning.

11:14

Meeting suspended.

11:17

On resuming—

Budget Process 2004-05

The Convener: The second item on the agenda is further consideration of the budget process for 2004-05. As previously agreed, we will consider issues surrounding performance assessment in health, in the context of how what has been learnt in health can be applied to other areas of the budget.

I welcome Dr Andrew Walker and Professor Kevin Woods from the University of Glasgow. Members will have received copies of the written submissions from both Dr Walker and Professor Woods, and I shall offer them both the opportunity to say something in addition to what they have written. Perhaps Andrew Walker can go first.

Dr Andrew Walker (University of Glasgow): Thank you for inviting me. In my written submission, I initially tried to explain roughly what the performance assessment framework is, just in case anybody was not clear about that. Members will probably have gathered from listening to the previous witnesses that Alistair Brown, who was sitting at the far end, is the man who is responsible for that. Perhaps the committee should have kept him here and quizzed him as well.

Most of the health services that we know and love locally are provided through 15 geographically defined NHS boards, and the performance assessment framework is how the Scottish Executive Health Department checks that the 15 local health boards are doing their job and are meeting the targets that are set down for them. Alistair Brown said that there are around 90 numerical quantitative indicators. I think that there are about 109 indicators in total, so there must be around 20 qualitative ones. The number grows quite a lot from year to year.

In my written submission, I tried to set out for the committee what all those indicators are so that members know what we are talking about when we talk about the PAF. You can imagine that, when everything is added together, it amounts to quite a chunky set of data. Numerical indicators are available on the Executive's website, although the qualitative ones are not currently available.

There are seven different headings. The first one is "Health improvement and reducing inequalities", which covers mortality rates, smoking rates and so on. The second heading is "Fair access to healthcare services", where we would have our waiting time targets and the number of GPs. The third heading is "Clinical governance, quality and effectiveness of health care", and that is where we would have NHS Quality Improvement Scotland's standards. The fourth heading is "Patients' experience, including service quality", which is largely assessed by boards themselves against Executive strategies to see whether or not they are achieving those aims.

The fifth heading is "Involving public and communities". Again, that is largely self-assessed by health boards against pre-defined Executive criteria. The sixth heading, "Staff Governance", falls into the same category, as it is largely self-assessed. Under the seventh heading, "Organisational and Financial Performance Efficiency", there are a variety of things such as length of stay and financial indicators.

One of my other hats is as budget adviser to the Health Committee. I was an adviser on the budget two years ago and I am an adviser this year as well. When the minister gave evidence to the Health and Community Care Committee a little while ago, he said that the PAF was part of a change in the culture of the NHS that would look for improvement in a transparent way. He suggested that the framework would pick up problems prospectively—I am not completely convinced by that—but he emphasised that the process is evolving. He said that the PAF is not completely perfect at the moment but that it is moving on. By and large, I think that that is a fair assessment.

On the impact of the PAF, the oral evidence that health boards gave to the Health and Community Care Committee certainly suggests that the framework is quite central to their thinking. When Lothian NHS Board and Highland NHS Board gave evidence to that committee last year, they certainly said that the framework was right in the middle of their thinking. As the career path of NHS managers might well depend on how well they hit a lot of the targets, one imagines that the framework will be very central indeed to the thinking of the management team.

I had not really thought about this until I wrote the document, but it is interesting that not many people beyond the small NHS world that I partly inhabit are aware of what the PAF is. When the latest delayed discharge figures came out the other day, people in the Parliament obviously wanted to comment on them, but when there is a big data release for the PAF, I do not see the Parliament being flooded the next day with questions about different indicators and why different boards behave in different ways. The Parliament may be at least partly aware of the PAF, but the public is hardly aware of it at all. I realise that the nature of the scoring for the indicators is quite technical—the statistical methods are appropriate, but they are quite hard for the lay person to understand. The fact that we

have not gone down the English route by producing league tables and traffic-light performance systems, and the fact that the qualitative assessments are not publicly available might suggest that the Scottish Executive Health Department sees the PAF, at this stage of its evolution, largely as an internal management tool.

If I may continue to speak from the NHS point of view—in a previous incarnation, I was a health economist at Greater Glasgow Health Board—I think that it is helpful for a health board to know what it is aiming for. When a health board gets its annual assessment from the Health Department, it is helpful to know exactly what will be discussed, what data will be available and what the evidence base for reaching decisions is. That is terrifically helpful.

My concern about the PAF is, first, that largely it still compares performance with national averages. For instance, if Scotland does not compare very well nationally for a particular type of cancer survival or a particular smoking rate, it may not be a terribly challenging or desirable target to reach the Scottish national average. It would be good if we could progress to more absolute targets about reducing things. Once boards have reached the Scottish national average, there might a tendency for them to think that they are now in what might be called a comfort zone, although if we take a step back, we might say that that is not really a very good comfort zone.

In a previous evidence session, a question was asked about what the highest priority was. When the minister gave evidence to the Health and Community Care Committee in, I think, November 2002, he admitted that the financial target was still important, on the ground that, if boards did not balance and have control of their budgets, they would find it hard to do everything else. Having seen Tayside's example, we would probably accept that.

When the minister was in front of the Health Committee last week, he picked out service redesign and public involvement as two of the key priorities for the next year or two. Incidentally, I notice that those priorities are two of the hardest to measure and two of the ones that it would be most difficult to disentangle from the PAF.

The second perspective I have tried to give is from the health gain point of view. The Health Committee often tries to pin down the minister on the difficult concept of outcomes. When politicians talk about outcomes, they are talking about what I might call political outcomes, such as reductions in waiting times. My training is as an economist, and my idea of an outcome would be better health: do people live longer and do they have a better quality of life? The Executive would acknowledge that that is one of the areas where the PAF is weakest.

If I was looking for more general lessons, I would go beyond the Health Department. Let us not get too bound up in the existing data. Let us try to think about what we want to measure and the ways in which we can measure it, not just about what data we have and how we can divide one figure by another to get another indicator. In that context, although figures such as those on cancer survival rates and post-operative mortality are helpful, they are largely about death and, fortunately, death does not affect most of the people who use the NHS, contrary to reports in the tabloids. A lot of people go to the NHS when they are in pain and want the pain to be reduced. That is not covered as an outcome measure at the moment: how many people's pain are we reducing and to what extent?

The final perspective I tried to give was in my mind as adviser to the Health Committee—I am sure that it is also in members' minds—and is the national budget assessment point of view. I can see that the PAF gives the health service a broad direction of travel, certainly in relation to some long-term targets such as reducing deaths from heart disease in people below the age of 75 by 50 per cent between 1995 and 2010. We can measure and track progress on such a target. A major issue for the Health Committee is what the NHS boards do with the £5 billion that is devolved to them. That takes a lot of the committee's time, as Kate Maclean knows. The PAF gives local NHS boards a broad direction of travel, but it is not integrated with the budget process or linked to expenditure, and it is retrospective, whereas the budget is prospective and looks forward a year or two. We are considering the expenditure plans for 2004-05 and the performance data that we have are from 2001-02. There is a bit of a gap.

As an internal management tool, to try to keep the health service delivering technical efficiency and getting more out of the existing resources, the PAF provides a helpful set of indicators, depending on how they are used. As an economist, I would like to take a step back and would like there to be more information on how many people are getting better and to what extent they are getting better—I call that health gain. That is probably the gap in the information and I hope that we can make more progress on that.

Professor Kevin Woods (University of Glasgow): Thank you for inviting me to contribute to the committee's consideration of these matters. I submitted a paper and subsequently received a letter from the clerks raising a couple of questions. The first question was whether health spending can be linked to individual objectives and tracked. The second was how the performance

management process in health works, and whether it would help with the first question. I would be happy to elaborate on both of those if it would help the committee.

The Convener: Feel free. That would be useful.

Professor Woods: Do you want me to launch into that?

The Convener: That would be helpful.

Professor Woods: I will deal with the first question. The short answer is yes, but it is not straightforward; it is potentially time consuming and costly. The formal name that is given to such methodologies is programme budgeting and marginal analysis. The marginal analysis component is somewhat easier in that all we have to do is obtain information that indicates how people are proposing to use additional resources. The difficulty is in constructing a detailed analysis of the health programme by breaking it down into component parts in terms of the cumulative historical spending.

11:30

There is a good example in the public domain of the kind of work that can be done at the margin. I have with me the 2002-03 monitoring report of the south east Scotland cancer network, which includes an annex that indicates what has happened to the additional resources that the organisation received. It sets out clearly the amount that was made available, what was proposed should be done with the money, why that was proposed and what the impact of that spending should be in relation to a number of objectives and targets that have been set for that network. In theory, a similar approach could be taken to any objective.

On the performance management process, it is important to say that the indicator set that Dr Walker has just described is, in a sense, a set of resources that feed the process and help it along. I will try to explain briefly how I believe the process operates.

The Scottish Executive sets the strategic direction for the national health service. It sets targets that it believes are achievable and describes a set of objectives relating to how services should be improved and changed, some of which will have specific targets attached to them. Traditionally, the department has issued priorities and planning guidance on a yearly basis relating to where it wants energy to be devoted. That is how the statement of 12 priorities that was referred to earlier is arrived at.

In addition to that, the department produces a substantial amount of other detailed guidance on the way in which services should be developed and resources should be used. After a local consultation process, NHS boards prepare detailed plans to invest those resources in changes to services in response to that guidance once they know their budgets or based on an assumption of what the budget might be. At that point, the department engages in a process of cross-examination and monitoring of the boards and of testing the proposals through the accountability review process. Those discussions are informed by the evidence that is gathered through the performance assessment framework. The process involves examining the extent to which boards are doing the things that they said they would do and testing the extent to which investment and service development are being linked. It is a cyclical process that goes on throughout the year, culminating in an annual meeting between the department and the NHS board.

Ms Alexander: Dr Walker, you said that you would expect that your papers would be a puzzle for the committee because they are nuanced and complex and present no easy answers, which is not the sort of thing that politicians are used to. I therefore ask you to expand on two areas.

You said that service redesign, which is currently a major consideration and should be a major driver of management time in the NHS, is not adequately reflected in the PAF and perhaps cannot be. How can we build in sufficient recognition of service redesign over the next five years? We must make progress in that regard as, obviously, one result of that could be considerable health gain.

You suggest that we are in danger of measuring what we have data on rather than what matters objectively, which is health gain rather than politically chosen statistics or mortality statistics that are chosen because they are available. My second question is about how much we know about measuring health gain. The committee can recognise your points, but we cannot drive forward that agenda or propose alternatives to the PAF or the system to which we migrate unless we begin to get clarity about health gain. I do not want to do you a disservice, but your paper only touches on the difficulties of integrating the findings of the National Institute for Clinical Excellence—NICE—and other issues into that.

First, given that service redesign should be a top priority in the next five years, how should that be recognised in the performance management process? Secondly, do we know enough about how to measure health gain and how can we learn more about that and integrate it into the PAF?

Dr Walker: Given that the PAF will reflect the impact of elements of service redesign such as length-of-stay shortening and prescribing of

different drugs, I would not say that the two are completely at odds with each other. Although we all think that service redesign is a good idea, it is not a well-defined policy and it is hard to know what it means. I am not clear that the exact meaning of service redesign is set out anywhere, which means that, until the policy is better defined, its meaning will be a little in the eye of the beholder. To make a decent performance indicator, we must know exactly what the policy is in a measurable way.

As I have alluded to, the way in which we have handled difficult numbers issues in the PAF to date has been through qualitative indicators, which means that the data are a bit softer. At the moment, the data are not publicly available, although, having talked to colleagues earlier, I think that that is an oversight rather than a deliberate policy. The answer to your first question is that qualitative indicators would have to be used. I cannot see easy ways in which to quantify such a broad and diffuse policy.

Your second question was about how to integrate health gain. At the moment, we concentrate on mortality, because that is an objective measure—observers can usually agree on whether someone is dead. Unfortunately, around 60,000 Scots die per year and about a million use the NHS, which means that there is a considerable mismatch between the number of cases in which mortality is a relevant indicator and the number of users of the NHS. You rightly say that measuring health gain is not as easy as it sounds, although it can sound simple and attractive. My favourite fact about Florence Nightingale is that, 150 years ago, she had a system of classifying patients into relieved, not relieved and dead; today in the NHS we do not have anything so sophisticated.

Economists, sociologists and psychologists have views on measuring health gain. With another hat on, I am an economic adviser to the Scottish medicines consortium, which decides whether to recommend new drugs to the NHS. We ask pharmaceutical companies to make a submission that quantifies the cost and the health gain of new drugs in terms of how many people will be made better and the extent to which they will be made better, either on a pain or disability scale or by trying to combine those into a more general measure of quality of life. Companies achieve that. Ways to measure health gain are already used in our decision making, although I admit that they are imperfect.

That model for new medicines is a good one and perhaps we could consider integrating it into other areas of the health service. I do not advocate measuring outcomes for all the million people who use NHS Scotland every year. I am saying that we should pick out the services that give us a lot of health gain for a moderate amount of money and then monitor how much of those each health board buys. To some extent the PAF does that, in that it talks about, for example, hip and knee replacements and heart surgery. I would like that to be extended to such matters as anti-smoking interventions, which are incredibly cost-effective, according to NICE. I would ask health boards how many of those they are buying, because at the moment they are not included.

At the other end of the scale are services for which the case is not proved or which do not offer good value. Those services should be indicated in the budget and it should be stated that they will not be bought because that would mean spending money for no provable health gain.

There should be a central body that goes beyond NICE and which should have two lists: the first would indicate which services are excellent value for money; and the second would indicate which services are unproved or offer poor value for money. The PAF could then have indicators showing whether local health boards are investing in services in the first list but not putting much money into services in the second list.

Dr Murray: Both papers are interesting, as are the tables of indicators, which seem to fall into different categories. There are services that are measured because they are easy to measure, such as the number of particular operations that are performed in a health board area; there are health improvement measures, such as screening and detection, which could have a greater health gain; and there are measures that might prevent people from being ill and having to use the health service in the first place.

The difficulties lie with the preventive measures, which are often not under a health board's control. Also, how robust are the statistics, for example on the proportion of adults who exceed weekly limits for alcohol units? How do we know that such statistics are accurate? We certainly know that people are untruthful about such matters. Another example is the taking of exercise. It is difficult for a health board to influence that, but the lack of sufficient exercise may be the most fundamental aspect of the ill health of the people of Scotland.

Professor Woods: We know about such matters because of the data generated through the Scottish health surveys, which are very rigorous. We know the level of confidence that we can have in the results for any particular category.

More generally, it is difficult to measure some health gain aspects because they are necessarily long term. Actions that are taken today might not bear fruit for many years, so it is important to have monitoring services that enable us to assess

whether we are making progress. That is why the PAF has a series of indicators that consider health targets longitudinally in order to assess how year-on-year performance is changing.

Outcomes are necessarily long term, but it is possible, through the qualitative process and discussions with health boards, to develop a sense of the extent to which boards are implementing processes that are believed to be valid and to make a difference. The technical jargon we use for such measurement is interim outcomes, or interim steps. What is measured is the number of people who are taking advantage of a particular service that is believed to have a long-term benefit—for example, the reduction of coronary heart disease.

Jeremy Purvis: Within the health budget there are four objectives and 14 national targets. There is also a proliferation of clinical guidance and standards for each board. The relationship between the centre and the locality is a fundamental problem. The pressure comes from the centre, but we would all hold up our hands in horror if it were proposed to abolish local boards and local accountability. There seems to be a major structural difficulty in getting a clear idea of what we would term our national clinical priorities and how services are designed at a local level to implement them. Is it possible that there is too much work going on in this area? Dr Walker suggested taking a more targeted approach in our priority areas to assess what is effective, which may not necessarily be the most expensive or the cheapest service. This is where the Finance Committee has a problem when it examines the budget. We look where the money goes and think that the Government is committed to that area because it is spending a lot of money, but that may not be the most effective way.

Dr Walker: I think that you are right. I sometimes feel that the Executive, especially when it appears before a committee that is scrutinising it, tends to say that the money goes down to local level and that what is then done with that money is a matter for local decision making. The Executive leaves it to the 15 health boards to make their own decisions and then gets upset when they come to 15 different decisions—hence the postcode prescribing problems. In fairness to the Executive, I say that the group that I work for—the SMC—is about to try to address those problems.

11:45

Personally, I do not have any strong feelings on where those decisions should be made, but my training tells me that they should be evidence based. Making one decision centrally in a group such as NICE or the SMC, using the best evidence, at least has arguments to do with economies of scale behind it. The trade-off from doing that is that when the SMC or NICE recommends something and local health boards are committed to spending money on it, neither the SMC nor NICE considers what is being crowded out locally as a result. Glasgow gave the example that funding the multiple sclerosis drugs was crowding out local investments that it thought were more important.

There is no easy way round that trade-off. If the members of the SMC are sitting in a room in Glasgow, they cannot consider the local implications in 15 or more different places. I know that that issue exercises all of us, whether it arises in local government, education or the health service. Personally, I would not mind as long as we had two things: first, an evidence-based decision; and, secondly, some idea of the local crowding out and the local public's views. I am sure that Kevin Woods will say more about that in a minute. We need some way to get the public involved in the priority-setting process, because that is lacking at the moment.

John Swinburne: I would like to reflect on what you just said about priorities. I sit on the cross-party group in the Scottish Parliament on ME. No one in the medical field knows exactly what myalgic encephalomyelitis is, yet it costs the economy of this country a fortune. Something has to be laid aside for research on that problem, to see whether we can cut down on that economic waste. People are suffering and no one knows why, or what ME is. The medical profession just shrugs its shoulders and pushes the issue into the corner, which is not good enough.

Professor Woods: I would like to go back to the previous point, because there is something that I wanted to add. Inevitably, there is a degree of tension between national and local priorities. That is the nature of the service that we have, with 15 NHS boards with powers of decision making. In addition, there are great pressures on ministers, from institutions such as this one, to change health services from a national level.

The evidence internationally is that when there is a publicly funded health service run by a Government minister and his department through statutory bodies, it is inevitably drawn into more and more sophisticated attempts to measure performance. The proliferation of indicators and measures is observed in nearly every system. There is no short cut. For example, there are always people who want to know a lot about the subject that John Swinburne just raised. If a public health service that seeks to provide a comprehensive service, from dealing with newborn infants to the care of the elderly and treating the terminally ill, is to be held to account—and it is the

notion of accountability that is driving the growth in the systems, indicators and processes—there will be a search for more appropriate measures of virtually every aspect of performance.

The Executive has been trying to take a balanced approach and to find a way of measuring aspects of the service without bringing the system to a grinding halt through people having to continually feed information upwards.

Jeremy Purvis: Am I right in saying that the existing mechanism in the PAF for reporting back to the boards is an annual letter?

Professor Woods: That is the outcome from the accountability review process.

Jeremy Purvis: The letter is from the minister or the chief executive.

Professor Woods: It is usually from the chief executive of the NHS.

Jeremy Purvis: It goes to the local boards and tells them where they stand and the areas in which they need to make improvements. If that is a two-way process, it might be an area where we can gain a bit more understanding about local pressures and the crowding out that Dr Walker talked about.

Professor Woods: Indeed. It is a two-way process—a dialogue. The final paragraph in my submission says that the indicators should be regarded as a tool for informing a process of dialogue and discussion. They should be prompts that cause people to reflect on what is happening and take appropriate action. In a sense, the review meeting is the pinnacle of that process. The board and the chief executive come together to consider the extent to which progress has been made, using those indicators to inform the process.

Jeremy Purvis: How much is that review about boards having to correct areas where they have not done what was agreed or have not performed well during the past year, and how much is it about how they will be operating during the year ahead? In your evidence, you said that there is no equivalent. That is the forward planning and the proactive work.

Professor Woods: In my experience, the process is a combination of two things. There is the backwards look—the process of accountability that asks how the local boards did. That might well lead to challenging discussions. The other component of the discussion is what the boards propose to do in the forthcoming year and how they intend to use the resources that have been given to them. They are asked to show how they intend to make investments and use resources to further the agreed objectives. That is where we get into the detailed scrutiny of local plans. The letter from the chief executive of the NHS generally contains both those components in that it looks back as well as forward.

Professor Arthur Midwinter (Adviser): I found both presentations to be very helpful to the committee's struggle to develop the performance side of the budget. They gave us some insights for next week's meeting, when we will try to sharpen up the performance information that we get.

I have a question for Andrew Walker and one for Kevin Woods.

There are indicators in the budget for falling death rates from cancer and other diseases. The technical support notes suggest that there has been annual improvement in those rates each year since 1995. Despite what Andrew Walker said about measuring death, can we assume that those figures are a reasonable proxy for improvement in health given that standardised mortality ratios are used as such a proxy in other aspects of health care? Would we be justified in making a link between the additional resources that have been allocated to the health service during the past six or seven years and those improvements?

Dr Walker: The health improvement measures for long-term reductions in mortality are in the budget. The rates are improving year on year and the Executive says in the draft budget that it anticipates that the 2010 target will be met.

Are the mortality figures a proxy for health gain? They show a long-term trend that arguably pre-existed the setting of the target for the fall in premature heart disease and cancer mortality, which we think has probably come about because of a gradual decline in the smoking rate and a gradual improvement in the diet and wealth of society. They probably also show that we have got our act together on heart-disease services, such as the use of statins—drugs that lower cholesterol levels—and the number of interventions that we do for people who have heart disease. However, cardiology is only one area of the health service. Although we can say that it is going well, as Mr Swinburne said we have to consider the ME service, the multiple sclerosis service, the chronic pain service, the rheumatoid arthritis service, the asthma service—arguably—and the diabetes service. Nothing in the mortality stakes will help us with that. The trick will work for particular areas of the service. It is arguable that it might work for cancer and oncology, but there are big areas that it will not work for and that is what I am trying to get at.

Professor Woods: The difficulty that is raised is the issue of attribution. Death rates might be going down and investment might be going in, but we cannot be absolutely sure what the connection is. The best that we can do—this is a perfectly

reasonable line to take—is to plan investments in accordance with the evidence that suggests that if we do X or Y, it should have a beneficial impact, perhaps some years down the track. There is an increasing amount of evidence about what should be done in relation to a number of health objectives and targets. Time may show that some of that evidence is not as good as it might have been, but the best that we can do at any particular time is to plan investments in accordance with the evidence base and observe what happens.

Professor Midwinter: My second question relates to the issue of attribution. As you were speaking, I thought back to lectures that I had heard on decision making and the notion of a black box. That is what the Finance Committee faces with the budget plans. We get sums of money, targets and statements that the ministers cannot say how the money will be spent when it goes to the health boards. Conventional economic theory might suggest that if we get the inputs and put them in a black box and the outcomes are okay, we have nothing to worry about.

What I found really interesting was hearing you describe how the PAF operated. If I have picked you up right, it is not just about the indicators but about the discussion round them. That stage is missing in our process. We have a spending review process, the grand launch of the document and the indicators, but we do not have a meeting with the ministers at the end of the process where we can discuss informally how things worked in practice, in the same way that you had meetings with the boards in your health service days. In the light of your experience working in the NHS, do you think that that would be practical for us?

I had a notion that the PAF might offer us lessons and, having heard what you have said, I am almost convinced that it does. How would the department feel? I am not asking you to speak for the department, as that would put you in a different position.

Professor Woods: I would be cautious about doing so. The PAF is an information source. What you are driving at here is that it serves a set of management processes between the department and the boards. The point to emphasise is that the dialogue continues throughout the year. There is an annual meeting, but if you were to go through the detail of the qualitative indicators in particular, you would see that the department indicates the frequency with which it will engage in formal discussion through monitoring visits and so on with the individual boards. I have not bothered to tot up how many visits there will be, but it is safe to assume that NHS boards will receive many visitors from the Executive inquiring about a particular aspect of performance. That is the only way in which that can be done. To that extent, the PAF is quite a costly process.

To answer the latter part of your question, I am not sure, but I suspect that Mr Chisholm might say that he continually appears in front of the Parliament to give an account of his stewardship of the NHS. I am not sure that I would like to comment on whether there should be engagement in a more detailed process.

Professor Midwinter: Towards the end of the process, if the Executive has flagged up certain indicators as targets, it would seem perfectly reasonable that we should want to see whether progress has been made against those targets before going on to a new spending review process.

I can well understand why you may not want to speak on behalf of the department.

12:00

Dr Walker: We talked earlier about the link between objectives and spending and whether it was possible to make such a link. Having been through one and a half rounds of the budget process with the Health Committee, I can say that that has been incredibly difficult to do.

When the Health Committee took evidence from the chief executive of the NHS in Scotland last week, he admitted that the Executive does not know how much the waiting times policy will cost in total. The Executive knows what the cost is for the waiting times unit and for the Golden Jubilee hospital, but the amount that is spent on waiting times at local health board level is not known. This committee's experience from this morning, when it tried to find out the cost of the National Health Service Reform (Scotland) Bill, reflects entirely the experience of the Health and Community Care Committee two years ago and, probably, of the Health Committee this year. The line from the Executive is always, "We give £5 billion to the health boards. What they do with it after that is within their control. We do not know the exact details of that, although we obviously set targets." I just wanted to make the point that it will not be as easy as we may think to link objectives and spending.

Ms Alexander: In view of the time, I will keep my question brief. The submission from Kevin Woods seems to be a plea for a more balanced view of performance. As he points out, there is clearly a tension between striving for ever-greater sophistication of the performance measures and not undermining the motivation of staff within the service. Julian Le Grand's comments on that issue are pointed out in the submission.

I do not invite Kevin Woods to comment specifically here—we have neither the time nor, indeed, the information—but his submission seems to hint at a reform of the draft budget's 13

targets over the medium term, so that we capture a more whole and balanced view of performance. I simply say that that matter is of interest to the committee and I ask him to keep us in touch with that as that work evolves. However, I do not know how much further we can take that issue just now.

Professor Woods: The issue that Julian Le Grand points to is the scale, weight and style of the process. As I say in my paper, information that can be extraordinarily valuable in helping people to chart how they are getting on becomes—some have said—a stick with which to beat them, which undermines the intrinsic motivation for doing a job very well. That issue needs to be thought about carefully. The Executive has produced what it calls a performance incentive framework. The framework is in its early days and so perhaps it should not be judged too soon, but it signals an awareness of that danger. It is welcome that people are alert to that set of issues.

In a sense, the issue was put very neatly in a letter in this morning's edition of *The Times*, which I will quote from if members do not mind. The context is the suggestion that GP performance should be published. The letter comes from a GP in Northumberland who writes that GPs in Northumberland have voluntarily been comparing and publishing their performance for some time. They chose to do that. The letter states:

"This was implemented by GPs themselves when they were part of the Primary Care Group, and not at the diktat of politicians or managers.

This has resulted not in any mass exodus of either patients or doctors from those practices at the lower end of the scale, but rather in a spirit of friendly competition between the individual practices."

The interesting point—which is the argument that Julian Le Grand makes—is that those people have voluntarily chosen to put powerful information in the public domain and to use it for the purposes of continuous performance improvement. The practitioners have reached that decision themselves; they have not done so in response to top-down pressure.

In the literature on performance management and performance assessment, a number of people have flagged up the danger that such things might turn from being useful devices that support intrinsic motivators to become things that are punitive and that undermine the sense of vocation and commitment that is vital to continuous improvement.

The Convener: That is a valuable point.

Jim Mather: I am interested in what you said about putting information in the public domain. I am also interested in how the burden of seeking health gain can be spread and how its achievement might more readily be progressed. Have you any thoughts on how best to produce, present and publish outcome data and recommended best practice to encourage health boards, GPs, employers, individuals, schools and other entities whose activities impinge on health care to do the right thing in order to maximise the chance of optimal future health care?

Dr Walker: Through the Scottish medicines consortium and partly through NICE, we already have systems that have started to do that. Things get formalised in guidelines, then NHS Quality Improvement Scotland comes along and checks up. I argue that our approach should be much more fundamental. New medicines might make up—I am guessing—between £50 million and £100 million of the NHS bill every year. Although they are very important and attract a lot of attention, they are actually quite a small part of the story—there is a whole lot more going on out there. I advocate a system that starts to work through all our existing services and which puts them into different lists according to how much we should invest in them.

For three years, we had the Health Technology Board for Scotland, whose style of working was to spend a lot of time getting together a very weighty report—in three years it produced about six assessments. What was needed was much quicker working in slightly less detail to produce a much wider range of health technology assessments, so that we could start to see a wider range of health gains. In a way, we might have lost that opportunity because of the style of working that was selected for that organisation.

Jim Mather: In addition to medicines, do you see there being an equal, or maybe even weightier, emphasis on nutrition, good diet and exercise?

Dr Walker: Absolutely. The old adage about an ounce of prevention being worth a pound of cure is backed up by most of the economics that we know about. NICE says that anti-smoking interventions are among the most cost-effective approaches that we can take. Dispensing drugs to people in the last days of their lives is one of the least cost-effective things that we can do, but we continue to spend money on those drugs for humanitarian reasons. The performance assessment framework would ideally encourage health boards to stop people smoking and perhaps place less emphasis on putting drugs into people who are basically dying.

The Convener: Is it possible, from an economist's point of view, to assess the balance of advantage of different forms of expenditure and to build that into how allocations are considered?

Dr Walker: I think so. As a result of last year's budget, the Health and Community Care

Committee asked the Health Department to start to examine the different programmes in the budget and to say what the outcomes of those programmes were. That way, when the Finance Committee asks us the perfectly reasonable question about what would happen if we moved £100 million from one part of the budget to another, we would know what we would gain in the programme that benefited and what we would lose somewhere else.

For some reason that we are not quite clear about, that recommendation seems to have been lost along the way, but I can guarantee that it will be repeated again when our paper comes to you in a month's time. Without it, we will be using our instincts and judgment as to the right thing to do. Our instincts and judgment may be well-motivated, but they do not give us a sound evidence base for the outcomes for the health of the population of Scotland.

Professor Woods: The key point that Dr Walker has just mentioned is evidence, of which there are varying levels. We know rather more about what works in some areas than we do in others. The evidence base needs to be expanded to enable us to consider the trade-offs that were described. On the other hand, it is sometimes difficult to say that we will do nothing until we have the evidence. There might be good theoretical grounds for proceeding in a particular way, and it is important that we proceed in a way that enables us to evaluate and test the impact of the changes in order to add to the evidence base.

The Convener: Is it not the case that the quality of evidence that can be gathered about, for example, mortality or the causes of mortality is of a significantly higher technical level than the evidence that we might have about the effectiveness of various health solutions? Michael Marmot produced a paper that identified and traced exactly the causes of various death rates and health outcomes internationally. However, less effort is put into examining localised health solutions and the effectiveness of particular types of intervention, whether smoking cessation, exercise or whatever.

Dr Walker: It is easier to be precise about evidence when the outcome evidence is either "dead" or "not dead". Unfortunately, the illnesses that most of us will deal with in our lives are of a chronic nature and will be to do with pain, immobility and so on. While it is more difficult to gather evidence relating to those areas, it is arguably more important to do so, as they will affect more people to a greater extent.

Professor Woods: Where there is good-quality evidence, it should guide investment decisions. However, where there is uncertainty, the Health Department has tried to reach a view based on advice, opinion and so on, while recognising that that evidence might not be as good as evidence gathered through clinical trials, for example. National statements about cancer, heart disease, mental illness and other such priority areas will be based on a blend of evidence that is underpinned by high-quality research but which also reflects a consensus of interventions that show promise and which are believed to be the appropriate way forward.

My point is that, especially when interventions are being tried in an experimental way, there should be a framework that enables the evidence base to be extended and improved.

Fergus Ewing: I am indebted to both witnesses for the stimulating discussion that the paper and their evidence have produced. However, I am unclear as to the utility of what is being proposed. In particular, I am unconvinced about the idea of adding more performance assessments to the 109 indicators that we already have. Obviously, more staff would be needed to administer the assessments and, as paragraph 7 of your submission indicates, possibly even a new quango.

I wanted to put forward what seems to be a fundamental criticism of that approach. In paragraph 6, you say that, while the NHS can tell when people die, when they go into hospital and how long they spend on a waiting list, it cannot tell whether people get better. Once I go to my GP, I will go back to my GP until I am better, dead or have received a clear prognosis. The same applies to going to hospital, because people return to the hospital as outpatients. I presume that we accept that the vast range of medical treatments, whether they are acute or primary and whether they involve operations or drugs, are effective—we are a long way from leeches—and that, if they are not effective, there are systems to deal with that, including disciplinary and other internal procedures.

Paragraph 7 of the submission says that

"we need a clearer national view on which services are particularly cost-effective".

What would be the point of such an exercise and how much would it cost? As it would inevitably add to the cost of administration, would you at least accept that there is a strong argument that the money would be better spent directly on treatment or, as Mr Swinburne said earlier, on research into those serious conditions, such as ME, for which there is no cure? I am afraid that I am a bit of a sceptic, but if you could give a specific, clear example of a new indicator that you would like to be used, which would add to the common weal and which would be money well spent, I would be most curious to know what that is.

Dr Walker: On what you said about adding to the number of indicators, I would be happy to get rid of some if you would like, although it is not in my power to do so.

Fergus Ewing: Perhaps you could tell us later which ones. That sounds like a good idea.

Dr Walker: To me, it is all about outcomes; it is not so much about processes, inputs and so on. If the patient gets better, that is the point of it all. A lot of this is about outcomes that are not specific.

You said that, if you had a problem, you would go back to your GP until you were better, dead or had a clear prognosis. My comments sprang from the experience of the health service of a number of friends and relatives who had more or less unsatisfactory outcomes. Their experiences were of, for example, back pain and being diagnosed with diabetes. The people concerned were certainly not dead and were probably given a clear prognosis, but, in my judgment, they were not in the best health that they might have been in had they received the best service that they could have got. There is perhaps an issue of quality and of whether people are getting the best outcomes that they can.

12:15

Fergus Ewing: I understand that point, and I do not mean to belittle those experiences in any way, or to simplify them. Some people will of course be dissatisfied or unhappy if some pain remains. However, given the difficulties that Dr Murray has described with the subjective nature, sufficiency and reliability of data, I am not sure about how the existence of a new performance assessment framework would help your friends who felt that they did not get the top service that we would all like them to have received.

Dr Walker: I understand that. You questioned the cost of having another quango, and I accept the Parliament's sensitivity to the idea of further quangos. We are spending £7.5 billion of taxpayers' money, so it must make sense to spend a very limited amount of it on a means of ensuring that the funding is spent in the best way. At the moment, it is hard to resist the introduction of a new service, and it is difficult to make checks or to question its cost-effectiveness right at the outset.

The most cost-effective measures that we know about in this area are probably anti-smoking interventions; one of the least cost-effective measures in terms of health gain for money spent is probably beta interferon, the drug for multiple sclerosis. If I had £1 million to spend, by my conventional way of measuring health gain, I could get at least 100 times as much health gain from anti-smoking interventions as I could get from spending that money on beta interferon for multiple sclerosis.

Fergus Ewing: I think that we would accept that, but how would gathering data result in more people giving up smoking?

Dr Walker: Because I am arguing for funding interventions by health boards that will help people to give up smoking. We have measures of proven effectiveness that NICE has evaluated, such as nicotine patches. How much are health boards putting into those measures to ensure that they are actually available to people? The measures are not in the performance assessment framework, but I am arguing that they should be in it. How many such processes of proven cost-effectiveness are health boards buying?

Professor Woods: The health service is incredibly complex. If we rely on performance management processes of the sort that I have described, there will be an increasing tendency to want additional indicators to inform assessments of performance. One area in which more might be done is the patient experience of the health service. That is not necessarily the same as the performance assessment framework per se; I am referring to a means of informing local services about how well they are doing. Some of the examples that the committee has just touched on might be relevant to that.

There are some valid, useful techniques around to support change processes locally. I am not talking here about patient satisfaction questionnaires, which generally show high levels of satisfaction; I am talking about techniques that allow us to discover the experience of the health service that patients have had. Without wishing to create an additional layer of bureaucracy or anything like that, but taking into account the balance in the current range of indicators, I would say that more might be done in using indicators that deal with patient experience to support local change processes.

The Convener: John Swinburne will ask the final question.

John Swinburne: The discussion has been stimulating and interesting. My generation would be better served if the Executive would take a quarter of it out of poverty; that would do more to help the health care of that quarter of a million people in Scotland than would anything else. Some of the money that is available should be pushed in the direction of taking my generation completely out of poverty.

The Convener: That is a rhetorical question.

John Swinburne: There is no answer to that, by the way.

The Convener: I thank the witnesses for coming along. We found the session stimulating.

Cross-cutting Expenditure Review

12:20

The Convener: The third item on the agenda is consideration of our approach to a cross-cutting review on economic development. In particular, we want to consider, in principle, whether to appoint an adviser. Members have a copy of a briefing that the Scottish Parliament information centre prepared and a note from the clerk. I invite comments from members.

Ms Alexander: I do not think that we can resolve the issue today, in view of the time. I ask that a paper be prepared for next week that might help in the discussion that we need to have. I will run through table 1 of the Scottish Parliament information centre briefing, which outlines the amount of money that is spent on economic development because, in my view, that is the key to the whole discussion.

The 50 per cent of the budget that is spent on enterprise and lifelong learning should be split up into money that is spent on the enterprise network, money that is spent on further education and higher education and money that is spent on industrial support at the hands of the Executive. That would demonstrate that less than 10 per cent is spent on the enterprise network, 38 per cent is spent on further and higher education, 2 per cent is spent on industrial support by the Executive, 10 per cent is spent on transport and less than 1 per cent is spent on VisitScotland.

It is interesting that more than 5 per cent is spent on rural areas and that 8 per cent is spent on the common agricultural policy and so on. A pie chart that examines the total spend and which breaks down the enterprise and lifelong learning budget heading would let us focus on the big issues, not least the 40-plus per cent that is spent on education. That would facilitate a discussion next week about what we are looking for in an adviser. The fact that we spend as much, if not more, on the CAP as we do on enterprise bodies would make for an interesting discussion, especially as we are the only committee that can reflect on such matters. If the clerks could provide that information for next week, we could revisit the inquiry's scope then; I will not expand on my views on that at the moment.

The Convener: Our next meeting is on 28 October. Do other members have comments?

Jeremy Purvis: I am not sure whether it would be possible, but it would useful to find out how that budget is divided within Scotland. At one of the committee's first meetings, I raised my concerns about the mechanisms for dividing up economic spend throughout Scotland. I think that that is done in a number of ways and I am not certain that the process is coherent. As the Finance Committee, it is part of our role to consider that issue.

Fisheries, VisitScotland, enterprise and transport are all headings in the table to which Wendy Alexander referred. In all those areas, there are different means for dividing up spend throughout Scotland. An indication of the division of spend in different areas of Scotland would be useful because it would make it easy to examine growth and results in those areas.

Fergus Ewing: I agree with Wendy Alexander that we should not move to appoint an adviser at this stage; I hope that that is a correct statement of her view.

On the more important issue of the inquiry's remit, which could be infinitely broad, I agree that we must consider spending geographically and along the current departmental demarcation lines. I would like to us to have an opportunity to consider other matters that impact on the economy. I hope that we can have a more detailed discussion of that—perhaps we could have a lengthier paper. For example, the burden of taxation is obviously key to economic development. The impact of regulation, not least regulations that are passed by the Scottish Parliament on business, is a key indicator that we read about from business commentators week in and week out. I hope that an inquiry will be able to cover regulation and taxation and I hope that members will concur that we want a rounded inquiry if we are to have useful outcomes that we can use to assess our performance.

Dr Murray: There is always a danger with inquiries that are as broad as this might be that we set our goals too wide and try to examine too wide an area of interest. I am less interested in what Jeremy Purvis said about the regions than I am in the focus on the key sectors, because they were identified in "A Smart, Successful Scotland". Funding has gone into the different sectors, but we do not have the details. It would be interesting to find out more about the level of funding that has gone into the sectors and about the outcomes. What success has the funding produced? That is crucial to the way in which things might be funded in the future. If we are to take decisions about putting money into key sectors in the future, we should ask how successful it has been. Has it started to succeed?

Jeremy Purvis: That is about scrutiny of Scottish Enterprise and how it divides its budget. It would be excellent if we could expand on the work done by the Scottish Parliament information centre to compare the situation with other devolved areas

in the world. I do not know if that is stretching it, even if it is just a paper exercise. I am sure that research has been done; I am thinking about Quebec, Catalonia and some of the Länder. That would address some of Fergus Ewing's comments about different systems.

The Convener: Our difficulty is that the exercise could become almost infinitely large. We need to narrow it down and to identify particular themes. Members want different things, but we have to reconcile those. Members must recognise that we cannot do everything.

The other important point is that the review must be cross-cutting. For us simply to replicate what legitimately should be the work of the Enterprise and Culture Committee would be entirely inappropriate. Our focus has to go well beyond the enterprise budget and look at the ways in which the enterprise budget links in with other budgets, such as the transport budget, in order to make our role appropriate.

On the appointment of an adviser, I do not think that at any stage there was a specific proposal to move forward. The suggestion was that, in principle, we recognise that we will need an adviser so that we can make progress. I was asking for agreement in principle so that we can request that an adviser be financed by the Parliament. The process of deciding who the adviser should be and how we should select them is a separate issue, which we can take on after further discussion. Are members willing to agree in principle that we should have an adviser, so that we can go through the bureaucratic process of placing a request, and that we will return to the specifics of how we appoint the adviser and what their remit should be at the next meeting, when we have a paper? Is that acceptable to committee members?

John Swinburne: Much along the same lines, could we also ensure that we get an adviser who can take a much broader outlook and who can, for example, advise us on the impact of fiscal autonomy on everyone's outlook?

The Convener: The discussion about what the adviser will do will be dealt with when we come to it. We are not at that point yet.

Professor Midwinter: As an adviser, I say that the wider you make the remit the more difficult it will be to find one adviser. People who are experts on fiscal autonomy are not necessarily experts on economic development or some of the other topics that have been suggested.

Kate Maclean: I presume that we are just agreeing that a paper should go to the Conveners Group to ask for funding for an adviser. We are not even looking at the scope or remit of the inquiry, or at the kind of qualifications or experience that we want the adviser to have. I would have thought that that was straightforward.

The Convener: Yes. Do we agree with what Kate Maclean suggested?

Members *indicated agreement.*

Items in Private

12:29

The Convener: Agenda item 4 is to seek the committee's agreement to take the draft report on the financial memorandum on the National Health Service Reform (Scotland) Bill in private at the committee's next meeting on 28 October. I ask members to indicate whether they agree to that.

Fergus Ewing: As I recall, I think that the advice from the Procedures Committee was that such decisions should be taken on a case-by-case basis. This is an example of a case in which it would be useful to have a discussion in public. I say that because, for example, we have had some fairly detailed submissions from a number of witnesses including health boards, the Convention of Scottish Local Authorities and others, and they would be genuinely interested to see the process by which we produce a report using as our guide, in part, the evidence that we have had from those witnesses.

There is something inherently unsatisfactory about witnesses' coming to the committee as they have done, giving us freely and voluntarily—at no small cost to their time—of their expertise, their knowledge and their evidence, after which we go into private session and out comes a report. The process of how we reach decisions is important. It is clear that no matter how one might want to dub this particular financial memorandum, it is certainly not the Executive's finest hour. However, I hope that, notwithstanding that there may well be—I suspect that there will be—different views about how bad the memorandum is, it should be possible to produce a report that brings out the substantive criticisms that I think all members have elicited from witnesses.

This is a case—I hope that other members agree—in which our proceedings might be enhanced if we have a serious and mature debate in the public eye. It would be deleterious to go into private session on this particular matter and I really cannot see any reason why we should do so.

The Convener: The committee has discussed the matter previously and there is disagreement about how we should handle it. I suggest that we simply move to a vote. I move that the committee agree to discuss its draft report on the financial memorandum to the National Health Service Reform (Scotland) Bill in private at its next meeting. Is that agreed?

Members: No.

The Convener: There will be a division.

Can I see all those in favour of that proposition—

Fergus Ewing: Just before we take the vote—

The Convener: I am sorry, I have moved to the vote.

FOR

Alexander, Ms Wendy (Paisley North) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Murray, Dr Elaine (Dumfries) (Lab)
Purvis, Mr Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)

AGAINST

Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Swinburne, John (Central Scotland) (SSCUP)

The Convener: The result of the division is: For 5, Against 3, Abstentions 0. The proposal is agreed to.

I close the meeting.

Meeting closed at 12:31.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, 375 High Street, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

Tuesday 14 October 2003

Members who want reprints of their speeches (within one month of the date of publication) may obtain request forms and further details from the Central Distribution Office, the Document Supply Centre or the Official Report.

PRICES AND SUBSCRIPTION RATES

DAILY EDITIONS

Single copies: £5
Meetings of the Parliament annual subscriptions: £350.00

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committees will be published on CD-ROM.

WHAT'S HAPPENING IN THE SCOTTISH PARLIAMENT, compiled by the Scottish Parliament Information Centre, contains details of past and forthcoming business and of the work of committees and gives general information on legislation and other parliamentary activity.

Single copies: £3.75
Special issue price: £5
Annual subscriptions: £150.00

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Standing orders will be accepted at the Document Supply Centre.

Published in Edinburgh by The Stationery Office Limited and available from:

The Stationery Office Bookshop
71 Lothian Road
Edinburgh EH3 9AZ
0870 606 5566 Fax 0870 606 5588

The Stationery Office Bookshops at:
123 Kingsway, London WC2B 6PQ
Tel 020 7242 6393 Fax 020 7242 6394
68-69 Bull Street, Birmingham B4 6AD
Tel 0121 236 9696 Fax 0121 236 9699
33 Wine Street, Bristol BS1 2BQ
Tel 01179 264306 Fax 01179 294515
9-21 Princess Street, Manchester M60 8AS
Tel 0161 834 7201 Fax 0161 833 0634
16 Arthur Street, Belfast BT1 4GD
Tel 028 9023 8451 Fax 028 9023 5401
The Stationery Office Oriel Bookshop,
18-19 High Street, Cardiff CF12BZ
Tel 029 2039 5548 Fax 029 2038 4347

The Stationery Office Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0870 606 5566

Fax orders
0870 606 5588

The Scottish Parliament Shop
George IV Bridge
EH99 1SP
Telephone orders 0131 348 5412

RNID Typetalk calls welcome on
18001 0131 348 5412
Textphone 0131 348 3415

sp.info@scottish.parliament.uk

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178