HEALTH AND COMMUNITY CARE COMMITTEE

Tuesday 26 October 1999
(*Afternoon*)

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HEALTH AND COMMUNITY CARE COMMITTEE
9th Meeting (Afternoon)

CONVENER:

*Mrs Margaret Smith (Edinburgh West) (LD)

COMMITTEE MEMBERS:

*Malcolm Chisholm (Edinburgh North and Leith) (Lab)
*Dorothy-Grace Elder (Glasgow) (SNP)
*Mr Duncan Hamilton (Highlands and Islands) (SNP)
*Hugh Henry (Paisley South) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Ms Irene Oldfather (Cunninghame South) (Lab)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Ochil) (Lab)
*Kay Ullrich (West of Scotland) (SNP)
*Ben Wallace (North-East Scotland) (Con)

*attended

THE FOLLOWING MEMBER ALSO ATTENDED:

Tavish Scott (Shetland) (LD)

WITNESSES:

Margaret Pullin (Royal College of Nursing)
Sheena Cochrane (Royal College of Nursing)
Sian Kiely (Royal College of Nursing)
Mrs Pat Dawson (Scottish Association of Health Councils)
Ms Pat Frost (NHS Confederation in Scotland)
Mr John Telford (Chairman, Shetland Health Board)
Mr David Eva (Director of Finance, Shetland Health Board)

COMMITTEE CLERK:

Jennifer Smart

ASSISTANT CLERK:

Irene Fleming

COMMITTEE ADVISER:

Dr John Forbes

Scottish Parliament

Health and Community Care Committee

Tuesday 26 October 1999

(*Afternoon*)

14:06

On resuming—

Arbuthnott Report

The Convener: Good afternoon. We will continue to look at the national review of resource allocation. With us we have representatives from the Royal College of Nursing: Margaret Pullin, Sheena Cochrane and Sian Kiely.

Margaret Pullin (Royal College of Nursing): Thank you for inviting us to give evidence. The RCN has extensive expertise in its membership so I have brought with me Sheena Cochrane, who until last month was a community manager in Renfrewshire and Inverclyde and has now been appointed manager of the local health care co-operative in Inverclyde. She has extensive experience in rural and remote areas. Sian Kiely is our research and information officer and is brilliant with figures. If you need information that we do not have here, she will be able to get you the answers by the end of the day.

The RCN wholeheartedly welcomes the Arbuthnott report, which was badly needed. There are some areas that still need to be looked at and more facts and figures are needed, but it has the potential to affect health in a number of areas. The RCN has 33,000 members in Scotland. They work in all areas: acute hospitals, mental illness, learning disabilities, maternity, general practice, looking after older people and children. We are everywhere; 80 per cent of the care that is delivered in the health service is delivered by nurses or midwives. That means that we are or could be at the forefront of delivering the recommendations of the report.

We recognise that the existing SHARE formula badly needed to be updated. It was only meant to last for 10 years, but it has lasted for more than 20. The formula does not reflect what is required today. Some aspects of it are not robust. For example, the sparsity index does not adequately measure the additional cost of providing nursing services over large areas, and the indicator of death rates for under-65s cannot comprehensively measure the relationship between deprivation and ill health.

We are in full agreement with the terms of the review, which are that resource allocations should be as objective and needs based as available data and techniques permit. We realise that that is a problem in relation to the data that have been gathered, but the aim is to promote equitable access to health care, and we cannot be anything other than in full agreement with that.

We owe it to the Scottish people to provide the best health care. It is in our interest. We are all involved in health care or we are all receivers of it at some point in our lives. Arbuthnott can help us to achieve the best health care for the Scottish people. The potential exists to deliver a much fairer way of distributing national health service resources. For example, school nurses are involved heavily in health promotion for children and young people. Health visitors look after pregnant mums, newly born children and older people, and perform many other functions. Sheena Cochrane can talk to you about that. Practice nurses work in general practitioner surgeries, and you will all be aware of the many health initiatives that they undertake, such as screening for cancer and asthma. The nurses that we need to highlight are the combined duty nurses in rural areas and island communities. They are often the first point of referral, and the only access that people in such areas have to a health professional. The Arbuthnott report tackles head-on the costs of remoteness and rurality.

To finish, deprivation is of major concern to all of us. The report addresses the additional costs of providing health care to people in deprived and socially excluded communities, and we must commend the Arbuthnott group for its emphasis on that matter and for recognising the strong links between morbidity, mortality and deprivation. Health boards with a higher level of ill health will be those that have a higher level of deprivation as shown by the indicators—for example, unemployment and poor housing, which have a major effect on health.

To sum up, we welcome the report. We were delighted that Kay Eastwood, the director of nursing services at Lomond and Argyll Primary Care NHS Trust, was on the steering group. We are pleased to see the emphasis on nursing's contribution to health care. Often it is regarded as virtually invisible, but this report has certainly not made the nursing input invisible, and we welcome that. We owe it to the people who work in the health service to get this procedure right, because they are not just workers in the health service; they make use of it as well. It is the job of nurses, along with other health professionals and those who work in the health service, to ensure that a fair and equitable service is delivered throughout Scotland.

The Convener: Your points that 80 per cent of care is being delivered by nurses and that often they, and others, think of themselves as being invisible were well made. I hope that the Health and Community Care Committee will never think of Scotland's nurses as being invisible. We should always ensure that we recognise the great work that you all do.

One area in the review in which the full scale of the roles that nurses are undertaking in health care in Scotland comes through clearly is in the indices that address rural areas and issues of remoteness. It is clear that the report is saying that there are extra costs involved in rurality, and some of the costs arise from having to have nurses with particular skills because they are sometimes taking on a GP's role, or an accident-and-emergency role. It would be useful for us if you could expand on that aspect of the report, so that we can gain a sense of the roles that those nurses perform in remote areas of Scotland.

14:15

Margaret Pullin: The obvious person to answer that question is Sheena.

Sheena Cochrane (Royal College of Nursing): Nurses who work in remote areas must possess numerous skills: they must be midwives, district nurses and health visitors. As you rightly said, often they must deal with certain types of emergency treatments—not medical treatments, but nursing treatments. Many of those nurses have extensive skills that they require to undertake their duties. To acquire those skills, they require extra training, which can be costly. In remote areas, they are often the first or only point of contact and they work in a triage manner to ensure that patients receive the most appropriate type of treatment.

Let me provide an analogy. If I am a nurse in Glasgow who must undertake a day's training, and the only place that I can undertake that training is in Edinburgh, all that is required of me is that I get on a train and go to Edinburgh for the day, undertake the training and return. However, if I am a nurse who is working in a remote area—[*Interruption.*]

Kay Ullrich: The problem is in the depths of my bag.

The Convener: Sorry. Kay has a portable personal appliance in her bag. Please continue, Sheena.

Sheena Cochrane: To recap, if I am a nurse in Glasgow who needs to undertake training in Edinburgh, I may need to take a day off work to receive that training. However, if I live in a remote area or on an island, the costs are very different. First, there are travelling costs: it may take a day to travel, it may then take a day to undertake the training, and there are accommodation costs. There are also extra allowances to pay to individual nurses who are away from their homes for a certain length of time, and there are replacement costs for those nurses while they are receiving the training. In an urban area there are normally colleagues who possess the skills to cover for them while they are away; in remote areas an experienced nurse may have to be brought in to deputise for that individual, which again implies a great cost. If we want such nurses to be skilled, we must ensure that they have training to underpin all that.

The Convener: Do you feel that the report has taken into account all those extra needs in rural areas? Has it considered them differently from the way in which they were considered in the past, through SHARE, recognising that it is not just a question of the distance from a GP's practice, but that there is much more to it?

Sheena Cochrane: Absolutely. It is nothing to do with distance; it is about travel and the time that it takes. The other thing to remember is that not all nurses are GP-attached; they do all work in GP surgeries or practices. In rural areas they generally work in a geographical location that may cover three, four or five GP practices. The time that it takes to cover those distances is a real issue.

Mr Hamilton: I ask for clarification. Your response says:

> "The RCN agrees that the proposed cost index should include an allowance for the additional resources required to fund the education and training needs of these community nurses."

Is that in any way protected or ring-fenced? How can we be sure that that will not be swallowed up in general spending?

Sheena Cochrane: I am not sure how that can be done unless something were to be put in the formula that would ensure that. I gather from the report that the allowances are given to the health board, which, in turn, distributes them.

Mr Hamilton: There is no mechanism of which you are aware?

Sheena Cochrane: I am not sure. There is a possibility of ring-fencing. That is not always a terribly good thing, and can be counterproductive. I would hesitate to say that the allowance should be ring-fenced, and I would expect the health boards to receive sufficient guidance to recognise the risk.

Mr Hamilton: My second question relates to that. I was taken with your suggestion, in paragraph 6.3 of your response, concerning the

local health care co-operatives. As you say there, the Arbuthnott report was not considering the stage after the allocation of moneys; the spending priorities must be set. That is something that this committee can take on as a recommendation, and I think that we should examine that.

My final question concerns the collection of data. Everyone to whom we have spoken so far has said that the best has been made of the data that are available, but that there are major problems concerning the things that are not already known and the data that are not already collected. In your response, you say that nurses can play a crucial role in data collection. First, specifically what additional data do you think that we should be considering? Secondly, what would be the burden on nurses? I am aware that data collection can often be an onerous and time-consuming task. Can you say something about that from a professional point of view?

Sian Kiely (Royal College of Nursing): In the information that is available there is some very good evidence from nursing, in particular from district nursing and health visiting. The data have been collected on the number of home visits and the number of people that each health visitor and district nurse visits in a year, for example.

Regarding the specific information that nurses can help with, many nurses are in a good position to collect data on the needs of a local population. A school nurse, for example, can collect good information about the health needs of the children in the school area that she looks after. The issues that have to do with the localities and communities in which the nurses work can be linked to deprivation.

A practice nurse can provide information on the GP population and can carry out needs assessments of that population. That will bring in issues to which the report relates, such as deprivation, morbidity and mortality. The burden that that might place on nurses has been mentioned, but many nurses are already collecting that information in order to influence their own practice and to assist them in their discussions with other professionals on what is the best care that they can provide for patients in their area. Many nurses have those skills and are interested in and willing to participate in those issues.

Sheena Cochrane: It is worth noting that education departments recognise the importance of such assessments and are undertaking to provide special courses on them for nurses. Many nurses who trained a number of years ago might not have those skills. Most universities are now providing such courses for nurses and especially for nurses such as health visitors, district nurses, school nurses and practice nurses.

Margaret Jamieson: You indicated that you would expect guidelines to be issued to health boards on allocation of nurse education. Are guidelines sufficient? We know that some health boards are better than others at allocating resources to individual trusts for provision of nurse education. I cite specifically the provision of conversion courses for enrolled nurses, for which some health boards have allocated nothing. I am concerned that you have said that guidelines would be enough, given that doctors in post-graduate education have a well-defined role and that the same is not true of nurse education.

Margaret Pullin: As I have said, I would be very wary of saying to health boards that they must ring-fence funding for that.

Margaret Jamieson: I am not suggesting that.

Margaret Pullin: Perhaps I was being diplomatic in using the word guidelines. I agree that we need something stronger than guidelines.

Margaret Jamieson: Are you happy that we should tell health boards that they have an obligation to ensure that they provide the facility to do that, as each nurse has an obligation to ensure that her practice is up to date?

Margaret Pullin: I see nothing wrong with that.

Mary Scanlon: I am delighted that in your paper you mentioned the nurse-led service that is based in Nairn. I would like to commend that service and to say that Dr Alistair Noble is absolutely first class.

I would like to move on to point 3.3 in the paper. That point relates to the nursing contribution to tackling deprivation and inequality. Much of this morning's discussion has been about the reallocation of resources, but how do the witnesses see the nursing profession practically addressing deprivation and inequality?

Sheena Cochrane: Nurses have been doing that for a long time in their own ways. There is an example of that in Inverclyde, where I work. I am sure that all members of the committee are aware of the problems in that area, one of which is the serious problem of mothers who have dependency problems and who have children under five. The health visitors in the area have started to set up groups to tackle that problem. Nurses are already doing the work to which you referred.

Nurses have always been aware of numerous issues related to deprivation. The review and its remit to examine resources and to identify problems of deprivation and remoteness will help nurses greatly. There will be some winners and some losers, but overall there will be fairness.

Sian Kiely: The work of nurses in health promotion and health education can involve

examining the multiple circumstances associated with deprivation—diet, drug issues, alcohol—and the housing and social circumstances of patients. They can provide that link in health promotion and health education activities.

Mary Scanlon: Do you think that there would have to be a fairly hefty shift from secondary to primary care to achieve the benefits that you mentioned?

Sheena Cochrane: I would love to see some sort of shift. It does not matter where one works in the health service, one feels that one does not have enough. Everyone would agree that there has been a great shift from secondary to primary care over the past few years, as a result of early discharge, day surgery and so on. Much more work is being carried out in primary care services, not only by community nurses but by GPs and others. I welcome any shift in that direction.

Mary Scanlon: Do you think that more needs to be done?

Sheena Cochrane: I would like to see more being done, as we are looking at ways to prevent disease. Disease prevention is the way forward; primary care will facilitate that.

Mary Scanlon: Thank you.

The Convener: One of the problems with the lack of data from the community services and so on is that the review has almost stopped, rather than taking us in the direction of greater use of primary care and care in the community. Those are areas in which nursing is at the forefront, whereas, to a large extent, most of the data that are already there are from the acute services. That issue has been brought up in many of the submissions that we have received so far. Community services can be developed in future if we have that extra data.

John Forbes is our expert, as opposed to all of us, who are—I am not quite sure what we are, actually; I hesitate to call us amateurs.

Dr John Forbes (Committee Adviser): I would like you to consider the model that was developed for the maternity services programme of care. I draw your attention to the fact that the model appears to reveal two significant life circumstance variables: the percentage of people in non-self-contained housing and the percentage of children in lone-parent households. I invite you to consider whether, based on your experience, there might be other useful indicators in determining the relative need for maternity services.

Sheena Cochrane: I agree. One of the most obvious indicators is substance abuse, while the age of the mother is also relevant. I am sure that employment has a significant impact.

Dr Forbes: That would increase the work load and the need for services in a particular area.

Sheena Cochrane: Absolutely. Social isolation and family support all come into it.

Dr Simpson: Is there any evidence that the distribution of funds within a health board reflects those inequalities? When the trusts and the board are drawing up their budgets and deciding how to spend money on allocating staff and so on, is there a transparent mechanism in respect of the inequalities that the report is so intent on dealing with?

14:30

Sian Kiely: The Accounts Commission for Scotland published a report this month on acute mental health services for adults. In that report, evidence is brought together that looks at whether the current provision highlights inequalities, as you suggest. What the report has found regarding mental health services is that the distribution of resources in health board areas often follows the historical pattern of service provision. Mental health services have continued to be provided on the hospital model, while acute services have been provided differently. In that instance, it is highlighted that distribution has not been based on unequal need or on inequalities, but rather on historical perspective.

Dr Simpson: Is it your estimation that that is true of other community services—that they are based on a historical perspective of the way in which primary care and community service have grown up, rather than actually identifying inequalities and the needs associated with them?

Sian Kiely: Reflecting on other areas of health care, particularly in the community, it may be that that is being replicated for certain areas of health care. Again, that could be dependent on previous decisions on the provision of funds. There is now more recognition of issues of deprivation and social inclusion and of the way in which many health professionals can intervene positively on lifestyle issues and in clients' and patients' lives. We suggest that the new awareness of social inclusion and deprivation makes this a good time to reassess the current distribution of care, as the report suggests.

Dr Forbes: I have one further question, which is on the formula for determining nurses' work load. Has there been any attempt to include some of the social, economic and deprivation factors that were identified by the Arbuthnott report in generating a work-load estimate?

Sheena Cochrane: At present, most trusts are using historical work-load patterns or data, which are outdated. There has been some innovative

work. There is a Glasgow model from a few years ago that people have been using, but they recognise that it needs updating. The Arbuthnott report is being examined in terms of new work-load models for nursing. I think that the Lanarkshire Health Board was involved in something, but I am not sure of the model.

Malcolm Chisholm: Would it be true to say that, in general, you are fairly happy with the redistribution that has been recommended and that your main concern is that the money should be spent appropriately, in line with the new priorities? Reading between the lines, that is what you seem to be saying. I welcome your suggestion that members of the Scottish Parliament should be involved in holding health boards to account. Perhaps we should try that on the minister tomorrow. [*Laughter.*] I also welcome your suggestion for more of a role for district nurses and for community psychiatric nurses.

I want to home in on your point 6.3 on local health care co-operatives, if the convener will allow me to. I feel that we ought to incorporate this in our report. If I am correct that you think that the arrangements are okay as long as the money is being spent appropriately, perhaps we ought to be asking how we ensure that. Since we have an expert on local health care co-operatives here, can I ask why you think that LHCCs will lead to targeting resources on areas of greatest need? How do you see that happening? What are the mechanisms for that in LHCCs? Not everyone perceives them in that way.

Sheena Cochrane: Local health care co-operatives are an ideal opportunity to involve everyone working on health needs in an area. For example, in the LHCC with which I am involved, there are representatives from GPs, community nurses, pharmacists, the social work department, housing, partnership agencies, the local health council and others—it is not only purely health individuals who are involved. One of the things that our co-op is doing—I am sure that other co-ops are of a similar mind—is looking at health needs by getting views from local communities. At present, that is being done via partnership and focus groups.

The LHCCs will be able to influence what is actually required to meet health needs, rather than what the health boards think is required. They will take account of health needs assessments, they will get the views of the local population and of the other people who are involved in the area—not just in health, but in social work, local authorities, housing and so on.

Malcolm Chisholm: Thanks. I am sure that we will follow that up, either now or in our future work. However, I want to return to my original point. In general, would it be true to say that you do not have any substantial concerns about the methodology and conclusions of the Arbuthnott report?

Margaret Pullin: With any report, there is room for criticism. However, we are reasonably comfortable with the general principle of what is being proposed.

Margaret Jamieson: You said in your submission that, ideally, LHCCs should be compatible with the geographical areas that are covered by local authorities. However, sometimes local authority areas straddle every social class. That can make things difficult, because if the majority of individuals in a local health care co-operative are from one part of the area, they may not have information about the whole area. How do you think that we should ensure that everybody's views and life circumstances are represented in LHCCs?

Sheena Cochrane: That is not an easy problem to deal with because, as you say, local authority areas are very diverse. I think that the solution is to get the right people on the LHCCs or, rather, the sub-groups of the LHCCs. We need to have patient representatives. It is difficult for professionals to include patients, but we are making progress on that. There are mechanisms to involve patients, such as audits and questionnaires, as well as one-to-one conversations. People also write in with complaints—we may not like that, but we can learn from it. Representation needs to be as wide as possible, and patients need to be more involved. This is not about what we as professionals believe is required, but about what the patient feels is important.

Dorothy-Grace Elder: I am interested in the welfare of the nurses as a factor in the well-being of patients. Before I go on, could anyone update me on the current so-called wastage, both in training and in the early years of service, when many nurses drop out for various reasons? Apart from the old enemy—back problems—the reasons for that nowadays include violent patients and even problems that could be more easily tackled, such as needlestick injuries.

The Convener: Margaret, I must stop you before you answer. Dorothy, are you deliberately trying me today?

Dorothy-Grace Elder: No. Honestly, convener, I think that my question is relevant. If we are wasting time and money—

The Convener: Dorothy, we could have Margaret and the other representatives of the RCN here all day to talk about all aspects of nursing, and that would be very interesting. However, our remit today is to talk to them about the Arbuthnott review. You have had an

opportunity to ask your question, and at some later date Margaret may want to respond to you in writing. However, at this point we should stick to the Arbuthnott review.

Dorothy-Grace Elder: It might, therefore, also be irrelevant to ask about the impact of agency nursing and whether that is the most efficient way of providing the service. However, I regard that as relevant to the Arbuthnott report and to health funding.

The Convener: I will rule that as irrelevant and move on to Kay.

Kay Ullrich: Margaret, I must apologise to you and your colleagues for having to leave in the middle of your presentation. As a Luddite by nature, I should never have allowed myself to be hooked up to new technology.

I am looking at the conclusion of your paper, where you say:

"The RCN seeks assurances that no area of Scotland will be disadvantaged as a result of the changes to the formula".

We would all hope that, but the fact is that we are talking not about new money, but about reallocating between 1.5 and 2 per cent of the money that is already available. I agree that the report is a step in the right direction, but it is not the answer to Scotland's health problems. You want assurances that no area of Scotland will be disadvantaged as a result of these changes, but I say that there will have to be losers as well as winners. Could you comment on that?

Margaret Pullin: We had an interesting discussion about that. I think that Sian will be able to answer that question—she has a head for methodology.

Sian Kiely: In our response, we indicated that we did not want any area to be disadvantaged. We hope that, in the redistribution and allocation of resources, there will be differential growth between health boards to ensure that the percentage increases and decreases can be accommodated so that no health board or geographical area will have a real-terms loss in income.

We hope that those plans will ensure that the distribution of resources will be equitable and fair. Nurses understand that the report should lead to equitable and fair access to health care for all patients in Scotland. We acknowledge that there are health board areas to which a larger proportion of resources is currently allocated and we recognise that the review may lead to those allocations being reduced in the future. Our concern is to ensure that the resources are there to provide the best quality care that nurses and health professionals can give patients.

Kay Ullrich: Thank you for that answer. We have to accept that, if the cuts are spread over four years, they may be slightly less painful. However, if there is no new money, the same pot will be available and there will be losers as well as winners. I go along with your sentiments; we must start to address the link between poverty and ill health, and Arbuthnott is a small step in the right direction.

Mary Scanlon: Your submission is very much about welcoming this and welcoming that—it is very complimentary. I would have liked a more rigorous analysis. In addressing deprivation and inequality, what is your wish list? What would you like nurses to do to address those issues? I know that similar questions have been asked, but I do not feel that we have got to the heart of your contribution to those areas.

Margaret Pullin: Our organisation has 33,000 members in Scotland, who have great skills and expertise as well as the willingness and ability to address all the major concerns. Nurses want to do that, have the skills to do it and would like to be assisted in doing it.

Mary Scanlon: How would you take the lead?

Sian Kiely: Perhaps I can give some examples. Nurses are working in many areas of the health service and there are specialist nurses with particular skills. For example, diabetes nurses undertake special health-needs assessments of patients and can advise on lifestyle and diet to help them with their condition. Incontinence nurses can help 70 per cent of patients with incontinence problems to live an active and enjoyable life by providing nursing care to limit their incontinence problems. In leg ulcer care, appropriate nursing care can reduce the pain and discomfort suffered by the patient. Specialist nursing is a cost-effective way of providing health care.

Nurses can help to counter the problems of deprivation by providing specialist advice that is appropriate to the community's needs; they can address the links that have been identified between deprivation and health problems. We hope that nurses can continue to liaise with other health professionals and other agencies to ensure that deprivation issues across Scotland are fully addressed.

Sheena Cochrane: Health visitors would like to have a more important role in the future. Many local health care co-operatives have supported the health visiting aspect of community nursing, but it will require greater funding. Health visitors are very much to the fore in working with deprived communities. We need to identify the people who have the time—away from a case-load scenario—to undertake research into that type of work, forging the necessary links and developing the

service. Health visitors dealing with public health issues could help with a lot of the problems that are related to deprivation.

14:45

Ben Wallace: In paragraph 4.4 of your submission to the committee, you make the point that the new formula does not take into account forms of nursing in rural areas other than the ones attached to a GP practice. What percentage of services does that account for in rural areas?

Sian Kiely: Nurses who are attached to GP practices might be practice nurses, district nurses and health visitors. Community nurses can also include community psychiatric nurses, community children's nurses and nurses working with clients with learning disabilities. The percentage that that would account for varies geographically and in relation to the population covered by the GP surgery. Rather than give you an isolated statistic, I would say that the proportion would vary on the basis of population and the provision of services that the primary health care trust and the surgery provide in that area.

Ben Wallace: The point is that if—as you have said—that is unsatisfactory at the moment, how would you correct the formula?

Sian Kiely: The current formula relates to the distance that a patient lives from the GP's surgery; to amend that formula we would need to consider the nursing services that are not tied to the GP surgery, but based in the community. We need to consider more than where the patient lives; we must take into account the overall provision of community services within a patient's local area.

Ben Wallace: Would you like to take some form of mean measurement of the extra mileage used by nurses outwith that sort of practice? It is all very well to say that there is a problem with the formula, but the difficulty in Arbuthnott is to reach some form of standardisation.

Sian Kiely: One issue that I would highlight is the time involved in visiting and caring for the patient and travelling between patients. It takes particular, professional skills to undertake such care.

Ben Wallace: Thank you.

The Convener: I would like to thank the RCN for making an oral contribution, as well as for giving us a written report. No doubt its representatives will return to discuss the 80 per cent of care that is delivered by nurses.

Margaret Pullin: Thank you very much indeed.

The Convener: We will have a short break before we take evidence from the Scottish Association of Health Councils. The meeting will resume at 14:55.

14:48

Meeting suspended.

14:55

On resuming—

The Convener: At the risk of starting a new trend, let us start on time. Next in the hot seat is Pat Dawson from the Scottish Association of Health Councils. I welcome her to the Health and Community Care Committee.

Could you start by making your statement? We will then open up the discussion to questions from the committee.

Mrs Pat Dawson (Scottish Association of Health Councils): Thank you very much, convener and members of the committee. On behalf of the health councils in Scotland, I want to say how pleased we are to have been invited along today. I wish it had been to talk about something that was easier to digest and on which I could make more value judgments.

The Convener: Hear, hear.

Mrs Dawson: Perhaps some committee members share that view—who knows?

I bring apologies from my convener and vice-convener, who, unfortunately, are unable to be here today. That is why I am here by myself.

The health councils have found contributing to this review a difficult exercise. As I said in my paper, some are still engaged in carrying out their consultations, both internally and externally, and in producing their joint responses in alliance with health boards. Indeed, some are still receiving invitations to seminars to debate further some of the issues and, as lay members of the public who are acting in a voluntary capacity, to obtain technical guidance and to get up to speed on the issues and how they will affect their local area.

As a result, I have received few substantive responses on which I can comment. I have, therefore, tried to construct a national critique from a patient's perspective. I am sure that the committee will tell me how well I have done that.

In the small booklet that Sir John described as being in high demand, we are told that the formula should be understood by, and transparent to, the non-expert. Given my opening remarks and the smiles around the table, I suspect that, if that were the only measure of the Arbuthnott report, the report would be a failure.

However, this review raises more substantive issues. Equity is at the core of the health service in

Scotland. One of our main ambitions is to examine how we can better serve the public in Scotland, especially in the new political context of the power that is vested in the Executive, the Parliament and this committee.

We share the review's belief in more equitable health care. However, it is extremely interesting that an analysis of inequality appears only in chapter 15 of the report. One might argue that, as consideration of a more equitable system was the review's starting point, a coherent, detailed and comprehensive analysis of the issues related to inequality and unequal health care provision should have appeared at the beginning.

We believe that, in this document, there is an over-reliance on the appliance of science. That is something that I am fond of saying with regard to the clinical effectiveness agenda in health care, which delivers more complexity and raises more questions than it answers. This morning, we heard that the proportion change, in terms of resources, between the SHARE formula and Arbuthnott is very small. That raises a question about where Arbuthnott has taken us. If the substantive difference in allocation between one formula and another is so small, what have we learned from the exercise?

15:00

The remit of the Arbuthnott committee is fairly broad. It is

"to advise . . . on methods for allocating the resources available to the National Health Service in Scotland".

It could be argued that it has been assumed that the method for allocating resources is through the health boards. In our submission, we ask whether there were discussions about whether health boards were the appropriate recipient of resources.

We discuss the common theme of policy directives, which require health boards, local authorities and the voluntary sector to work together to provide care in the community, implementing integrated care patterns. However, the Arbuthnott review has sought to consider, in isolation, some care programmes that are to be delivered in partnership with others and co-resourced by others. That is an interesting position. Perhaps Arbuthnott could have said that there is a need to be more innovative in some parts of resource distribution. We need to develop joint practices and joint resource allocation with those partners. I believe that, this morning, one of the experts made a similar submission.

As members will know, health councils operate in all parts of Scotland, and the issues raised by those in remote areas are extremely important. Over the past five years, there have been great developments in approaches to the support of health care in remote and rural areas. We welcome the establishment of the Highlands and Islands health resource centre. However, it would have been reasonable to calculate the unavoidable and inevitable fixed costs for the smaller health boards. Where do patient transport and travelling costs figure in Arbuthnott? The patient travel scheme is not itemised. Concern has been expressed about the potential differences between urban and rural deprivation.

On page 4 of the SAHC submission, I have excelled in my use of numbers. After "Inequalities in Health Care", it should read chapter 15 and not chapter 14—that is why I am not let near money.

The Convener: Thank you. It is excellent that you have come to give us the patient's point of view. We want to make use of the Arbuthnott review and all the evidence presented to the committee to improve patient care. That is at the centre of our work.

Malcolm Chisholm: First, I would like to thank you for a radical and refreshing submission. You have made suggestions that other people have not—yours is the only body to have raised the fundamental and thought-provoking question of health boards.

I want to home in on one sentence in your submission. You write:

"Are our Health Boards' boundaries promoting and perpetuating inequalities in health care?"

What do you mean by that?

Mrs Dawson: In September, a motion on equity in health care provision came before our association's annual general meeting. An interesting debate followed, in which many people agreed that it is a fundamental principle and a desirable aim that we must all try to achieve. However, because of the wording of the resolution rather than because the issue is not important, some people said, "Wait a minute. Our health board is already delivering a range of patient-care services to a higher standard than is being delivered in other health board areas." When the issues were analysed further, people began to ask how we could get to a position in which equity is an issue that is rounded up for rather than rounded down for, and how we could ensure that patient care is not lost or lessened because of the issue of equity.

People in rural and remote areas recognise that the most important issue concerns the appropriateness of accessibility. Accessibility is different from mere access. In terms of utilisation, access means something, but for many people in Scotland, accessibility means something different. It is about whether health services are available,

whether health centres are open all the time, whether services are appropriate to people's needs, whether information is available in their languages and whether health-care provision reflects the way in which people live their lives and engage with the health service.

This morning, Professor Watt talked about inequity. It is not just about the patient knocking on the door of the doctor or the health service; it is about the effect of a referral. Once one has knocked on the door and seen a nurse or a general practitioner, is there equity in terms of subsequent referral, the availability of medicines or access to further treatments? We feel that a range of inequalities exist as between different health boards, as between geographical areas, as between professional groups and for a number of other reasons.

Notwithstanding those inequalities, we can focus on what I refer to in the submission as the numbers game. The clear message is that the smaller the numbers—whether in clinical evidence or in statistics—the more difficult it is to get the sums right and draw the right conclusion. If that is true, why is it assumed that health boards are the critical mass to distribute NHS resources equitably? I do not know the answer to that question.

Hugh Henry: I would like to clarify what you are driving at. You suggested that perhaps the current boundaries or the current shape of the health service might not be the critical mass that we need for the future. Are you beginning to question whether health boards per se are the right type of organisation to distribute health funds and to be accountable for them, given your suggestions about partnership delivery of care programmes?

Mrs Dawson: I thought that you were going to go on to ask another question.

Hugh Henry: Depending on your response to the first question, I may go on to ask another.

Mrs Dawson: I am not sure that it is entirely related to Arbuthnott but, as you have raised the question, I must answer—

Hugh Henry: Allow me to explain why I think that it is relevant. One of the themes that we have heard consistently in our discussions concerns the difficulty of tackling inequalities of health provision. In your submission, you have touched on the complexity of the situation, and we cannot be unaware that a range of factors is involved in tackling health inequality. One thing that comes across very clearly is that, to tackle health inequality, we must consider poverty and the issues that surround it. Kay mentioned that earlier.

There are two aspects to this. The first is the physical distribution of the resources that are currently in the health budget. The second is how that distribution addresses the issues that Arbuthnott wants tackled in the long term. I am beginning to wonder whether, underlying your contribution—and perhaps fundamental to it—is an assertion that you cannot look at the allocation of health resources without looking more broadly at the allocation of other resources. Should the committee be putting a caveat in our conclusion about Arbuthnott that we must start to look at the broader allocation of resources from other agencies? That poses fundamental political questions about who is responsible for health care delivery.

Mrs Dawson: The conclusions from the acute services review on which I served were that there are large areas in which the acute care planning structures that we currently have need to be at higher levels than that of the health board. There are only a couple of health boards in Scotland that have the required critical mass in terms of the functionality of their hospitals, their range of specialties and all the rest of it. You could argue that, for acute hospital services in Scotland, the current number of health boards could be reduced.

However, the closer you get to the patient—this is my personal belief—the more likely you are to address health inequalities. For example, you have just heard from the Royal College of Nursing about where LHCCs might take us in terms of their flexibility, their planning function and their public health contribution. I have heard committee members talk about how close they are to established geographic or practice communities. At that level, around community development, tackling health and homelessness, diet, action groups and action zones—all those areas where we look at inequalities in health—there certainly seems to be a great deal of evidence that the smaller and closer a service is to people's lives and homes, the better.

That was not your question, which was about joined-up policy and whether money from different pots could make a difference in health. There is evidence that shows that money spent on housing, or in other ways, makes a difference to people's health and their quality of life. If you make a radical change in spending, you must change the way in which money is allocated and who is accountable for it. I would rather not answer that question. I prefer to suggest that it is an entirely appropriate and necessary debate for your committee.

Hugh Henry: You seem to be suggesting that there is potential for a certain part of the health budget to be allocated and managed at a higher level—either at Scottish or sub-Scottish level. At patient-care level, the service needs to be integrated with and more accountable to other

services. Are you suggesting that if the health budget was split, with one central service responsible for some of the acute services, that the rest would be more easily integrated with local authority care services?

Mrs Dawson: I think that that is entirely likely.

Hugh Henry: That resource allocation is perhaps something about which this committee needs to put down a marker. I do not think that we would have the time to tease that through to a conclusion.

The Convener: The question, whether one formula fits all, was asked earlier. Can there be one formula that delivers for people in remote areas and for people in deprived areas? That can be turned on its head, and we can ask whether one formula for health care will ever deliver what we want, or whether we need greater integration so that the formula takes into account social work and care in the community and all the other things.

Mrs Dawson: When you take evidence on community care, and when you look at areas where there is good practice—where seamless care is delivered and where there is integration of services—I suspect that one of the crucial findings will be the importance of joined-up budgets, where people with different hats work together in a common accountability framework to a common end, which is to meet patient-driven need.

Mr Hamilton: I welcome this outbreak of radicalism that is sweeping the Health and Community Care Committee. Who will man the barricades?

Is your point that you are not unhappy with the methodology that is enshrined in Arbuthnott, and that you are not unhappy with the health boards, but that you are unhappy with the marriage between the two? Would you be happier if we stuck with the current structure but with a different, or at least amended, methodology?

15:15

Mrs Dawson: I think that you heard some radicalism this morning when Professor Graham Watt talked about the end of the microscope that you were looking down. He suggested that the wrong question was being answered. My view is that the wrong question has been asked of Arbuthnott. I would have extended the scope of the review. I would have asked, "If we cannot come up with a resource allocation through care programmes, why are we not going back to the people who set the scope to tell them that within that scope we cannot answer the question?" I would have asked to have the scope extended.

Mr Hamilton: The next part of your submission addresses the acute services review, which has already been referred to this morning. One of the terms of reference for that review was that it would not be constrained by the existing construct. Presumably, if there is to be a standing or an ad hoc body, that remit would be a more appropriate one for it?

Mrs Dawson: The questions that we have asked about whether health board boundaries decrease or increase inequalities are fair ones.

Mary Scanlon: You talked about reducing the number of health boards. What is your view on having trusts funded centrally? On the matter of integrated, seamless care, do you think that one budget is sufficient? If not, how would you see that care being achieved? You emphasised the issue of unmet need. Can you expand on that?

The Convener: Before Pat expands on that, I should say that the first part of your comments strayed from our remit, but I will be kind. If Pat Dawson wants to answer, that is fine. The issue of unmet need is well within our remit.

Mrs Dawson: Direct funding of trusts is an option if health boards are scrutinised. I am not suggesting that that would be the only way of providing funding, but it is one possibility. However, assumptions would have to be made about whether our current trust structure supports equitable health care with regard to geography and other factors. Because of the need for accountability, one issue cannot be addressed without addressing the other.

I make a plea to develop and promote seamless and integrated care across boundaries, including the voluntary sector. I hope that you will receive evidence from a number of organisations to support that view.

With regard to delivering care, questions need to be asked about how health boards, local authorities and other partners take risks with the money that they devolve and the people to whom they devolve it. I think that it is within the realm of Scottish intellect to solve that problem and I believe that that will be one of your findings when you address community care.

On the issue of unmet need, I cite in the submission a recent Royal College of General Practitioners North East Council conference at which we looked at inequality in health care provision. The analysis in chapter 15 of the report is about different operation rates and other indicators of deprivation. My submission draws the committee's attention to barriers to people even getting into the system. We can count the number of people in the system but not those who are not.

There is also unmet need in terms of people using the wrong services. We do not count that terribly well. I would have hoped that a range of

other issues would be explored in terms not just of utilisation but referral patterns. For example, why do some GPs in some areas refer more patients for certain types of interventions? It is not just about the expression of unmet need through demand but clinical practice acting as a barrier to need.

Ms Oldfather: Your submission queries the idea that one solution fits all and makes some good points on that, particularly in relation to island communities, posing very relevant questions about transport and travelling costs. That is not just a problem for island communities. We spoke this morning about centres of excellence and how people have to travel to get good care. A lot of patient transport costs are absorbed by the voluntary sector. Is that something that you feel applies more widely, or just in island communities?

I also welcome your points on joined-up thinking, which is particularly important. If we cannot tackle it in Arbuthnott we should do so when we look at community care. There are a number of areas in which the committee could investigate further the ideas of joined-up budgets and partnership.

Mrs Dawson: There is a patient travel scheme in the Highlands and Islands. People are paid travel costs for themselves and someone to accompany them if they travel more than 30 miles to a hospital. I do not know where that fits into Arbuthnott—the question needs to be asked. The scheme also applies in areas in Argyll and Clyde and to some, but not many, areas in Grampian.

You are right—a number of other organisations such as the Women's Royal Voluntary Service and a range of disease-specific organisations are transporting patients to and from hospitals, GPs and clinics—you name it, there are people in the voluntary sector doing it. Or patients have to ask family or friends to take them to and from hospital. I have raised this on a number of occasions. It is a hidden cost. Moreover, we have the ridiculous situation of some NHS premises charging patients to park in their grounds. The legality of that should be challenged. It does not make sense in relation to social inclusion.

Ms Oldfather: There is a big issue there about hidden costs. I do not see it in the report and I know voluntary organisations in my area are bearing the burden. We do not have some services locally in Ayrshire, so patients travel to Glasgow, which is a 25 to 30 mile journey. Some voluntary organisations are being put out of business, which is having an effect on patient care and transport.

The Convener: Far be it from me to suggest something to one of our sub-groups—I cannot remember who is on our sub-group on access to services, but would they like to consider the hidden costs of patient transport? They do not have to make any suggestions, but they could ascertain whether this is an issue that the committee should address. I think that Pat has raised some very important points.

Dr Simpson: I have a supplementary on this issue. One concern that I have, Pat—I am interested in whether you share it—is that the acute services review, with its apparent, quite rational, centralisation of some services, will affect the rurality element in this report and has not been taken into account. That is fair enough, because the review was based on current or historical need, but are you concerned that the formula is out of date before it is implemented, because of the acute services review?

We have decided, for example, that everyone in Edinburgh should travel to Glasgow for paediatric surgery. The numbers are tiny, but does Lothian Health get a 0.000001 index because its service has been removed to Glasgow and there is an additional element of transportation and other costs involved in that process? The answer is no, because Edinburgh is not thought of as rural.

Mrs Dawson: You have picked a difficult example, because paediatric cardiac services are commissioned centrally, through the national services division. As I understand it, the costs are not borne by Lothian Health. Your question would have to apply to acute services where major rationalisation will take place as a result of the acute services review, and there are very few of those.

At issue is how managed clinical networks will support care and whether we will lose any more cancer centres, for example. I understand that there are one or two refinements around neurosurgery and renal transplantation, but they will not have a big impact on costs to boards. However, there will still be hidden costs to patient travel. Children's services are not the best example of that, because their travel costs are met. We would need an example from the adult services. I cannot give a full answer to Dr Simpson's question, but I suspect that the effect on boards will be minimal and that there will be an added cost to patients.

The Convener: Before I ask Dorothy to speak, I would like to welcome the party of young people from Boroughmuir High School who are with us. I hope that you will find what we are talking about interesting. We are discussing how we can allocate resources to ensure that people have equal access to care.

Dorothy-Grace Elder: Pat, I agree with you about the extraordinary complexity of this document. It is difficult for informed stakeholders on health councils to understand it—never mind

patients. Busy hospitals are unlikely to have time to comprehend the document while they are trying to implement it.

You make the point that

"Patients and the public gave clear messages to politicians that they did not want market driven or two tier services in their NHS."

First, could you expand on that?

Secondly, you say that

"people who seek to highlight inequalities are repeatedly told that lack of resources is the reason."

Given that you and, I think, all of us have clocked that only a small sum of money is being moved around, rather than anything new being added—I know that that will not go down well with the convener, but never mind—what is wrong with the remit of this report?

The Convener: Pat, the first question was about transparency and the complexity of the report.

Dorothy-Grace Elder: No, convener, I was agreeing with her on that. The point was that the message was being delivered to politicians that patients did not want market-driven or two-tier services in the NHS.

15:30

The Convener: Do you want to answer that, Pat?

Mrs Dawson: It is safe to say that the idea of a market-driven service, involving consumerism, purchasing and fundholding, did not go down well with the Scottish public. Nor did they like the effects of that. They do not want people to get better services depending on where they live, the colour of their skin or any other determinant. Recently, we have heard how gender can affect access to coronary artery bypass grafting. We have to ensure that our service is equitable in terms of resource allocation and in the view of the Scottish public.

No organisation that represents patients or patient interests would deny that the reason that is given for the lack of availability of the services that people want is that the resources are not available. That may be because the necessary money is not in the appropriate budget or because there is not enough money in the pot. That is the reason behind differences in fertility services, drug rehabilitation regimes and a whole range of other services.

We need to sort out those inequalities in health care, but health boards and others who manage resources will ask, "Well, what would you have me spend the money on?" We need to decide where we should set the priorities and how we can involve the public and politicians. That is not a theme that comes through Arbuthnott. If that is because it is considered to be a sub-health-board issue, perhaps that is a legitimate omission. However, I felt that Arbuthnott did not examine how a health board area such as Glasgow, with high levels of deprivation, could see involving people in priority setting as an overriding priority.

I cannot remember what your other question was.

Dorothy-Grace Elder: I think that, earlier, you asked, "What is this achieving?" in relation to the rather small sum of money that is merely being redistributed. Were you criticising the original remit of the report and, if so, what is wrong with it?

Mrs Dawson: I would have liked to ask the Arbuthnott committee why it did not see fit to question people about the structures to which they were giving money, whether they were suitable and why they did not come back at any stage to the people who set the scope of the remit to challenge that remit and look instead at more innovative ways to deliver equitable health care and social inclusion strategies, joining up different strands of Government policy. None of those questions seems to have been asked. There seems to be an assumption that a medical, scientific and statistical model is driving the report.

Dorothy-Grace Elder: Would you have liked them to ask why we could not recommend larger sums of money? [*Laughter.*] No, I mean it—would you?

The Convener: That is a motherhood-and-apple-pie question—and it has already been asked three times. I think that we will have a final point from John.

Dr Forbes: This may be a difficult issue to consider, but your initial comments on the transparency of the formula suggested that you might have ways of identifying the steps that could be taken to reduce the extent to which people are disenfranchised by such a complex formula. Do you have any suggestions as to what steps could be taken?

Mrs Dawson: Compared with the implementation of "Designed to Care: Renewing the National Health Service in Scotland", we have spent more time today debating health policy in Scotland than we have ever spent in the past. We have made a huge advance today by talking in public with school children, members of the public and the media present. We hope that the message is starting to go out.

Arbuthnott chose to use a formula, to which the vast majority of people in Scotland would say, "Shock, horror; it is all about maths and sums"—they would not engage with something involving

figures and how they interrelate. That meant that you were up against it before you even started trying to make resource allocation interesting. The message should be about the benefits that patients are going to derive. You have to win on that message: things will be better for patients in Scotland. That message is muddled and there are some areas where there will be big losers.

Representatives from Shetland Health Board, who will be speaking later, have their own questions about how they should go about telling the population of Shetland that the board will receive less funding over the next few years because things are more equitable. Will people understand? No, although the little book makes a start. All policy and health board documentation, and any other documentation that follows, needs to be in a format that is reasonably understood by everybody. We need to engage with the media, voluntary organisations and a range of stakeholders in order to promote those messages. We were up against it with the Arbuthnott report.

The Convener: Thank you, Pat. We all learned a great deal from that and we will raise some of those matters with the Minister for Health and Community Care tomorrow. I am sure that you will return to talk to us on many other issues.

For the benefit of the people in the public gallery, I should say that we are not being handed cheques or wads of money in those brown envelopes. They are from the official report, which wants clarification on points that people have made in their contributions.

We are running behind schedule, so—if everyone agrees—we will have an unofficial break at this point, after which we will hear from Pat Frost from the NHS Confederation.

15:37

Meeting suspended.

15:38

On resuming—

The Convener: We move on to our penultimate contribution of the day. I welcome Pat Frost from the NHS Confederation to the Health and Community Care Committee. Pat, could you give us a general contribution to start with? We will follow that up with questions.

Ms Pat Frost (NHS Confederation in Scotland): Thank you, convener.

The NHS Confederation is a UK-wide body; it is the only membership body for all the health boards and trusts in Scotland. In England, Wales and Northern Ireland, it also covers those organisations. About 95 per cent of UK NHS bodies are members, but we have just set up shop in Scotland, post devolution—in April this year—and we are changing the constitution of the UK body in order to be able to do that. To date, 13 health boards and 13 trusts have become members, which is about half the organisations in Scotland—we are still pretty new.

I am the organisation's acting director—that is, the start-up director. For those people who do not know me, I have spent a long time in NHS management in Scotland and England.

The submission that I sent to the committee was based on input from a number of member organisations. Members will see from the submission that I cannot offer expert information, advice or knowledge, particularly on statistics. I can give an overview from a wide range of NHS bodies in Scotland that have been affected in different ways, from Shetland to Glasgow and from Lothian to the Highlands. Perhaps that is the value of my evidence today.

Hugh Henry: Is there a general consensus among the bodies that you represent that there was a need for such a review to be undertaken?

Ms Frost: Definitely.

Hugh Henry: Given that response, do those bodies accept that the methodology employed by Arbuthnott was rigorous and acceptable? Notwithstanding that there will be winners and losers, as Kay Ullrich said, is there a general acceptance of Arbuthnott's recommendations? We have heard from a number of witnesses today that this should be only the first step, but what is the view of your members about where we should go after this phase?

Ms Frost: I will try to tackle all those questions, but perhaps you will come back to me if my answers do not capture them all.

As I said in the submission, there is overwhelming and universal support in the NHS in Scotland for the Arbuthnott report. The method of dealing with allocations is 22 years old and the world has moved on. We want to attend to different issues, not simply to fund institutions according to historical accident. The report fits in with the new objectives of the health service in Scotland and has been universally applauded for trying to direct money towards the strategic objective of fair access to better health for the nation. It is not just about access to services; it is about achieving equality in heath and, in a sense, that is what we came into this business to achieve.

In terms of the methodology, members will have seen responses from Lothian, in particular, and I know that Chris Spry from Greater Glasgow Health Board is coming to talk to the committee tomorrow. The representatives from Shetland, who

are speaking hotfoot after me, have serious reservations about the statistical methodology. The perception is not just that the boards that look as though they will receive more think that the methodology is great and those that will not do so well that think it is awful; the perception is that more work needs to be done to make the methodology more robust.

Some of the extreme effects—particularly for the small boards, such as Shetland—show that the system is not quite right. Tomorrow, the representative from Glasgow will say that, given the problems of deprivation in Glasgow, the approach cannot be right as the shift towards Glasgow is not as great as the health board feels it should be. Borders Health Board is also very anxious. The impact on the very small boards will be huge, and the results will be harder to deal with in a small area with a small budget.

The presentations to the committee by the people who ran the Arbuthnott group make it clear that there is a lot more work to be done. People are anxious to ensure that the method is robust. It may be that one formula cannot answer the needs and problems of the different areas in Scotland.

You also asked what happens next. Many of the responses that I have had from organisations reflect the fact that one allocation cannot be considered in isolation, especially as health boards are now charged with working with local authorities to change the health status of large populations. In responding to that charge, people found it difficult not to stray into the area of care in the community.

15.45

In trying to improve the health of the Scottish population, we cannot consider health service funding separately from other funding. Although the Arbuthnott committee identified a great many factors around the different aspects of deprivation, it considered them at a macro level. We must do further work to discover what needs to be done in different population groups. The groups that responded to us said that the role of funding of care in the community needed to be examined carefully.

Mr Hamilton: There seems to be a recurring theme today: one size does not fit all. In your submission, you mentioned that there is

"a disproportionate effect of relatively small changes in population in rural communities"

and that we should consider whether changes below a certain level should be disregarded. Do you have anything else to say on that? With what would like to replace it?

You also say:

"The robustness of the formula for areas of highest deprivation and in the accuracy of rurality factors needs to be tested again now."

What do you mean by that? Do you mean that, having done this all as a blindfold test, we should reconsider whether the settlement is realistic and fair once the blanks have been filled in?

Ms Frost: There are a couple of points. The effect of small numbers is important because of the disproportionate effect that population changes can have. When the members of the Shetland team give evidence, they will tell you that if a forces base moves from Shetland—200 people with young families—Shetland could, in theory, lose 1 per cent of the budget, although there are other layers to the formula that act as a safety net. In a small place, that is not realistic. The robustness of the formula for very small populations needs to be tested. That may reflect one of the issues that the Arbuthnott committee considered. The report says throughout that the formula was intended to work only at a macro-population level.

One of the tables at the back of the report shows what would happen to even smaller chunks of that budget—such as the general medical services budget—for small populations. That is clearly not robust. In the submission, I suggested that we needed something to protect small populations, small health boards and small communities from shifts in funding that were disproportionate to population shifts. The problem relates to statistics and small numbers and I urge the committee to flag it up as something that the Arbuthnott group should reconsider.

Mr Hamilton: As for testing, would you want the committee to say that some of these allocations are wrong? To do that, we would have to go back to the methodology and we will not do that as a committee. I am curious as to what exactly you expect the committee to do about this, apart from just flag it up.

Ms Frost: Flag it up, but in such a way that it shows that the effect on the ground is not feasible. It was not the Arbuthnott committee's intention that the proposals should be implemented without further detailed work, particularly on their impact. Is there enough cognisance of the problems in rural areas and do the proposals do enough for urban deprivation? There is anxiety that something will be implemented simply because it is in print, so I make a plea for further scrutiny of the proposals.

The Convener: Do you have a view on what should happen about the long-term monitoring and review of the process? Some people have said that there should be a standing body looking at this, rather than an ad hoc review as and when people decide that they want one. If there were a

standing group, new data could be looked at all the time.

Ms Frost: The view of the membership of the Scotland confederation is that that is an absolute necessity. I made the point in my response that SHARE was initially seen as an absolute revolution. Now, 22 years later, it looks fossilised. We must keep abreast of two things. The first is whether the formula needs adjustment to deliver new objectives for the care services in Scotland. The second is whether the formula is delivering.

As I tried to say in the response—the point was made in the Arbuthnott report—although it is clear that there are links between all aspects of deprivation and good or ill health, no one is clear what the causality is. As more knowledge comes to bear on that, we might want to refine the different elements that are taken into account. People have flagged up to me some of the elements that are not included, such as educational attainment and low pay. The trouble is where we stop taking practice into account. The Arbuthnott committee had to make a decision on that. Other factors will become more obviously important as our knowledge about the causal link between deprivation and ill health improves.

Malcolm Chisholm: I was interested in what you said in your submission about long-stay services. You wrote:

"Many long stay services have now been transformed to community based services . . . We must establish how big a problem this is for the robustness of the formula."

I have been thinking about that for a while and I am not entirely sure what the answer is. Sir John Arbuthnott's written statement says quite clearly that all that has been taken account of and that a health board that has transferred most care from a hospital into the community would not be penalised.

You referred to Lothian's submission, one of the main points of which is that those who have moved to new care models may be disadvantaged. Lothian points out that data based on traditional forms of care are a key source of information. Were you flagging that up as something to be looked at, or do you have similar concerns to those expressed by Lothian about boards that are further down the road of, say, closing learning disability beds or having more community mental health services disadvantaged under the formula? Alternatively, are those concerns based on a misunderstanding, as Sir John Arbuthnott says?

Ms Frost: I think that Lothian feels that it would be disadvantaged under the formula. Any study must use the data that are available, but it is clear that the way in which we measure community services produces less robust and less all-encompassing data than the way in which we measure institutional services does.

To reassure boards that are in Lothian's position, we would need to show that the measures being used will accurately reflect need and the funding that is required to sustain the replacement services. I am talking about a situation in which a service where it is easy to count the people in beds is being replaced with a style of service in which the measure that might be used—and this is very common—is the number of face-to-face encounters between a health professional and a patient or someone in community care. The robustness of the data is important, as is whether there are enough data on the new style of service to be reflected in the funding formula. Those are the key problems, and we need the committee to provide more information on them.

Dr Simpson: I have a couple of questions, the first of which is a general one. Is it the view of the confederation that the report is fair? The shift in resources is around 2 per cent. Under SHARE, which, as you said, everyone welcomed, people's health has become relatively worse and inequalities have increased, despite the redistribution effect. Do you think that the report is fair, and will it achieve anything?

Ms Frost: It depends on what you are asking the report is fair about. Health boards that perceive a huge reduction in allocation feel that it is not fair, even though we are assured that the proposals amount not to an instant reduction but to a change in growth over time.

In terms of whether the report is fair for the Scottish population and whether it will achieve anything to improve health, we must remember that we are talking about funding for sickness services. The review reflects the pattern of spending on those services. If we are to change the health of the Scottish population, we must examine much more than the health services, which are only the tip of the iceberg. You will know better that most of us, Dr Simpson, what is behind the ill health that you deal with.

With regard to redressing inequalities of access to services that deal with illness, some of which is almost certainly caused—although we are not sure how—by economic, educational, housing, transport and expectation inequalities, the report is a major step forward. It is the first time that that range of factors has been taken into account in health funding. That is fair for Scotland. As to the details of who gets what, for some of the more extreme examples—I am sorry to keep going on about Shetland, but it is an extreme case—the report is not quite right or fair.

Dr Simpson: I acknowledge your caveat about

size. I do not know whether you would agree with me but, when funding for health boards was cut, the calculations seemed to be based only on a capitation fee, with no baseline core funding. The same seems to apply in this review: there is a core element of health provision, which is much more expensive for smaller health boards. I am not sure that that has been allowed for in the formula.

Ms Frost: I will provide a couple of examples. If you are staffing a service in an urban area, you can usually employ a large number of part-time staff. It may be difficult to achieve, but that can be done for primary care and hospital services. If you are trying to provide a GP service in a remote area—the most extreme example that I know of is on an island where the GP practice covers 125 people—you cannot roll up a part-time GP, a part-time nurse and so on: you must include an inducement payment.

There are a number of GP practices in rural areas where, to attract someone, an inducement payment has to be made to give the GP a reasonable income. Rural areas face different costs and different problems. In places with bigger populations, people have much more flexibility in dealing with the costs of service provision. That has to be recognised. We are again straying on to issues surrounding the costs of current service provision, and we must keep our minds on addressing overall inequalities. However, the costs of service provision and the difficulties in changing them are real. That will be a big issue for MSPs.

16:00

The Convener: We will take a couple of points from John and then finish, unless someone else has a burning question.

Dr Forbes: The first point is a small one. In your submission, you mentioned that one of the weaknesses that your membership identified was the use of one-year data. Is that because the wrong year was chosen, or is a larger data set required?

Ms Frost: We need a larger data set. Everybody is anxious about changing health service funding for Scotland on the basis of one year's data. That is simply not robust enough.

Dr Forbes: So there is nothing peculiar about that year.

Ms Frost: No, it is just that the sample is too small. People are made nervous by the fact that the sample is based on one year; they want it extended to cover another year. We are not saying that the findings are necessarily wrong, but we are dealing with a mighty service and huge sums of money. To make major changes on the basis of one year's data is not supportable.

Dr Forbes: My second point is slightly more complex. It concerns the assessment of the overall effect of the changes on a health board that is not a winner or a loser, but is surrounded by boards that are losers. How would you gauge the impact of such a situation on the access afforded to, for example, the residents of Fife, who might be using services outside the Fife administrative area?

Ms Frost: It is important to realise that there are mechanisms in place across Scotland to allow the health boards and their trusts to work together—in large geographical chunks—to devise a joint planning approach that makes sense as regards changes to services. There is huge cross-boundary flow everywhere in Scotland, particularly in Fife, which is sandwiched between two tertiary centres. Those mechanisms are pretty robust. The principle from which people are working—it has been articulated in all the submissions that have been made to you—is that no health board is prepared to allow its community to get a worse deal than others are getting.

I do not think that the situation that Dr Forbes describes is a particular problem. The spirit enshrined in the report informs the work of health service funders below board level. People are concerned mainly about primary care and community-based services.

The Convener: Thank you, Pat, for your contribution. We may hear from you again on a range of different issues, but it is nice to have had you here today. Thanks for answering all our questions.

We will take a five-minute comfort break before meeting the people from Shetland.

16:03

Meeting suspended.

16:10

On resuming—

The Convener: Good afternoon, gentlemen. We welcome John Telford, chairman of Shetland Health Board, and David Eva, its director of finance. We are also joined by Tavish Scott, MSP for Shetland. He is the first MSP other than those who are members of the committee to have attended it. Other MSPs cannot vote here but can sit in, ask questions or make contributions at my discretion, so he will obviously have to keep on the right side of me.

Mr John Telford (Chairman, Shetland Health Board): Thank you for inviting us. It is a privilege to be at the Parliament at such an early stage. I also thank the staff of the Arbuthnott group, who came to Shetland and spent time going through

the report with us. I do not agree with the outcome but at least they tried to help us understand how they got to it.

What is missing from the basic criteria of the report is plausibility. I am an accountant and any time you produce a set of figures, the first thing you look at is the end result, and then, whether that result looks reasonable. If it does not, you query how you got there. When you look at the financial evaluation of what would have happened if Arbuthnott had been in place, the huge swings among the island boards beggar belief. Although it is not in the context of the island boards but of using the formula at a sub-board level, in paragraph 16.6 Arbuthnott raises questions about using postcode analysis within boards. Shetland only has two postcodes, so that context applies to us and we very seriously question whether the small population causes serious flaws in the formula.

We must look at the impact of Arbuthnott. I know the minister has given assurances that there will not be cuts and that the formula will be phased in over time without some sort of differential growth procedure. Despite that, it is important that we have development. It is an interesting coincidence that £1.3 million, the basic figure that we would lose out on, is the same as the development fund that we have for the next four or five years of our health improvement programme. If the Arbuthnott recommendations are put in place, there will be no development in Shetland.

It will be a sad day if one of the first things the Scottish Parliament does to Shetland is leave us stuck in the 20th century in health care terms while the rest of Scotland moves into the 21st century. The service cannot stand still. There is progress in health all the time. There are new drugs; for example, Shetland has a high incidence of multiple sclerosis and there are demands for beta interferon to be used more than it is. Junior doctor hours and clinical governance are also areas where there must be development. Although there may not be cuts, if there is not real and effective growth and room for new developments, health care in Shetland will be seriously disadvantaged. That is all that I want to say at the moment. I leave it to the committee to ask questions.

16:15

The Convener: It has been a recurring theme today that it is questionable whether there can be one formula that fits all. Do you feel that there cannot be one formula that suits everyone's needs? On the one hand, there is the situation in Shetland and in Argyll and Clyde—which, although regarded as a mainland board, contains about 23 islands—and, on the other hand, there is Greater Glasgow, which has atrocious levels of deprivation. We will hear from the Greater Glasgow Health Board tomorrow.

Mr Telford: We certainly do not seem to have a formula that works—that is all that I can say. The old SHARE formula was supposed to be the answer, but ultimately it had to be changed for the islands because it did not work. We have been having discussions with our colleagues in the local authorities as to how the rate support grant formulas work and the differences between this area and that area. All the island boards have the formulas adjusted; it seems to be very difficult, if not impossible, to devise a formula that works across the board and takes into account the discrepancies between the islands and the mainland.

Mary Scanlon: It is really quite a shock when one considers the losses—or the percentage changes, I should say—that Shetland will have to endure. I am surprised to hear you say that there will not be any cuts. You mention that, because of Shetland's small population, the application of this formula will lead to a high level of instability, which is obvious when the formula is spread over lower numbers. You also talk about reducing existing clinical services. The British Medical Association reckons that you will have 33 per cent fewer general practitioners. Is it simply a problem with the formula? What has gone so wrong that such a remote rural area has not benefited from the formula?

Mr Telford: In trying to tackle deprivation mainly in the central belt, the formula is geared towards economic and deprivation statistics that do not seem to flow through to the island boards in the same way as they do on the mainland. It may be because numbers on the islands are so small.

Considering some of the details that we have seen of the allocation to Shetland and within the various programmes, we see that the numbers are up and down quite a bit. I am not a statistician. I do not have the expertise—I do not think that any of us do—to go into the reasons why that happens, but the results seem to be quite erratic. In the Western Isles, the numbers go away up—although I am not knocking the Western Isles getting more funding; that is not what I am here to do. Our numbers, on the other hand, go down. In island communities which are not all that dissimilar in terms of the health resources that they receive, that seems very strange.

Mary Scanlon: Do you feel that all the unique factors relating to Shetland, such as patients having to go to Aberdeen for treatment, were taken into account? If not, which factors do you think should be taken into account to produce a more equitable distribution?

Mr Telford: Perhaps the formula does not

recognise that there is a base cost of providing a minimum level of services. For example, we run a maternity unit. It probably does not matter a great deal whether we have 50 births in a year or several hundred, we still have to have the service. We have to have two consultant surgeons, although it would be nice to have more, because we have to have a baseline service. The report seemed to accept that there was a linear progression on a graph that goes from somewhere up here above my head down to zero, in line with the formula. It cannot do that: it has to start with a reasonably acceptable level of service and then build on that.

Mary Scanlon: You could not be expected to have economies of scale. I appreciate that you obviously have fixed costs that are greater than in other areas.

Mr Telford: That is how we feel.

Dr Simpson: I am really struggling here. I feel very sympathetic towards you, because your figures look pretty awful. For example, there is a 31.6 per cent reduction in general medical services and the non-cash-limited GMS is going to be very hard to manage. However, of the island groups—with 21,000 people in Shetland, 17,000 in Orkney and 31,000 in the Western Isles—the Western Isles and Orkney seem to have gained substantially. Although it is perhaps unfair to ask you to comment on this point, how have they won while you have lost? As the formula does not work for Shetland, it should not work for the health boards on Orkney and the Western Isles either.

The Convener: I want to ask a supplementary to that question. Do you think that Shetland has been in a better position historically than Orkney and the Western Isles, and that, as a result, you are now experiencing a levelling-down?

Mr Telford: That may not be what the Arbuthnott report is about, but if we consider the present level of provision in the islands, perhaps Orkney has been badly treated by the SHARE formula and has needed an increase in funding. However, I think that the Western Isles already receives generous funding compared with Shetland. We have not been badly treated; we provide a reasonable service. However, it would not be unreasonable to be funded in line with the rest of the country and to receive our fair share of the growth for new developments.

Perhaps Arbuthnott has come to these conclusions because of factors such as unemployment and benefit claims—I do not know. Although Shetland's economy is now at a delicate stage with changes such as RAF cutbacks, the economy was stronger than the economy of the Western Isles when Arbuthnott took his snapshot. However, I am not convinced that that has much to do with providing health services at the moment. Perhaps in 20 or 30 years, money ploughed into the economy will show through in health gains. I am not knocking the Western Isles, but I am not sure whether putting an extra £7 million into that health service will benefit the health of the population quickly. However, taking a few million pounds out of the health service in Shetland would have a negative impact.

Mr Hamilton: I commend you for not attacking the other health boards. If I were in your position, I would be putting the boot in with all haste.

Your submission makes crystal clear the case that there are potential flaws in the report's methodology. Frankly, it is irrefutable that something is seriously wrong. All day, we have heard how only a small percentage of the budget is actually changing hands and yet you will suffer severely in this apparently static situation.

Does Shetland think that it is the exception or does it now doubt the report's methodology? Many people will gain and many will lose. Should we doubt even those who will gain, as they will do so through the same system by which you will lose? On the other hand, if you think that you are exceptional, can any area of data collection be developed to provide a more equitable situation in which the methodology is fine, but needs a few more variables?

Mr Telford: I do not know. However, we think that the end result is wrong in our case. There are two possible reasons for that. Either the methodology is wrong for the small number of people on the islands; or the whole methodology is wrong. With a small board such as ours, the beauty is that the numbers are quite small and what is happening can be seen quite clearly. That might be more difficult with the diffusion of a larger board. Perhaps that is a microcosm of the much bigger problems, but I do not know that. I can only speak about our own position.

The Convener: Dorothy, you may ask a question as long as you do not ask Mr Telford whether he thinks that more money should be put into the health service in general.

Dorothy-Grace Elder: Mr Telford would immediately reply that he thinks that more money should be put in.

The Convener: We will take that as a given.

Dorothy-Grace Elder: We have had disagreements about the remit of the committee. We do not, however, disagree about the immense amount of gobbledegook in the Arbuthnott report, which uses English as a third language and which is not understandable to most people.

I would like to ask about Shetland's special needs vis-à-vis how it might be affected by the

formula, particularly with regard to the treatment of multiple sclerosis. The rest of Scotland often looks to Shetland to see what is being done there, for example, regarding the fears in Shetland that result from the demands for beta interferon, which you want to supply. How are you affected by that special problem?

Mr Telford: Beta interferon is no different from any other newly developed treatment. If we do not get additional funding for anything additional or new that we provide, we must make cuts and savings elsewhere. Such decisions are becoming difficult for the board to make.

I would like a national policy and national funding to be agreed for beta interferon, so that treatment is available regardless of one's postcode.

Dorothy-Grace Elder: Is beta interferon being prescribed in Shetland?

Mr Telford: It is not. Some patients in Shetland participated in clinical trials of the drug and we continue to supply it to them, but we are not prescribing it to any new patients. There are considerable doubts about its clinical effectiveness and its value, so perhaps it is not a terribly good example. It would be better to use as an example a treatment that is generally agreed as being clinically desirable.

Kay Ullrich: I welcome your health board's submission because it puts the issue in perspective for me and, I am sure, for other members. We have talked about winners and losers, but the submission makes clear the effects on the so-called losing health boards.

Do you agree that the review of resource allocation should have taken place?

Mr Telford: From our point of view, I am not convinced. It is possible to examine the services provided by a small health board, and I am proud of the fact that we run a pretty tight ship—we do not waste much money on administration and we have done much to put resources into patient services. The resources that we have are about right for the service that we provide at the moment. If new money is provided to fund new developments and to tackle problems such as clinical governance and junior doctors' hours as they come along, we can continue to provide a service that has incremental growth.

I would certainly prefer that the review had not taken place.

Kay Ullrich: Is that because of the effect on Shetland?

Mr Telford: It is obviously a fairly selfish point of view, but that is the case.

Kay Ullrich: One thing that we all accept is that the review examines the link between ill health and poverty and deprivation factors. Do you agree that there is poverty and deprivation in Shetland to some extent?

Mr Telford: Absolutely. I have no objections to the overall objectives of the report, and we all recognise that in parts of the country there is massive deprivation. I wonder, however, whether some of the issues are connected more with economics than with health. I do not know how shifting funds around the health service will necessarily solve some of the problems quickly.

Kay Ullrich: We have established that there will not be new money—we are talking about 1.5 per cent to 2 per cent of the debt being reshuffled.

Mary Scanlon: I would like to go back to the economic issues. I am very aware that Shetland's economy is based on oil, farming and fishing and that those three sectors face problems.

In the penultimate paragraph of your submission, you say that the only scope for meeting the new demands and fulfilling the Arbuthnott recommendations is to reduce "existing clinical services". What did you have in mind, given that the purpose of the report is to overcome inequalities and deprivation?

Mr Telford: That is correct—sorry, but I am not quite sure that I understand the question. Are you asking where would we make the savings?

Mary Scanlon: Your submission states:

"The only scope for cost reductions to meet unavoidable new demands therefore involves reducing existing clinical services."

I hope that the report will not cause deprivation. The Shetland economy might change radically, given that it is dependent on at least three major sectors, all of which are facing difficulties.

Mr Telford: It would be invidious of me to sit here and say what we would cut, as we are talking about finding savings of £0.5 million. As a board, we will have to examine all our areas of activity to see where we could make cuts. As I said, we run a tight administration. We have kept our central administration costs frozen at the same cash level for the past three to four years and would have to consider making cuts in patient services.

I listened with interest to what the representatives of the Royal College of Nursing said about multi-skilled nurses in remote areas. In all our inhabited islands, a multi-skilled nurse provides the only medical services, which is a very expensive service. If we have to spend £40,000, £50,000 or £60,000 to support that nurse in that job, should we make savings in that area? That would be a horrendous and invidious choice to have to make, but we will have to consider such a

choice.

16:30

Mary Scanlon: You said that you have cut your management costs and so on and, from your submission—

Mr Telford: I challenge anyone to examine our management costs and to show us where we could make significant savings.

Mary Scanlon: Thank you.

The Convener: As a supplementary point, you also said that £1.3 million was coincidentally the amount that you had put aside for development through the health improvement programme. What sort of work would you have undertaken had the anticipated growth continued?

Mr Telford: One of our strategic objectives is to move services back to Shetland from Aberdeen, which is our main service-providing partner; over the years, we have been slowly pulling back services. As an example, we now have two consultant anaesthetists, which extends the work that we can do, and we are trying to encourage visiting consultants from Aberdeen to operate in Shetland. Two or three years ago, we got two new operating theatres so that the consultants could come to the patients, rather than the other way round.

People tend to forget that Shetland is quite a big place. I know a lady who has to travel from Unst, one of the islands, for chemotherapy treatment in Aberdeen. She goes by road to the ferry terminal, has two ferry crossings, travels the length of Shetland to get to the airport, flies to Aberdeen, has her chemotherapy and does the same journey in reverse. People feel bad enough having chemotherapy without undertaking such an horrendous journey. We want to try to bring back to Shetland as many patient services as we can. That is not a cheap option, but it is desirable and would be beneficial for patients.

The Convener: At the end of the day, this is all about services for patients.

Mr Telford: The most important people in the health service are the staff—doctors, nurses and so on. In Shetland and in rural medicine generally, recruitment is one of our biggest problems—getting good people into rural areas. If the board does not have development funds, we will not keep the good members of staff whom we have and we will not be able to recruit good people. We have recruited two bright, young consultant anaesthetists who are introducing pain clinics.

We are considering the development of a small high-dependency unit, so that people do not have to risk life and limb to travel to Aberdeen and back in an air ambulance in a force 10 gale. They could be stabilised in Shetland and kept there until conditions allowed them to travel.

People will not come for jobs in Shetland if there is no money for new developments, as they want to develop their career. That applies across the board.

Margaret Jamieson: You indicated that £1.3 million was set aside for development and that you hoped to bring back services from the mainland to the islands. I take it that the guiding principle is that, in your view, that would improve patient care. That would have a knock-on effect on your recruitment and retention of quality staff who could provide a better quality of service to people in the area. Do you think that that is something for which you could make a special case, given the drive to ensure that patients are treated as near to their homes as possible? Is that a way in which you could argue against Arbuthnott's recommendations?

Mr Telford: We have been making that case for many years and it has been the board's policy for quite some time. I was pleased when the remote and rural resource centre in Inverness came into being, but I would be sorry if it came up with lots of good ideas without the money being available to implement them. That would make it a bit of a nonsense as far as we are concerned.

Margaret Jamieson: Do you have evidence that you have looked at examples of best practice in other health board areas and that you have adapted and adopted them to ensure that your board gives best value?

Mr Telford: I would like to quote some specific examples, but it might be difficult to do so during this formal evidence session. I like to think that we give best value as far as we can. In Shetland, everything has to come by plane or by boat, which puts up the cost of everything that we do. In some cases, we have to send patients to Aberdeen, which also has cost implications.

On the whole, we run things as economically as we can and we achieve best value. Under the previous Government, all hotel and domestic services were contracted out and, before I was a member of the board, I did not think that that situation was desirable.

Margaret Jamieson: Will you bring them back?

Mr Telford: I cannot express a view on whether that is desirable, but it means that there is no scope for savings there. The poorest employees of the board were paid even less, but it meant that the board could recruit two consultant physicians whom it did not have before. There were, therefore, medical benefits, but at a cost to some of the staff. As a board, we drive costs down pretty

hard. Although we have not had the reorganisation of trusts that the rest of the country has had, we have organised our own management structure and had the sad task of making one of our managers redundant earlier this year. We keep squeezing administrative costs, to put money into patient care.

Malcolm Chisholm: Some of us will have to undertake to study this, because it is complex and I have not really got my head round it. I have looked again at the table and it appears that, for remoteness, Shetland is getting much the same as Orkney and the Western Isles—23, 24 or 25 per cent above the national average—so that is not a significant variation. I thought that that was the main way in which islands would gain, so I cannot understand how that has happened.

Looking at the table, I see that your area seems to fall down in the terms of age/sex weights. Does that sound plausible in terms of the age/sex structure of Shetland in comparison with Orkney? You do not do well in terms of deprivation either, but I would have thought that that would be reflected in the existing formula to some extent, with the main difference being remoteness, for Shetland and for the other islands. Perhaps you could comment on the age/sex weights. Is it likely that you will be less well off than Orkney in relation to those factors?

Mr David Eva (Director of Finance, Shetland Health Board): We have the youngest age/sex structure in Scotland, but I do not know how much younger it is than in other board areas. The team that came up from the Scottish Executive confirmed that we lost out on economic factors and life circumstances compared with Orkney and the Western Isles. I still do not understand why the difference is so great, because the differences in the figures themselves do not seem particularly great. Perhaps the swing from the existing SHARE formula compared with Orkney has happened because we are doing better than Orkney at present.

The Convener: I have been looking at the table. As well as figures for remoteness, there are figures for population structure and morbidity and life circumstances. The morbidity and life circumstances figure for Shetland is –8 per cent, whereas the figure for the Western Isles is +8 per cent. Many of those figures will have been calculated using the figures from the most recent census as a starting point and cranking them up. I assume that, at the time of the previous census, Shetland was doing pretty well for itself economically.

Mr Telford: That is correct, but when it translates into the actual cost of providing the health service, the variations are not as great as the formula would suggest.

The Convener: You can gather from the committee's questions and comments that aspects of the review are a mystery to us, even after a full day of informal briefing and after today, a full day of investigation. Having read every page of the report and every submission given to us, I do not necessarily see it as transparent, plausible or obviously equitable to people. The fact that we cannot come up with any reasons for the marked difference between Shetland and the other two island boards shows that—in that respect, if not in others—there is a problem with the review.

Tavish Scott (Shetland) (LD): Malcolm asked the question that I was going to ask—it was the right one to pose. The committee has considered carefully what Shetland Health Board has had to say. I ask John Telford to illustrate the second point, on the second page of his document, about non-doctor islands. It brings home what the delivery of medical services in places such as Shetland is all about. It illustrates what it is like to be the male nurse on Fair isle, for example, what that means for patient care and how that nurse liaises with his colleagues in Lerwick, never mind Aberdeen.

Mr Telford: One of the things that I like about the Arbuthnott report is that the map on the front has Shetland in the right place—that is fairly unusual. It is not a totally facile point, as I never cease to be astonished by how many people think that Shetland is in the Moray firth and that it is a half-hour ferry journey to Aberdeen. They do not realise that it takes 14 hours, which is a different ball game.

In small communities such as Fair isle, the nurse is the only medical connection that the local population has, apart from telephone calls to GPs. She—or he, to get it right for Fair isle—has to serve the population and has to keep himself up to date, when liaising with professional colleagues is difficult. Where finance allows, we are trying to take advantage of tele-medicine and conference calls. We have not reached the video stage yet—I believe that next week we are inaugurating a link from Lerwick to Aberdeen, from our accident and emergency unit to that of Foresterhill, so that we can get specialist accident consultant advice fairly quickly.

After the tragic loss of the air ambulance in a crash a couple of years ago, we are all conscious that it is dangerous—not just for the patient, but for the pilots, the nursing staff and so on—to put people in aeroplanes to Aberdeen when it is unnecessary. We are aware of the distances involved. Given all the risks involved, should a nurse on Fair isle call out the air ambulance on a bad night? It is a difficult issue. From the board's point of view, keeping someone in the position to provide that service is expensive.

Kay Ullrich: You were talking about people not knowing where Shetland is. As somebody who comes from the deepest, darkest central belt of Scotland, I assure you that I am aware of where it is, having landed at Sumburgh in a crosswind. Believe me, colleagues, it was not fun—I thought that my end had come. The aircraft simply drops through the wind on to the runway. It is an isolated place as far as transport is concerned—I can assure people that it is not easy getting in and out, even by air.

The Convener: We are glad that you made it.

Kay Ullrich: Of course you are.

Dr Forbes: I want to make a point about the small number issue, which you highlight in an impressive way in your submission. Looking at an indicator such as the standardised mortality ratio—which I believe the report uses for the combined experience of the islands as part of the calculation—would you be content to seek a combined index, based on the experience of the island boards?

Mr Telford: We might be, but I am not sure about the other islands. To get back to my fundamental point, our present resources are not unreasonable, and as long as there is funding to support the current position and to support necessary developments, we do not want to throw the baby out with the bath water. We do not need a completely new formula.

16:45

Mr Eva: We think that the decision in Arbuthnott to lump islands together or to split them up seems to be rather arbitrary. We want to know the basis of that decision. We cannot say whether it will produce a better result.

The Convener: Is there anything else that you want to say to us?

Mr Telford: I want to thank the committee and to say that if members ever want to come and see the health service in Shetland, they will be very welcome.

The Convener: Having heard what Kay just said, I believe that the answer is probably no.

Kay Ullrich: Shetland is a wonderful place to visit.

Mr Telford: Thank you for the commercial.

The Convener: I have heard from my colleague Tavish Scott that Shetland is a wonderful place. Thank you for the invitation; we will certainly consider a visit, because the committee intends to leave Edinburgh at some point in the session.

Thank you for your excellent written submission. Your evidence today has given us some food for thought. We will take up some of the matters that you raised when we speak to the minister tomorrow. We wish you a safe journey home.

That brings us to the end of today's business. I thank colleagues for their patience, questions and attention. I look forward to seeing you all again tomorrow.

Meeting closed at 16:47.

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