HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 3 May 2000
(*Morning*)

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HEALTH AND COMMUNITY CARE COMMITTEE
11th Meeting 2000, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Malcolm Chisholm (Edinburgh North and Leith) (Lab)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
*Mr Duncan Hamilton (Highlands and Islands) (SNP)
Hugh Henry (Paisley South) (Lab)
Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*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

WITNESSES

John Aldridge (Scottish Executive Health Department)
Pat Dawson (Scottish Association of Health Councils)
Sarah Melling (Scottish Executive Health Department)
Neil McConachie (Board General Managers Group)

CLERK TEAM LEADER

Jennifer Smart

ASSISTANT CLERK

Irene Fleming

LOCATION

Committee Room 2

Scottish Parliament

Health and Community Care Committee

Wednesday 3 May 2000

(*Morning*)

[THE CONVENER *opened the meeting at 09:37*]

Budget Process

The Convener (Mrs Margaret Smith): Good morning everybody. We are here to investigate the Executive's budget. The First Minister and the Executive have called upon the parliamentary committees, and indeed the whole population of Scotland, to examine the budget. The Health and Community Care Committee must consider the health budget in particular.

Do the witnesses intend to give a brief presentation on the figures, or would they prefer to go straight to questions?

John Aldridge (Scottish Executive Health Department): I have not prepared a presentation, but I would like to clarify a couple of points.

The Convener: Perhaps you could give us an explanation of what you do before we begin our questions.

John Aldridge: Thank you. I am the director of finance in the Scottish Executive health department. On my right is Mrs Sarah Melling, who is head of the financial monitoring and control division of my directorate.

The departmental report that you have before you is the descendant of a long line of documents that goes back to something called the "Scottish Commentary on Public Expenditure"; it seeks to explain spending across the Scottish Executive's block of expenditure. It tries to adopt a consistent approach across all programmes, which means that, occasionally, compromises must be made since what would be ideal for one programme might not be ideal for another.

The targets in the health and community care chapter have been picked to tie in with the commitments that were set out in "Making it work together", the Executive's programme for government, which are the most important commitments that the Executive has made. It is clear that the programme for government commitments do not cover the health department's whole range of activity. We might want to revisit that in future to ensure that the targets, aims and objectives that we include in the departmental report cover the full range.

I apologise for a typographical error. On page 48, footnote 3 of table 4.1, which refers to pre-natal illness specific grants, should read "the above figures exclude mental-illness specific grants".

The Convener: There are those of us who say that you would have to be mad to have children, but I think that that is taking things a bit too far.

We will try to restrict our questions to the presentation of the figures, the technical aspects of the budget and the figures that you have presented to us. We might query the way in which aims, objectives and targets and so on are thrown about in a haphazard way at points. There are questions about why issues are raised at one point when they might fit better elsewhere. We will raise a number of such presentational issues with the Finance Committee. We are aware that the document is for consumption by the population at large—not that I am suggesting that you would have seen 20 people reading it on the bus today—and should be as transparent and accessible as possible. Because of time constraints, we will not touch on a number of issues today but will comment on them at another time.

Mary Scanlon (Highlands and Islands) (Con): We are supposed to have an informed and reasoned input to the budget process, as are the people of Scotland. To enable us to do that, you need to speak a language that we—and the people of Scotland—understand, and to present the information in a way that allows us to make informed decisions about priorities.

I have a copy of the Highland Health Board health improvement programmes and trust implementation plans. The long and boring five-year plan and ten-year plan documents are of great interest, but how do we know that they are following the Scottish Executive's spending plans, commitments, aims and objectives? I see those in the HIPs and TIPs, but I do not see the equivalent information in your document, so my first point is, where is that information?

My second point follows on from that and gives you an example of why we need that information. Last week, we had two excellent submissions that made it clear to me that we must put more resources into preventive care. On pages 56 and 60 of "Investing in You", where do I see that we could shift resources from x to y to put more emphasis on preventive care? The figures are not given to us in a way that reflects the aims and objectives, or that allows us to shift resources to meet the priorities that we feel are not being resourced adequately.

09:45

John Aldridge: Thank you, convener. I will deal with those questions in turn.

The first was about the Scottish Executive equivalent of HIPs and TIPs, and where to find the national guidance that sets the scene for development of those programmes and plans. That guidance comes from a number of documents. There is the "Priorities and Planning Guidance for the National Health Service in Scotland", which is produced from time to time. The most recent one was produced the year before last, and was reinforced last year, following the election of the new Administration. It sets out the priorities for the health service across Scotland, and identifies the three clinical priorities of cancer, coronary heart disease and mental illness and the new focus on children's services. It also sets out the broad areas in which health boards and trusts must direct their activity, which are towards developing primary and community care, restructuring hospital services and, crucially—the point that you mentioned in your second question—improving health and preventing ill health.

The priorities and planning guidance document sets the guidelines, or the broad parameters, within which HIPs and TIPs should be developed. Successive Administrations have taken the view that it is important to leave a fair amount of discretion to the health boards and trusts to take account of local circumstances in responding to the national priorities, which must be set out clearly. As I said, the Administration attempts to set out those priorities in the priorities and planning guidance. The Administration is considering what process should be gone through to produce the next version of the priorities and planning guidance—should it be the same kind of document, or how should it be developed? I am sure that the committee will be asked for its views on that in due course.

That is where the national picture comes from. I am not saying that there is not room for improvement, but that is the current situation.

Your second question was about resources for preventive action in health. You will be aware that, following the Chancellor of the Exchequer's budget announcement, the Minister for Health and Community Care in Scotland announced that £26 million of the additional resources will be devoted to the health improvement, public health agenda. That reflects the minister's clear view that more emphasis must be put on health improvement and illness prevention.

As you said, the amounts that are listed under other health service expenditure on page 56 of "Investing in You" are not the only expenditure on preventing ill health and improving health. Much of the expenditure that goes to health boards is also used for that purpose, to meet local priorities. Many health boards have imaginative and positive initiatives to tackle those issues.

Mary Scanlon: I did not really want the 42nd or 99th announcement about the £26 million that depends on people smoking more cigarettes to have more preventive health care.

You mentioned a number of documents that provide the background to the budget figures, in particular the priorities and planning guidance document that is two years old. I come back to my initial point: this consultation is open not just to the committee, but to the people of Scotland. Do you expect those people, and every community council in the country, to get your plethora of glossy documents and examine all the spending announcements and re-announcements on hypothecated taxation? Do you expect them to plough through the document on priorities and planning guidance to find out whether their health board is spending their money properly? You said that things could be done better; this is an opportunity for us to do that. How can the information be presented to us, and to the people of Scotland, in an open, transparent, honest and easy-to-understand way that will allow us to have an informed input?

John Aldridge: I certainly have no quarrel with the idea that the information should be presented as openly and transparently as possible. However, because of the wide range of information involved, that is not easy. It would be difficult and possibly not helpful to present all the figures in one document—that document would be very large—and we must ensure that the information, which is in the public domain in one form or other, can be brought together more effectively to enable people to make the contribution that you describe.

Mary Scanlon: You are the guys who put together the figures; you can make things easy—or impossible—for us. If the process is to be inclusive, your challenge—indeed, your responsibility—is to produce figures that allow us to participate. We do not yet have such figures.

John Aldridge: We would be very happy to take on board any of the committee's suggestions to improve the presentation of figures.

Mary Scanlon: Okay.

I am still not clear about the preventive thing—the £26 million that is going here, there and everywhere. However, on the HIPs and TIPs, we are interested in a one-year informed input to the budget process, not in whether Susan Deacon provides a few glossy brochures at £7.95 a time to tell women in Govan how to stop smoking or in constant announcements or re-announcements

throughout the year. How do you monitor whether the health boards are following the spending priorities that you set out in the documents? How can you be sure that what you and Susan Deacon have said is implemented at the grass roots?

John Aldridge: The system of performance management that applies across the health service in Scotland provides a range of different ways of monitoring. Each year, the health board produces a health improvement programme and each trust produces a trust implementation plan—the HIP and TIP. They are submitted to the department and form the basis of the monitoring process that happens over the year. Beyond that, the health boards and trusts in any health area sign a corporate contract with the health department, which commits them to specific aims for the year. Such aims might vary from area to area, but they must be consistent with the national priorities that are set out in the priorities and planning guidance and other documents.

The priorities and planning guidance document provides the basis of the year's performance management and monitoring, which is conducted through phone contact and formal and informal meetings between representatives of the health department and the health boards and trusts. That is how we monitor what the health boards and trusts are doing and ensure that they are in line with the priorities.

Mary Scanlon: Finally, you say that the three priorities are cancer, heart disease and mental illness. Can you tell me where, in the figures in "Investing in You", I can identify those priorities? How can I tell that money is going to them?

John Aldridge: The three clinical priorities?

Mary Scanlon: Yes.

John Aldridge: That is not clear from the figures in "Investing in You", because of the need to allow for local discretion in the way in which resources are spent. If the Administration said that a certain percentage would be spent, in future, on cancer, coronary heart disease and/or mental illness, and that that was the only amount that could be spent on each priority, that would call into question the discretion to deal with local priorities that the Administration believes that health boards should have. For example, in one health board area heart disease might be a particular problem and mental illness might be less of a problem. The balance would need to be slightly different from that in another health board area, in which mental illness was the most important of the three priorities. It is for local authorities to set their own priorities.

Mary Scanlon: I am not satisfied with how we consider clinical priorities in a health budget. No committee member would disagree about the three main priorities, yet I cannot say that I have had input in ensuring that those priorities are being met. I return to the relationship between the health department and the health boards, and the monitoring. You are not presenting figures in a way that ensures that we are meeting clinical priorities.

The Convener: There might even be a case for making absolutely clear within the text the reason why an objective—the three disease priorities, children's services, strategic aims, or whatever—sometimes cannot be met. There is a need for some background information for a layperson who might read the document, to explain that a certain priority is not being met for the reason that you have given.

There is also a case for providing a historic example. You might not be able to say what Lothian Health will spend on cancer care in a year's budget, because that is for the health board to decide, but you could say what it has spent in previous years. From that information, a trend could be plotted that would be even more effective several years into an Administration.

About four of us want to say exactly the same thing. We recognise the disease priorities that the Executive has set, and I do not think that anybody would object to them. The same could be said of the flagship policies that the Executive trumpets—possibly quite rightly—such as NHS Direct, ambulatory care and diagnostic units, and walk-in-walk-out clinics. However, a whole series of policy developments are mentioned in passing, in "Investing in You", for which we have no idea of the cost; nor do we know where the money comes from or where it goes, or how expenditure will be monitored. The problem is that, for each objective—and some even have a target date—we have the what, but not the how or the who.

We need to be able to see a more logical progression, even if that means that you have to say that an issue is for people to decide locally. The issue may come down to performance management of health boards and trusts by the central department, and decisions being made locally, but some indication must be given of the cost and the financial path, as well as how the policy will be pursued. We must start spitting it out, so that it does not take a degree in health accounting to read the figures.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): The convener has made most of the points that I was going to make, but those points take us to the central problem with the document. First, by far the biggest block—the hospital and community health services—is not disaggregated. Secondly, no connection is made between the expenditure lines and the objectives. I want to illustrate that and ask some questions about the

capital expenditure.

Many of the objectives relate specifically to capital expenditure. The eight new hospitals account for the biggest sums and there are also the ambulatory care and one-stop clinics. However, we have no idea how much capital is being spent and in which year, or how much those new facilities will cost. Nor do we know whether it is additional money, whether it comes from some other budget or whether it is a transfer of resources. We are completely in the dark about how those central objectives are being costed. Is not it possible to have a genuine capital expenditure line within HCHS, and possibly even a disaggregated one that says how much money is for the eight new hospitals, how much for the ambulatory care units and how much for the one-stop clinics?

10:00

John Aldridge: I am happy to take that point on board. It would probably be helpful to have a line showing how much is spent on capital each year. What comes out of the accounts is the figure spent by the health boards themselves, rather than what is also spent by the trusts.

In future documents we can certainly provide disaggregated figures that would show what capital projects are in the pipeline and how much money is associated with them. That might not be easily split into the amounts that are likely to be spent in each year, because it will not be certain in advance how much will be spent in a given year rather than later in the project. However, we can certainly include the total cost of those projects.

Malcolm Chisholm: You say that the NHS spent around £145 million on capital in 1999-2000. Do you have any idea how much will be spent this year and next year?

John Aldridge: The provision for capital in 2000-01 is about £194 million.

Malcolm Chisholm: That appears to have gone up quite a lot from last year.

John Aldridge: Yes, it has.

Malcolm Chisholm: Why is that?

John Aldridge: The increase comes from a decision by the Administration that the capital line had got too low and not enough was being spent on capital. There was a deliberate decision in the previous spending round to build in more spending on capital.

Malcolm Chisholm: What does "capital" mean? The private finance initiative projects have yet to come on stream. We know that that money is technically revenue. When the PFI projects come on stream, will it appear on a separate line that indicates that that revenue is really capital?

Sarah Melling (Scottish Executive Health Department): The capital for trusts is given to trusts through the revenue line. The £145 million in the HCHS current expenditure line is mainly trust expenditure. We could split that down to say what capital that is, but it is not given to trusts as capital on that line. We are back in the old capital charges debate again.

Malcolm Chisholm: There is an interesting line at the beginning of the document, entitled

"Capital spending (by private sector on PFI projects)".

The figures, which are for total expenditure by the Scottish Executive, show £473 million for last year and £669 million for this year—the biggest figure in the line. After that, it dips for some reason to £412 million in 2001-02. How much of that spending will be on health?

John Aldridge: We should be able to provide you with the health figure, but I do not have it with me today. It is a substantial amount. Three large PFI projects for the health service are currently under construction—Motherwell, Hairmyres and the new royal infirmary for Edinburgh. Together, they will account in any one year for a sum in the three figures of millions.

Malcolm Chisholm: So they are not included in those lines yet. Which is the first year in which they will kick in?

John Aldridge: They should kick in next year.

Malcolm Chisholm: Our favourite topic, capital charges, has been mentioned. How much is included for capital charges in health board allocations for this year?

Sarah Melling: It is £345 million.

Malcolm Chisholm: Thank you.

Mr Duncan Hamilton (Highlands and Islands) (SNP): I will come back in later, but I have a quick question on PFI. First, in a written answer, I was told that information on the costs of individual PFI projects in the health service is "not held centrally". That cannot possibly be true. Is such information held centrally and can we have a breakdown of the indices?

Secondly, we are all clear that some areas are broken down into minutiae and in other areas vast, sweeping statements are made. Where can we find the figures for health board and trust budgets in an accessible way? On the ground that the NHS management executive is responsible for examining the figures and agreeing the plans on an on-going basis, would not it make sense to have at least a general NHS management summary of the implementation plans as part of the budget so that people can see the flow from

allocation to service delivery?

John Aldridge: Sorry. I did not quite catch the first point, on PFI.

Mr Hamilton: Presumably there is continuing analysis of the costs of PFI per project in the health service in Scotland. Is that true?

John Aldridge: We know what the total contract cost is.

Mr Hamilton: Presumably we also know the various components.

John Aldridge: That depends on the terms of the contract.

Mr Hamilton: We are coming back to the idea that there are some things that are commercially confidential and some that are not. We are concerned with the costs to the health service. Is it correct that those details are held centrally?

John Aldridge: We will have the costs that the health service will have to meet in payments per year to service the PFI agreement and the total cost, but those will not be differentiated.

Mr Hamilton: Why not?

John Aldridge: We would not expect it to be, because under the contract the health service pays for a facility.

Mr Hamilton: In other words, we are going through this process, attempting to discover whether there is value for money in a range of areas, but we cannot do the same for PFI projects?

John Aldridge: It is difficult to answer that question, because I am not clear what assessment you want to do that you are not able to do.

Mr Hamilton: If we had the figures, we would be able to examine the public sector comparators and decide whether there was value for money. Without the figures, we have to take it on trust.

Sarah Melling: Before a project is commenced, a business case will have been produced which will have demonstrated that the PFI scheme was the best value for money.

Mr Hamilton: But the project is not then open to the rest of us to examine. Even under Malcolm Chisholm's proposal we are being asked, as part of the budget process, to accept a line that says, "That is PFI. That is the way it is and it is not going to be broken down by project." How can we—or anybody else—go back to the man in the street, put our hand up and say honestly, "Yes, that line makes sense. There is value for money and I am pleased that the Executive is doing things that way"? PFI might well be the best deal in some instances, but we need to be able to see that it is. It strikes me that PFI is an area where everyone is incredibly defensive and secretive about something that they should not be defensive and secretive about.

John Aldridge: Convener, I am not sure that it is right to say that people are being particularly defensive or secretive. PFI projects, whether in the health service or anywhere else, and the Scottish Executive's part in them are auditable. I understand that Audit Scotland has indicated that it will follow and audit the Edinburgh royal infirmary project. That should give at least some reassurance.

Mr Hamilton: Not really. Whether or not we have an indicative project is not the point. We want to examine the money that is being spent on these major projects, which are trumpeted as a major new investment in hospitals.

If people are being asked to decide whether their money is being allocated properly and whether public involvement is wanted, they have to have access to the information. That is the basis of the transparency about which we keep talking. Why does that apply to some areas but not to PFI?

John Aldridge: As I have said, it is because of the terms of the contracts.

Mr Hamilton: Therefore it is impossible to know whether this is value for money.

John Aldridge: As I have said, I do not necessarily accept that. Systems are in place, including provisions for the schemes and the Scottish Executive's part in them to be audited.

Mr Hamilton: Those are systems to which we do not have access and that we cannot mould or justify to our constituents.

The Convener: You are saying that there are ways in which the schemes can be monitored but that those fall short of absolute public scrutiny in the form of figures being presented to the Scottish Parliament Health and Community Care Committee. As Duncan Hamilton said, we have to take it on blind trust that the schemes have been monitored for value for money. That may have been done in good faith, but mistakes may have been made. You are saying that the only way in which these figures can be made transparent is if and when an audit is done on a project.

John Aldridge: All the projects are audited. There is no wish to prevent appropriate scrutiny of PFI projects.

The Convener: We will move on. I think that we should make a point to the Finance Committee. In a couple of places the document states that there are eight major hospital building projects. We all want new, modern hospital buildings, but if that programme is being used as one of the main

planks of health policy, the committee needs the greatest possible powers of scrutiny for such a substantial part of the budget. The committee will discuss this again in due course.

Dorothy-Grace Elder (Glasgow) (SNP): Can I ask a supplementary question on VAT in relation to this?

Kay Ullrich (West of Scotland) (SNP): My colleague, Duncan Hamilton, has more or less taken the words out of my mouth. We have all the figures here on what is being spent—except for what is being spent on PFI, of course. Is money held back in reserve? If so, how much?

John Aldridge: We attempt to allocate all the money to particular headings. Most of the money is given to health boards, and through them to trusts. A small amount is held back to deal with contingencies in year.

Kay Ullrich: How much?

John Aldridge: For 2000-01, the unallocated amount is less than £3 million at present—out of a total of £5 billion. It is not a large amount.

Kay Ullrich: How much was the reserve last year?

John Aldridge: At what stage?

Kay Ullrich: At the beginning. How much money was put aside at the beginning?

John Aldridge: We identified a small amount at the beginning of the year—I do not recall exactly how much. The amount varies during the year. Some activities do not spend on the pattern that was expected and money is added to what one might call a reserve and is certainly available for contingencies and other priorities that emerge in year. Other things may arise that require additional expenditure that had not been forecast. The example last year was the meningitis C vaccination campaign, which had not been planned for and for which the health programme had to find resources in year. The resources were found by reallocating resources from some items and using underspends that had emerged in various parts of the programme.

Kay Ullrich: How much was spent from the reserves last year and on what was it spent? You mentioned meningitis. Why cannot we know what was spent?

John Aldridge: All the reserves that we had, with some underspending, were used up on the meningitis C vaccination campaign.

Kay Ullrich: So your total reserves were used up on that?

John Aldridge: Yes.

Kay Ullrich: How much was that?

John Aldridge: I think that it was £17 million last year.

Kay Ullrich: What are the reserves in the coming year?

John Aldridge: I have told you already that we have £3 million unallocated at present, but I have no doubt that during the year some items of expenditure will vary from what is forecast, so more resources may become available in year.

10:15

Kay Ullrich: I want to return for a moment to what Mary Scanlon said. I was rather concerned by what you said about monitoring health boards against the Executive's priorities. I know that people are very concerned about postcode prescribing. Cancer drugs are a topical example of that. In some areas Taxol, Taxotere and various other cancer drugs are being prescribed, but in others they are not because of cost. What can you do to stop that sort of thing happening?

John Aldridge: There is a limited amount that can be done through the financial monitoring of health boards.

Kay Ullrich: But postcode prescribing is taking place on grounds of cost.

John Aldridge: Once the resources are with health boards and trusts, it is for them to decide how to spend them. It is for colleagues in the Scottish Executive to monitor their performance in those areas and to identify what they are spending money on. I accept that postcode prescribing causes a great deal of unease. That is one reason why the Administration is establishing the new Health Technology Board for Scotland, which is designed to provide advice, in the first instance on the use of new drugs, but also on other aspects of health technology, with a view to ensuring consistent use across Scotland of new cancer drugs and so on. It will be for health boards and trusts to take account of the advice, and how they do so will be monitored through the performance management system.

The Convener: I would like to pick up on one thing that you have said. The Health Technology Board for Scotland will be an advisory body. Decisions about the use of drugs will remain at local level with health boards. "Investing in You" states as its aim ensuring that people's access to services is not determined by where they live. People are not to be denied services simply because of geography. There will continue to be public concern about the fact that people in one part of the country have access to certain services whereas people in other parts do not because of local decisions. I understand that it is not your place to comment on that.

Dorothy-Grace Elder: I would like to ask a question about VAT, before moving on briefly to another subject; unfortunately, I have to leave the meeting for half an hour. Can you confirm whether the PFI deals are eligible for section 33 VAT shelter? Full public works projects by the NHS and other bodies normally receive section 33 VAT shelter.

John Aldridge: I am afraid that I do not know the answer to that question. I will send a note, if that is acceptable.

Dorothy-Grace Elder: If section 33 VAT shelter does not apply in this case, millions will have been wasted.

The Scottish Association of Health Councils is concerned about the lack of growth and, worse, the decrease in the contribution to the voluntary health and community care sector. The figures show either a standstill in the allocation or very little increase. Would you like to comment on how those figures were arrived at?

The Convener: Before you answer that question, Mr Aldridge, Irene Oldfather might want to add something to it.

Irene Oldfather (Cunninghame South) (Lab): Actually, my point was about national priorities. I have been trying to pick up on Mary Scanlon's point for quite some time.

Last week, we were presented with the very impressive record of what is happening in Finland. Their health promotion strategy seems to be tackling national priorities and has changed lives. We were told that there have been 70 per cent reductions in cancer, heart disease and so on. Those are impressive results.

Page 57 of "Investing in You" discusses a health promotion fund, the Health Education Board for Scotland and cutting death rates from cancer by 20 per cent by 2010. Are we not tinkering around the edges? We have national priorities and we must implement an aggressive programme to deal with the problems. Does Mr Aldridge have any comment on that?

I do not like the language that is used on that page of the report, particularly where it says:

"The Welfare Food Scheme serves families receiving social security benefits".

We need to consider how to tackle that issue more widely, rather than by targeting families on social security and calling it a welfare food scheme—that is extremely inappropriate.

The Convener: Perhaps I can pull those two questions together. Last week, we discussed the Finnish example at some length. The voluntary sector is a crucial partner in public health. We discussed ways in which we might ring-fence voluntary sector funding and projects that are vulnerable to cuts when councils face funding problems, but that do good work in health promotion. We want to consider the issue from a radical point of view, although we appreciate that that is difficult in the context of a one-year budget. Could you address the issue of the voluntary sector and public health in general?

Irene Oldfather: According to table 4.10, grants to the voluntary sector are being reduced.

The Convener: Yes. That is the point that Dorothy-Grace Elder was making.

John Aldridge: I will deal first with the issue of grants to the voluntary sector. There are two sets of grants to the voluntary sector: section 10 grants, which come from social work, and section 16(b) grants, which come from health. I can confirm that ministers are keen to support the voluntary sector.

The apparent reduction in the social work grants to the voluntary sector—down to £1.5 million from £1.8 million—is a consequence of an in-year decision made by ministers last year to add an extra £300,000 to the voluntary sector grants budget. The budget had been flat, but ministers added extra resources for one year because of the importance they attach to the voluntary sector. The figures for this year and future years will be considered in the context of the extra resources that are now available to the health sector. Ministers have not yet reached decisions about that.

The Convener: I am sure that ministers consider the voluntary sector to be as important this year as it was last year.

John Aldridge: I would be very surprised if they did not.

There is much sympathy with the view that we should be more radical in the way in which we approach health promotion and national priorities. The Administration has established the demonstration projects, which are designed to develop a radical approach of attack. One project concentrates on heart problems, there is one on cancer, one on children and one other, the subject of which I cannot recall.

Resources have been put aside specifically to run the demonstration projects. Currently, each project is in a different area of Scotland. In the context of the extra resources available to the health programme, the Executive will consider what provision ought to be made to roll out those projects more widely, assuming they prove their worth.

Irene Oldfather: It is important to nail the issue of the projects proving their worth. Health promotion is a long-term investment by its very nature and it will be very difficult to prove a

project's worth in five years; it took 25 years in Finland. I have some concerns that the flexibility of the funding depends on a project proving its worth within five years because I do not think that we will see the changes in five years.

We have to make a radical change and an investment in public health. We have the experience of other European countries to draw on. Do you feel that the objective on page 57 is realistic? Should not we be going for a reduction of far more than 20 per cent by 2010?

John Aldridge: When I said, "assuming they prove their worth," I was not suggesting that there would have to be absolute proof that they had achieved all their objectives at the end of five years before they could be rolled out more widely. That is not the intention. The point of establishing demonstration projects is to find out which approaches are more effective than others. Assuming they succeed in identifying the most fruitful ways of approaching an issue, they will be rolled out. If new approaches emerge as well, they will be supported too.

I hope that I can reassure you that there is no suggestion that we must wait until cancer has come down by 20 per cent in an area before the demonstration project is rolled out more widely.

Irene Oldfather: How much of the health budget is targeted at demonstration projects?

John Aldridge: I do not have that figure with me, but I can let you have it later. It is a relatively small amount, but it is the amount that is needed to run the demonstration projects. It would take a lot more funding to roll them out across Scotland.

Irene Oldfather: How much would it take to roll out a project across Scotland?

John Aldridge: It would depend on the project, but you would be talking in terms of £10 million or more.

Irene Oldfather: That is a small amount for improving Scotland's health.

John Aldridge: It may be a lot more. It would depend what needed to be rolled out.

The Convener: The figure for the demonstration projects is included under "Miscellaneous minor items" in table 4.9. In 2001-02, the total expenditure for that line is £20.3 million. Although it is a presentational point, these projects are the kinds that ministers make great play of. We heard last week about a demonstration project in Paisley. We are supportive of it. We are concerned about what happens at the end of a project, when a decision is taken on whether to roll it out. A strategy is required for that. Rather than bury the figures in "Miscellaneous minor items", it would have been beneficial to itemise them in some way. They are major projects and it would have been worth commenting on where they fit in the long-term strategy, particularly in terms of the strategic aims and the major disease groups.

Irene Oldfather: Are we really saying that education and media campaigns form the basis on which we are to improve Scotland's health by 2010? We have a target of cutting deaths from cancer by 20 per cent and halving coronary heart disease by that year. It seems to me that we need a far more radical approach, and much tougher targets.

John Aldridge: There is no doubt that although education and media campaigns have their part to play, they cannot do it alone—that is well recognised.

Irene Oldfather: Exactly.

10:30

Malcolm Chisholm: Another long-term trend is the shift from secondary to primary care. How can we find out about that from the figures? Can we decipher that, or are there other ways for us to monitor such a shift?

John Aldridge: As far as the financial figures are concerned, there would be some indication from the move, over time, between the "Hospital and Community Health Services" line to the "Family Health Services" line. That is at a fairly high level of aggregation but, broadly speaking, family health services are the primary care services, whereas the hospital and community health services are the hospital-based services.

Malcolm Chisholm: I have two points about that. First, how much of the HCHS line is going to primary care trusts? How much of it is going to community services, which I suppose I would include under primary care?

John Aldridge: I was coming on to speak about that. If we take primary care in the broader sense, including community care, I agree that it is more difficult to find that out from the figures. Approximately £1 billion of the hospital and community health service resources went to the community trusts, the equivalent of today's primary care trusts, but the primary care trusts also have the budget for prescribed drugs, which is about a further £500 million.

Malcolm Chisholm: That is the second point that I was going to make. Is it correct that the prescribed drugs budget floats from budget to budget and that it is not under HCHS, but in the unified budget to health boards?

John Aldridge: Yes—that is right.

Malcolm Chisholm: That is another confusion. We know the explanation, but that information

should be explicit in the document, otherwise there will be a lot of confusion.

On the subject of considering shifts towards primary care, much of the increase in the money going to family health services is presumably because of drugs and inflation.

John Aldridge: Yes.

Malcolm Chisholm: I heard some good news on that front a week or two ago. Can you update us on the drug cost scenario for the next couple of years?

John Aldridge: I would like to make two points about prescribed drugs costs. The good news to which you refer, Mr Chisholm, is that the UK Government—control of drugs prices is a reserved matter—has taken steps to limit the price of generic drugs. The price rose substantially last financial year and consultations are taking place on a proposal to limit the total price of generic drugs to the level of 15 months ago. That would get it back down to its level before the big increases. That is being done because of a feeling that the generic drug manufacturers had taken advantage of the closure of one manufacturer to put up prices beyond a level that was warranted.

The result should be a fall in the costs to primary care trusts in meeting prescribed drugs expenditure—although not all the way to the level of 15 months ago because of the growth in the volume of prescribing since then. Also, there are new drugs on the market. That is the good news. The other point about the transfer from secondary to primary care is that new drugs become available on the market and a lot of them are very effective and operate to keep people out of hospital. In may cases, the increase in prescribed drugs expenditure genuinely reflects a transfer of responsibility and activity from the secondary care sector to the primary care sector.

Malcolm Chisholm: It is mysterious that there is nothing in the document about income. Can you explain how income from prescriptions relates to public expenditure and why it is not mentioned?

John Aldridge: Prescription charges are netted off the total health budget. Charges account for about 4 per cent of the health programme income in Scotland. Those include prescription charges, dental charges and charges for wigs and eye tests.

Malcolm Chisholm: We have expressed interest in the joint investment fund. That might not be reflected in the document because it is not yet in place, but could you tell us how we would know when it is?

John Aldridge: The joint investment fund does not have any money attached to it; people have identified that as a problem.

Kay Ullrich: It is a contradiction in terms.

John Aldridge: There is no specific money attached to it. However, the intention was that health boards would work with the trusts in their area to identify a part of the budget dealing with a particular service that needed to be reviewed. The joint investment fund would allow health boards to draw together spending and activity in different trusts and agencies in an area, re-examining how they fit together and trying to improve services.

Progress in making use of that mechanism has been very patchy. Some areas have gained useful benefits, but it has been difficult to get it off the ground in other areas. To many people, the JIF remains a useful mechanism for bringing together the different parts of the NHS community to consider the pattern of services and how best to provide them.

Malcolm Chisholm: In future, would not it be a good idea to record that in the document, so that people could see such shifts taking place?

John Aldridge: That is a helpful suggestion and something that we could consider.

Mr Hamilton: I have another helpful suggestion. You will be aware of the furore that sometimes surrounds arguments about health spending increases and that one of the committee's targets is to discover what "real terms" means in the context of the NHS. Am I right in saying that the figures in "Investing in You" are in cash terms?

John Aldridge: Yes, apart from those in table 4.15.

Mr Hamilton: Okay. What is the assumption that you make about inflation? What deflator do you use when you consider the overall picture of health spending?

John Aldridge: The only deflator that we apply to the health programme as a whole is the gross domestic product deflator. That is applied in order to express the health programme in real terms, to allow comparison with other programmes. Currently, the GDP deflator is 2.5 per cent.

Mr Hamilton: Your estimate of drug inflation, despite what you have said about the future, is about 9 or 10 per cent.

John Aldridge: The provision that we are making is about 9 to 10 per cent, which is the estimate of the increased costs that will have to be met. Those costs are not all inflationary—some of them relate to increased volume and different drug mixes.

Mr Hamilton: What is your estimate of drug inflation?

John Aldridge: We do not have a figure for cost inflation as such. We estimate what the costs for

prescribed drugs will be, taking account of likely changes in volume and the mix of drugs—new drugs coming on the market, old drugs dropping out of the market and so on—based on past experience.

Mr Hamilton: What about inflation? I understand the various components in the overall increase, but it would be useful to know what element of that was inflation. Am I right in saying that you would expect the inflation in the drugs budget to be more than 2.5 per cent?

John Aldridge: I am not trying to be difficult, but there is no figure for drug inflation. Each drug changes its price by a different amount—some will go down and some will go up. We do not calculate a figure for drug inflation as such.

Mr Hamilton: In the sense that all the inflation targets are simply estimates, a more accurate estimate would be not less than the flat 2.5 per cent rate. Take the example of wage inflation. What is your estimate of that?

John Aldridge: In issuing resources to health boards and trusts and in their indicative allocations, we make a judgment about the pressures that they will face because of pay and price increases, which, historically, have operated at a level slightly above that of the GDP deflator—usually by about 1 per cent. We tend to build in that assumption.

Mr Hamilton: On what basis are you currently estimating wage inflation?

John Aldridge: We do not have a separate wage inflation forecast.

Mr Hamilton: Are you saying that in negotiations with pay review bodies and so on, you have no idea what you think wage inflation will be?

John Aldridge: Governments have always taken the view that they provide evidence to the pay review bodies on the resources available to the health service—that is now clear, following the Chancellor of the Exchequer's budget announcements. They also provide evidence on the state of the economy in general and what it can afford in terms of comparative increases for different groups of workers. For example, if average pay increases are running at 2.5 per cent, the Government will draw attention to that. The Government does not say that it is assuming that there will be a pay increase of 2 per cent and so on.

Mr Hamilton: This is an important question. Are you saying that the Government does not wish to put a particular figure on wage inflation or that the Government does not have a figure for wage inflation?

John Aldridge: The Government never makes a specific wage inflation assumption.

Mr Hamilton: The reason I ask is because the information that I have received from the Government is that it has an assumption for wage inflation, but that it does not want to make that public. That might be an issue that me should take up with the Executive.

John Aldridge: Can I ask where you got that information?

Mr Hamilton: I received a parliamentary answer. What percentage of a health board's budget—given that it will have to meet wage increases—is spent on wages?

John Aldridge: Pay accounts for approximately 70 per cent of a health board's costs.

Mr Hamilton: If 70 per cent of the costs are on pay and we think that pay is above the GDP deflator—

John Aldridge: That is not what I said. I said that in the past, overall pay and price inflation has tended to run at about 1 per cent above GDP.

Mr Hamilton: You are not suggesting that the rate of inflation in relation to pay will be less than 2.5 per cent. We know that the Government's announcements to the pay review bodies are way above that.

John Aldridge: Yes. The increases announced for the coming year are above that.

Mr Hamilton: What I am getting at is that when we take away the increased inflation for equipment, wages and drugs—that is above the GDP deflator—there is no real-terms rise in the health budget.

John Aldridge: The only real-terms description that the Government applies to the health programme—or any other programme—is in the use of the GDP deflator. That is for comparison purposes across programmes. With regard to extra resources, Governments have always taken the view that increases should be expressed in cash. For the health service, those increases are sufficient to meet cost pressures on pay, prices and developments, taking into account the fact that any organisation can improve its efficiency.

Mr Hamilton: With respect, "Investing in You" is meant to go out to the public, who are meant to compare one area with another to determine whether enough money is going into health and so on. It is about prioritising. To use a flat 2.5 per cent deflator, which you say is for the comparison of different subject areas, is very misleading. The point about having an accurate real-terms indicator is that it tells us what we get for the money.

A flat comparison is meaningless because there are different areas of inflation within different services. That is especially the case in health. With that in mind, how can we tell whether we are getting an appropriate rise in health care funding? How can a flat comparison be meaningful to anybody reading the document?

10:45

John Aldridge: Because the document compares the amount of money that is put into the system, not the output or the outcomes.

Mr Hamilton: How can people tell whether their money is being used well if they cannot measure whether the outcome is worth having?

John Aldridge: Because the input and the outcome should be described in terms of what is being delivered. The factors that I have mentioned already—cost pressures, pay pressures, new developments that might save money or cost more, efficiency savings in the health service—must be taken together to identify what the health service delivers in terms of activity, better patient care and improving health. We will not find out what the health service has left to spend by deducting what we think it is spending on pay and price inflation from the total amount of money that it has. The only way that the health service can deliver its services or provide new ones is by employing people of an appropriate standard to deliver those services. It is not true to say that the health service spends its money on continuing to do what it has always done and has a certain amount left over at the end that can be used to do other things.

The Convener: Part of the problem that we have is that we are presented with an administrative departmental budget—although I notice that the management executive budget is not itemised either—but the operational end of the spending is in the health boards and the trusts. Efficiency savings and spend-to-save programmes are mentioned, but the document gives us no idea of where major savings could be made to shift allocations around. Duncan Hamilton's point is well made: we know that the major pressure on health budgets is the cost of providing decent pay for the staff. That will never decrease.

I accept some of what you are saying, but what you are saying is not in the document. There is a paragraph about drugs and another paragraph that mentions the Accounts Commission's prescribing report, on which we have been briefed. Obviously, that is an area in which efficiency savings can be made, while ensuring that the budget is used better. However, the document makes no mention of which savings might realistically be made. You can argue that costs can be balanced and efficiency savings made, but those savings are not presented in the document. Examples would be useful. It would be helpful to plot trends in areas such as the one that Malcolm Chisholm mentioned. Does money spent on community care represent a saving? We have seen that it does not, unless the standard of care is decreased. The document does not help us get answers to such questions.

Mary Scanlon: Malcolm Chisholm raised a point about income raised from prescriptions for dental and ophthalmic services. I will sleep easier tonight knowing that prescription charges are netted off. Mr Aldridge, you speak a language that I do not understand. I am sure that you know what you mean, but "netted off" means nothing to me.

We are examining a budget that has two laudable objectives: walk-in-walk-out hospitals and 80 one-stop clinics. I am not particularly against those objectives. However, how can I make an informed judgment about them when I do not know how much the hospitals or the clinics will cost? We need to know how much investment is needed. What will the hospitals and one-stop clinics cost?

John Aldridge: The target is set to launch the first of the additional one-stop clinics and the walk-in-walk-out hospitals by 2002. The centre cannot simply say what it will cost. We have to get business cases from the boards and trusts that will run the facilities, to investigate the costs that will fall to them to build, equip and run the new facilities. We have to consider those business cases and ensure that they provide value for money. Only at the end of that process will we know how much they will cost.

There is not much experience of walk-in-walk-out hospitals in Britain. However, where they have been set up, the capital cost has tended to be around the £20 million mark.

Mary Scanlon: We will have a new generation of those hospitals in Scotland and we will have 80 one-stop clinics—not just one—by 2002. I need to have an idea of how much all that will cost and where the money will come from. Will we take money from the acute hospitals, primary care, GP services or somewhere else? To move toward this new dawn, we need information.

John Aldridge: The capital expenditure would come from the capital programme, as I explained. That runs at £194 million this year.

The convener mentioned schemes that will save money. One-stop clinics will do that by reducing the number of times people have to go to hospital.

Mary Scanlon: Does that represent a shift of resources within the acute hospitals?

John Aldridge: Yes. Where walk-in-walk-out hospitals work best, they draw together a number

of activities that are scattered around in a traditional hospital so that people can get tests and treatment for minor problems in one location. That should save money.

Mary Scanlon: So that money comes from the existing budget; it is not new money.

John Aldridge: Running costs are from the existing budget; the capital costs will have to be found.

Mary Scanlon: I return to Duncan Hamilton's point: are the projects likely to be private finance initiative projects and open to scrutiny?

John Aldridge: I would guess that proposed walk-in-walk-out hospitals will be investigated to decide whether it makes sense to build them under the PFI or to fund them publicly. That will depend on the business case. One-stop clinics tend to be relatively small; I suspect that they will rarely be suitable for the PFI, if ever.

Mary Scanlon: Are one-stop clinics likely to be an extension of general practitioner services in, for example, remote and rural areas?

John Aldridge: There is no reason why they should not be, in some cases. It will be up to people to come forward with proposals for the way in which they think one-stop clinics can best meet the needs in their area.

The Convener: When health boards and trusts make proposals for clinics, ACADs and so on, how voluntary will that be? You mentioned the JIFs, and everyone would agree that having JIFs is a laudable idea. However, when we consider the need for a shift in resources from the secondary to the primary sector—whether that be in community care, or in relation to the JIF, or just in general, as Malcolm Chisholm was saying—the problem is that it is incredibly difficult to get resources out of the acute sector and into the primary and community sectors.

If you have a fixed parcel of money in the department's budget that is allocated to one-stop clinics, or to walk-in-walk-out centres and so on, we can have more faith—even though we might ask questions about the PFI—in the way in which things are funded. We know that the money is there, and that decisions do not come down to the local health board level on whether resources are available or on whether resources can be shifted from the acute sector out into the community. If the local health board does not have the resources, or the ability to shift the resources that it does have, money will not go into the primary and community care sectors. How can we have faith that that will happen when all the evidence is that it is easier to get blood out of a stone than it is to get money out of the acute sector and into the primary and community care sectors?

John Aldridge: Walk-in-walk-out centres will certainly require substantial amounts of capital resources that will have to be provided either centrally or through the PFI—where again the money to pay the contract price in due course would be provided centrally. Any resources for the set-up capital costs of one-stop clinics would be found centrally.

I recognise your point that there might be a case for having a special, ring-fenced amount of money for those purposes. We have set up a small fund for service redesign. Health boards and trusts that are redesigning their services—which is often so that they can develop one-stop clinics—can get a bit of help with that. It often helps to have an additional person to help to manage the process of setting up a one-stop clinic, and the fund can provide support for that purpose. We have resisted deciding centrally that another two one-stops are needed in one health board area or that another 10 are needed in another area. Instead, we strongly believe that such proposals should come from the local area, where people can judge what is needed locally. That should be reflected in the HIPs and TIPs that are submitted to the department each year, which form the basis of the performance monitoring and management of the health service through the year.

The Convener: In the priorities and planning guidance document, how much financial guidance is given to health boards?

John Aldridge: It does not provide financial guidance as such. Alongside the priorities and planning guidance document, health boards will have their allocations—they will know how much money they have. Guidance is issued from time to time on how they should account for that money.

11:00

The Convener: That would be for the current year only; it would not indicate to them what they could expect for the three years of their project planning.

John Aldridge: That is an important issue. A couple of years ago, the Scottish Office—as it then was—issued for the first time indicative allocations to health boards for forward years. It gave one year's firm allocation and indicative allocations for the following two years. Those allocations could not be absolutely guaranteed, but they were an indication of what the Scottish Office expected health boards would be able to spend in those years. The last year of that is the year that we are in now.

The indicative allocation for this year was confirmed last December. Since then, extra money has been made available, which will increase the amount that health boards have. They have been

given advance indications. I think that that is a practice that we would wish to continue, to give health boards not only one year's firm allocation, but indicative allocations for future years, to enable them to plan for the longer term.

Mary Scanlon: In the HIPs and TIPs that have been put forward to you—especially the HIPs—are you satisfied that there are plans for capital expenditure and investment in 80 one-stop clinics?

John Aldridge: I have not seen all the HIPs and TIPs.

Mary Scanlon: But you are supposed to be monitoring HIPs and TIPs.

John Aldridge: The Scottish Executive does that. Colleagues have the specific responsibility of looking at the performance management function.

Mary Scanlon: Can we assume that, within the HIPs, 80 one-stop clinics are planned?

John Aldridge: I would expect that, over the period that is covered by the HIPs, there will be additional one-stop clinics to meet the Government's commitment. I cannot say that definitively, because I have not seen them.

Mary Scanlon: People will have to start building them quickly, because the target date is 2002. As I said at the beginning, there is a difference between the Scottish Executive's targets and what the health boards are doing. Given that there is a target for 2002, we could naively assume that there are plans throughout Scotland for the planning, investment and building of 80 one-stop clinics. Those plans should be there.

John Aldridge: There should indeed be 80 more one-stop clinics in place by 2002.

Mary Scanlon: Therefore, if we got a researcher to go through all the HIPs, we would find out where they are and how much they are costing, because the health boards will have to have those costs in their expenditure already.

John Aldridge: I would like to be slightly cautious: one-stop clinics do not necessarily need a great deal of investment, either capital or otherwise. As I said, they can save money. Sometimes all that is needed is a relatively simple reorganisation of services in a hospital, so a great deal of investment might not be needed, and the one-stop clinics might be achieved very quickly.

Mary Scanlon: As well as the walk-in-walk-out hospitals. That is interesting.

John Aldridge: What I said is not true of walk-in-walk-out hospitals: they need much more planning because they are large capital projects. A number of trusts around Scotland have plans for walk-in-walk-out hospitals that are being considered.

Irene Oldfather: I will ask a follow-on question. In the acute services review, some health boards are proposing relocation of maternity units. Is that included in the capital programme? Is it included in the figures that we have in front of us?

John Aldridge: In so far as it requires capital investment, it would have to be funded from the capital line. I know that there are a number of proposals for changing maternity services and other acute services. Glasgow is consulting at the moment on a change to its maternity services. There are proposals in Fife and elsewhere as well.

Irene Oldfather: In Ayrshire.

John Aldridge: Yes. In so far as they require capital spending, a bid would have to be put in for capital support with a business case.

Irene Oldfather: Would the bid be put in for this after consultation?

John Aldridge: Yes.

Irene Oldfather: So, in some cases, it will not be in the current capital programme if the consultation exercise has been, or is about to be, completed?

John Aldridge: As I said, there is £194 million in the capital programme for this year. Most of that has now been committed to projects, either definitely or provisionally, depending on the outcome of further work.

For future years, with the capital line remaining at broadly the same level—probably a little higher at about £200 million—as you go on from year to year a smaller proportion of that line is fully committed, so there is capacity to deal with any proposals that come in—for example, following consultation on changes to maternity services—which need to be accommodated.

The Convener: Thank you both very much for coming to the committee this morning. This is a new process for us, and it is for you too. You may be a little more acquainted with the figures than the rest of us, but it is still a new process. We appreciate the manner in which you have answered our questions this morning.

There are probably two or three other issues rumbling along. One of our colleagues, Richard Simpson, was unable to be with us this morning and has a couple of questions that he wanted to raise. If it is acceptable to you, we will put those questions to you in writing. Thank you for your contribution this morning.

John Aldridge: Thank you, convener. I will be happy to respond to any further questions in writing.

11:07

Meeting adjourned.

11:14

On resuming—

The Convener: We move to the next part of our evidence taking on the budget process. Pat Dawson from the Scottish Association of Health Councils is with us. Good morning, Pat.

Pat Dawson (Scottish Association of Health Councils): Good morning, committee.

The Convener: You are a veteran of this committee, having been here before.

Having said that, this is a new process for all of us. We will want to talk to you about the experience of patients in more general terms than with the officials earlier. You can kick off by making a short statement, then we will question you.

Kay Ullrich: I apologise in advance that I have to leave at half-past 11. I am not walking out on the committee.

11:15

Pat Dawson: Thank you, convener and committee, for this invitation. Are they still called invitations? [*Laughter.*] If you ask me back, could it be on a subject other than money?

I am delighted to be here and the association is delighted to be asked again. Reviewing the section on health and community care has been a difficult process. From the point of view of the association, health councils and the wider public, we are pleased that ministers and the Scottish Parliament are heralding a consultation process about budget allocations and spend within the national health service. However, as was raised by many of the committee's questions this morning, I am not sure that the document lends itself to public scrutiny, or is as easily written, as logical in its processes or as clear in its linkages between allocation and budget expenditure as it could be.

I hope everybody has a copy of the general points I e-mailed to you yesterday. In the first section, I try to raise some of the issues on the content of the chapter on health and community care on which one might have queries. While two thirds of the budget is spent on local authorities and on health and community care, only 20 pages of a document of some 120 pages are allocated to those areas. There is a big question here about the level of detail that is given and the range of activities for which detail is given.

There are organisations here that I had no idea existed, nor what they did, nor how they allocated their money. I had some queries about where I expected to see expenditure allocated; for example, the Health Technology Board for Scotland. If we are heralding that it will change postcode prescribing and inequalities in other dimensions, and since it is a new entity, why is no expenditure allocated to it?

Dorothy-Grace Elder has raised this matter already this morning, but we are concerned about the allocation to the voluntary sector and about the mental illness specific grant. I have not consulted the Scottish Council for Voluntary Organisations, of whose policy committee I am a member, on this. However, speaking as somebody who will be supporting the launch of the voluntary sector health network by the minister next week, I am disturbed that there seems to be a reduction in voluntary sector expenditure. Under health board expenditure, it is difficult to see the expenditure on support to the voluntary sector in the work that is commissioned through health boards and trusts. There is not much detail on that sector other than some broad headings, where there is either a standstill budget or a decrease in budget. More specific cause for alarm is the standstill projected for the mental illness-specific grant, on which the committee has already taken evidence.

The other broad area that I wish to highlight is whether this rings true to the public. On page 48, the section talks about budget expenditure. We keep being told that it is a UK budget. We need to be clear about how this fits into the budget headings and how it will be distributed. Although it is clear that £26 million will go into public health expenditure and health improvement—that money is welcome—it is not clear how it links with the rest of the document.

We are concerned about how many times we can be told about a certain pot of money. I brought with me "Towards a Healthier Scotland", which says that £15 million is being spent on the demonstration projects. However, "Investing in You" mentions miscellaneous expenditure up to £20 million. There is a range of packages on community diet—diet is an important component of public health. There is investment in health education and health campaigns, alcohol misuse, and diet action initiative plans and so on.

It is not clear where those packages of money sit within this framework, yet they are heralded in the document. Members of the public are told repeatedly, "This is what we are doing on health", but it would be difficult for the public to consider "Investing in You" and say, "I can see from this how much money my health trust receives." It would be clear to them how much the health board receives, but the point that was made earlier was that expenditure on health board and the HCHS is a huge amount of money. Where does it go? It is

not delineated in any way.

This may be about linkages in the agenda for parliamentary action—improvements could be made to the linkages and explanations in the document—yet there is nothing about the patients project. My organisation supports the voice of the patients and the public in this process. We are concerned that health councils are not identified separately in the document, and that the patients project is not identified in any way. We have a clear objective to focus on patients, but we also have objectives and targets to do with staff.

The Convener: We could never say that there is a lack of good rhetoric on partnership between staff and patients from the Executive, or indeed from any government. However, the lack of rhetoric in this document is quite obvious. You are right to point out the lack of patient-centred language in the document. It reads as an accountancy document, rather than something that is accessible to patients and that reflects services to them. It is much more about administrative systems and services involving staff. In your comments, you ask what is meant by a home nurse, a district nurse or a health visitor. One of the big issues in the health service is how we make better use of its staff. That area is hardly touched on in here.

Who wants to kick off questioning? Any bidders?

Mary Scanlon: To continue the line of the questioning that I pursued previously, I see in your submission that you have raised some points. I am interested in the differences between the Scottish Executive's spending plans and objectives and what is achieved at health board level. How can we ensure that the targets that are outlined in "Investing in You" are met? I want to address the walk-in-walk-out hospitals, the one-stop shops and NHS Direct. The target for NHS Direct was early 2000 but it is now May. Are the targets realistic and achievable?

Irene Oldfather talked about the closure of hospitals and so on and we know that there is no new money. You said that the acute services review is not being debated in public, and neither is the review of the public health function. Are we clear about what the objectives are? Are you concerned about the autonomy and discretion of the health boards, or do you think that there should be more centralised control and direction? Can we trust our health boards to pursue the objectives that are set out for the three main clinical areas?

Although it now appears that the one-stop clinic will be a backroom in some hospital—I had thought that it would be something new—are the targets for the capital plans achievable? Are you satisfied with the relationship between the Government's targets and the health board's ability to meet those targets? Are you concerned that the acute services review is not being debated and that we could be losing services so that new services can be introduced?

Pat Dawson: "Investing in You" lists a range of targets, some of which are delivered by the department and some of which rely on health boards, trusts and others to deliver—that is not made explicit in the document. You are right that we are relying on others to achieve the departmental aims and objectives.

The priority and planning guidance is just guidance. There is no public influence on the priority and planning guidance. It is not consulted on but is simply issued by the management executive to the service. The management executive is telling the service what will happen, what the clinical priority areas are and what the flows of planning are to which it expects the service to adhere.

Like many people here, I think that it would be difficult to find much in that priority and planning guidance that was not appropriate. However, it took much lobbying activity, through the consultation on "Towards a Healthier Scotland", to have children included in those priorities. There is now a way to sensitise the Executive to the fact that the priority and planning guidance must fit better with what the public and professions want for their health service. Clearly, the admission that children are a priority is important.

My submission suggests that the target of early 2000 for NHS Direct, which was heralded in the programme for government, has not been achieved. Although it is a focal development for patient access, which could bring significant change to the way in which patients and families access advice about health care, emergency and general practice services and a range of other forms of primary care support, we have not been involved in it; therefore, it has failed as an objective of the department and the management executive. I understand that many general practitioners and GP and medical organisations have been involved so I question why patients have not been involved, given that it is a patient-focused service.

Mary Scanlon: As far as you are concerned, NHS Direct does not exist yet, even as a planning measure.

Pat Dawson: It does not exist as far as patient organisations or health councils are concerned.

You asked about one-stop shops and ambulatory care centres. That issue is quite confused. In your template for gathering evidence in support of the document, one of the critical areas about which we did not hear when previous

witnesses spoke was the issue of evidence. We are clear that co-ordinating services through one-stop shops brings benefits to patients. The health council movement—and, personally, I agree—is not clear that ambulatory care centres have any meaning for the public or that there is sufficiently robust evidence to support that policy objective. If I were a member of the committee, I would ask the Executive for evidence that the walk-in-walk-out hospital, which is in some way different from the one-stop shop, is appropriate, realistic and beneficial to patient care. I cannot answer that for you.

11:30

Mary Scanlon: You are saying that although walk-in-walk-out hospitals and one-stop shops are a top priority for the Scottish Executive—they are moving forward into a new dawn—they are not tried and tested and there is no conclusive evidence that they benefit patient care.

Pat Dawson: There is evidence that one-stop shops, in which diagnosis and support are part of one process, benefit patient care. I have not seen any evidence in support of ambulatory care centres. The management executive hosted one conference, at which there was a lack of clarity about the potential gains or outcomes for patient care.

Mary Scanlon: I believe that the Minister for Health and Community Care is visiting an ambulatory care centre down south next week. I think that she should have done that before she made such centres a major objective.

The Convener: One member of the Health and Community Care Committee will accompany the minister on that visit, but we will deal with that later in the meeting.

Pat Dawson: The royal colleges have produced evidence on early diagnosis and ambulatory care in relation to diagnostic equipment and capital costs for scanners and diagnostic radiography and so on. That might be a more realistic priority for major capital investment in ambulatory care centres, if indeed they are different—I do not know that they are.

Mary Scanlon: That is not entirely clear.

While we are examining the figures and pontificating on the priorities for the budget for future years, an acute services review is being carried out, which is centralising and rationalising services and closing down maternity services. There are threats all over Scotland, in places such as Argyll, Perth and Stracathro. While we are deciding the what, how, where and when, a big exercise is taking place into which none of us seems to have any input. Your submission says that the acute services review has not been debated in public. What are your views on that?

Pat Dawson: I was a member of the acute services review steering group. The review was complex and lengthy. It was clear that its recommendations would have an impact throughout Scotland. I was involved in a presentation to senior managers from Denmark. I heard how their local hospitals were very different to ours, and how they tackled the rationalisation debate differently in terms of the concentration of services. In Scotland, we hoped that managed clinical networks, on which a lot of work is being done, would solve some of the problems of Scotland's geography.

You are right to say that at the moment people across Scotland are frightened by rationalisation and by what is happening to something local and accessible that has aye been there. I do not think that trust reconfiguration will stop people identifying their hospital as the western, the royal and so on. Because of misinformation and lack of information, we have a poorly informed public. I mean that in the kindest sense. Documents such as "Investing in You" will not lead to the Scottish public becoming better informed. The document does not assist them in any way. It does not have an index and does not explain what expressions such as "real terms" or "netted off" mean.

Mary Scanlon: That is newspeak.

Pat Dawson: We are talking about simple things that would improve the layout of a consultation document. This is not rocket science.

Set against the public concern about rationalisation is the ambition of royal colleges, doctors and nurses to provide the highest standards of care. There is evidence that, in some areas, the more care of a particular type that is delivered, the better the standard of care and the outcomes for patients. That leads practitioners to say that rationalisation and centralisation of services is necessary to ensure better outcomes for patients. It is very difficult to rebut that argument. It is difficult to say that smaller units can deal as well with a broad range of type and severity of conditions as centralised sites can. The problem is that the debate about rationalisation has taken place without the managed clinical networks being in place. The service that could have delivered the best available advice and care, and the pathways to that care through tertiary and secondary centres, is still evolving.

Mary Scanlon: In Scotland there is a fear that we are losing services and hospitals—maternity, paediatric and accident and emergency services are under threat in many hospitals—without getting anything to replace them. The ACAD one-stop shops are a long way off. There is a crisis of

confidence in our health service. We see ourselves losing services on which we have depended since the end of the second world war, and all we are getting in their place is vague targets and hopes for the future. That concerns me.

Pat Dawson: You asked about the accountability of health boards. During the debate on the Arbuthnott report, the association suggested to this committee that it was concerned that the performance accountability reviews, which are part of the process that was outlined earlier, are conducted behind closed doors.

As the committee knows, the role of health councils is to represent the interests of the public in the NHS. They try very hard to scrutinise what health boards do and, to a certain extent, to hold them to account. The vast majority of health councils work closely with health boards on the production of their health improvement programme. Some boards are well placed to say to this committee and to the populations that they serve that they have a HIP document that is suitable for consultation and is in the public domain and that, as a result of the consultation that is taking place on priorities, there is a higher level of understanding. With others, that is not the case.

However, in some areas health councils have been active in facilitating dialogue with communities and with the public more generally, and in contributing to the HIP process and the planning tool that results from it. Within our current structures, health councils are the statutory organisations that should be at the interface between the public and boards, but it is not easy for councils to hold boards to account.

Mary Scanlon: Do you feel that the system of selection and appointment of health council members allows them to be impartial observers, scrutineers and watchdogs?

The Convener: As we are pushed for time, I would like to return to the budget document. We could talk to Pat Dawson all day about a variety of issues.

Malcolm Chisholm: I thank Pat for a very useful submission, which will assist us greatly in compiling our report. I have three questions. In a sense, you have answered the first one: what do you think patients will make of this document? Further to that, how do you think that next year the document could be made more transparent for patients?

Pat Dawson: I thought that I was going to get all three questions together.

You asked me the same question about the Arbuthnott report. You are on a hiding to nothing when you start talking about higher maths, without which the Arbuthnott report is impossible to understand. I have many ideas about how the budget document could be improved, to do with its design, its consistency and its linkages, the flow from the aim and objectives through to the targets.

Other problems are the lack of an index or explanatory section and the fact that the health and local authority contents are minimal. The total budget for justice is about £500 million, which is less than the amount that Greater Glasgow Health Board gets on one line. I would also like to know why the local authority spend on social work is a line in the health section as well as a line in the section on local authorities.

Malcolm Chisholm: My second question relates to the objectives. I was interested in what you said about ambulatory care, although I understood that the advantages of one-stop clinics would apply in a more general sense to ambulatory care. We will probably return to that. We may ask the minister about it next week. You express reservations about the objectives and about your lack of involvement in NHS Direct. Those reservations apart, are you comfortable with the objectives that are set out on pages 52 and 53, such as the introduction of an instant appointments system?

Pat Dawson: I suggested in my submission that, historically, the health service's experience of technological innovation and change is not good and that time scales have often lagged. I understand that about 600 GP practices are now connected, with another 200 still to go, so the programme is behind time, but progressing well.

If an appointment is a year from the date of the consultation with the GP, it does not matter whether it comes in the post or is made at the GP consultation. The important thing is how soon after the GP consultation the appointment is. However, I accept that objectives and targets set out in the document would benefit patients and would meet modern expectations. For that reason, they are to be welcomed.

Malcolm Chisholm: What you said about your relationship to health boards reminds me of our fundamental problem this morning—that this massive chunk of the budget is not disaggregated or open to scrutiny. As health councils, do you have better access to what health boards spend their money on? Do you have a role in the scrutiny and analysis of that? Could any of that experience be of help to us? It seems to me that next year we need a budget from each health board, detailing what it has spent its money on in the previous year, even if that board cannot tell us what it intends to spend its money on in the following year.

Pat Dawson: Scrutiny happens at various levels. Councils have a good relationship with boards on the five-year planning process that I described, and public consultation should be maximised within that process.

All boards and trusts produce annual reports, which say how money was spent in previous years. It would be useful if I could submit to the committee a review of how health councils have interacted with their boards on such questions, but at the moment, while I might be able to point to one or two examples, I could not tell you the bigger picture, nor could I tell you any areas where the health councils felt that there was good practice that could be shared and commended to the committee and to health boards.

The Executive has awarded us a grant to employ a health council development officer; part of her remit is to examine the interface between health boards and health councils, and to disseminate best practice. We need to work on that, because it is new to us, and it is reasonable that within a different approach to public and financial scrutiny we should examine such matters further.

11:45

The Convener: May I come back to the objectives on pages 52 and 53 that Malcolm Chisholm mentioned? Good objectives they may be, but are they achievable based on the current budget? Or—I will give you a get out—does the information that we have enable us to tell whether they are achievable?

Pat Dawson: Do you want me to comment on whether the objectives are the right ones?

The Convener: No. I take it as given that we accept that the objectives are good, and that we want them to be achieved. Given that, questions arise. We have to make an input to the Finance Committee on whether the Executive's objectives are deliverable based on the budget. Does the information that we have in front of us allow us to make that decision, or is the relevant information lacking or lost in the minutiae of some figures, so that we cannot say whether the objectives on pages 52 and 53—never mind any others—are achievable?

Pat Dawson: I cannot tell you that, because, for example, I do not know how much money NHS Direct will spend, and whether the money has been allocated to boards or to someone else's budget. NHS Direct was to have been launched in Scotland by early 2000, but we have already passed that date, so that objective has not been achieved.

Mary Scanlon's questions were on one-stop shops and walk-in-walk-out hospitals—indeed, John Aldridge's answers were on those subjects—but there is nothing in the budget document that tells me or the committee where the funding is coming from.

On the building programme, Ben tried to eke out where the capital is coming from—

Mr Hamilton: I have been called some things in my time, but never that.

The Convener: Pat, you do not know how much you have insulted him. [*Laughter.*] Can I scratch that from the *Official Report*?

Pat Dawson: I understand that linking up to GP practices was last year's objective with last year's money. I do not think that you are any further forward in saying whether the objectives are achievable.

Mr Hamilton: One of the things that strikes me about the way in which the information is presented is that each policy subject area is listed separately. However, we are supposed to be in the much-vaunted area of joined-up government. The voluntary sector is a good example of an area in which there are different funding mechanisms. No attempt has been made to show how different funding streams could come from different avenues. Do you think that that is a structural weakness in the presentation of the information? Does the health section show the entire spend on health?

Pat Dawson: I do not know, therefore I agree with your criticism. I have already illustrated that a range of expenditures is identified in "Towards a Healthier Scotland", one or two of which are picked up in "Investing in You", but in terms of traceability, there is no match between the objectives and the financial information.

As I said in my submission, there are issues regarding mentally disturbed offenders. That is one good example of seamless Government. I do not mean to be critical of the Executive, but within the budgetary component, that means nothing, because no new money is attached to that area and it is not clear where the expenditure, in terms of different budgets, comes from. However, it is a nice example of a cross-cutting Government initiative.

In addition, if you consider the objectives of the Millan review, although "Investing in You" says that the Executive will introduce new legislation, the target is only to produce a report; it does not give a timetable for the legislative change. So it goes on. We hope for refinement of some of the objectives and some of the targets.

I agree with Irene Oldfather's point about the length of, and lead-in time for, the public health agenda. We must try to pull out the longer-term

objectives from "Investing in You" and hold the Executive and the Parliament reasonably to account for what is achievable. Most of the objectives are not achievable within a short space of time. There is a mix of targets; some have been passed, others are for one or two terms, others are for two years, and others will not be reached until 2010.

The Convener: I must bring this section of questioning to a conclusion. Thank you Pat, not only for answering the questions, but for your written submission. A number of your points will certainly be picked up in the representations that we make to the Finance Committee.

I now call Neil McConachie, who is the chairman of the board general managers group, to give his evidence. Good morning, and thank you for listening patiently to everyone else's evidence. Do you wish to make a statement before we start asking questions?

Neil McConachie (Board General Managers Group): If I may, convener. You will find that many of my points have been covered in some of your previous discussions, therefore in a sense I am re-emphasising some of the issues from a health board general manager's point of view.

On behalf of the health board general managers, I thank you for the opportunity to talk to you today. I should emphasise that the chair of the health board general managers is not an executive position, but merely an administrative, co-ordinating position. However, in producing my comments I attempted to gather the views of my colleagues. We believe that this process can lead only to improved dialogue and understanding.

I intend to confine my comments to four areas: the budget presentation; issues surrounding the inclusion of the health programme in "Investing in You"; patient responsiveness, which will touch on some of the issues regarding one-stop clinics; and community care and grant-aided expenditure.

On the budget presentation, I wish to refer to the intention to review budgets over a period of more than one year. Clearly, the great majority of the document applies only to year one, which is 2001-02. From the planning point of view, there is no doubt that there is advantage for patients in us being able to plan investment with greater certainty over a longer period of time. Those who deliver services undoubtedly also appreciate the certainty of longer-term investment plans. Last year, three-year indicative budgets were given, and that was welcomed.

It is to be hoped that as the Scottish Parliament becomes more established, a three-year minimum budget projection for the health services will become the norm. Indeed, health boards are required to develop, in conjunction with NHS trusts and other partners, five-year health improvement programmes, with five-year budget projections. For those to have stability and credibility, there must be some commonality with the national budgeting process, so that cross-checking can take place.

The line on stability is consistent with that taken in "Making it work together: a programme for government". "Investing in You" makes reference to the introduction of

"a fairer system for the allocation of NHS resources"

by the summer of 2000.

The impact of that statement on funding for future years is unclear; it suggests potential uncertainty for the boards that may be affected over a longer period.

The comparisons with previous years in "Investing in You" are helpful in communicating widely the impact of budgetary change. In that regard, however, tables 4.1 and 4.15 seem to compare apples with pears by comparing projected or estimated outturns with plans. Table 4.15 shows the expenditure for hospital and community health services in 2000-01 to be marginally lower than in 1999-2000. Clearly, that is not correct and is not intended, but it sends a certain message.

I will skip over the question of the conventional, familiar budget headings, including HCHS, as there has been some talk about that. At health board level, as has been mentioned, there is undoubtedly a link with the national planning and priorities guidance—covering cardiovascular disease, cancer, mental health, child health, the shift to primary care and supportive care in the community, and the reshaping of hospital services—that was issued to the health service. The most recent full document of two years ago also covered the extremely important issue of inequalities and the overall question of improving health.

Inevitably, local communities will seek freedom to assess relative weightings in priority areas according to their situation and to the willingness to address local priorities—priorities being the important word. Table 4.4 acknowledges that, and makes clear what is expected of health boards in using their allocations. The explanatory note to that table states

"Health Boards are expected to . . . continue to develop and improve services in line with declared priorities".

Against that background, the presentation under the broad headings in "Investing in You" is appropriate, given the fact that the more specific headings will be dealt with on the basis of local priorities.

The description of capital expenditure is brief, without clear links to strategy and objectives. Capital is extremely important, not just for the new resources; there is always a need to replace dated equipment, and there are concerns around the accommodation for care of the elderly and mental health patients in some parts of the country.

The assumption in table 4.8 is that the turbulence that was experienced last year in medicines expenditure will not continue this year. Despite the forecast of a further 10 per cent increase in the medicines bill, that assumption will require to be monitored continually.

From a health board point of view, as opposed to that of the health or sickness services, the document's aim to

"improve the health of the people of Scotland"

is important. That, again, is consistent with the programme for government, and the consistency of aims between the programme for government and "Investing in You" is welcome.

The inclusion of health, as opposed to health services, is welcome. That recognises and highlights the fact that the comparative health profile of Scotland cannot be improved by focussing solely on—if you will allow me the term—sickness services. The emphasis on prevention must be right, and the involvement of partners other than the health service—so-called cross-cutting—is critical; that includes national Government. Further, as we know, housing, education, employment, the voluntary sector, social inclusion, lifestyle and life circumstances are major determinants of the overall health status of the public.

Concerns around drugs are highlighted, rightly, but our culture around alcohol must be tackled, and requires a higher profile.

It is believed that the community planning process should provide for greater integration of plans and shared local priorities to improve health. We believe that great potential is provided through the relevance of the health improvement programme to community plans. It is worth emphasising again, however, that such health initiatives require patience.

The references to improving health are largely confined to the "other health services" section. I want to re-emphasise that the recent review of the public health function was explicit, and the locus for public health activity should continue to be health boards. Many public health activities are already taking place, and a substantial portion of the £259 million health board expenditure—referred to on page 49 of "Investing in You"—is devoted to those services.

The embodiment of the provisions should be in the annual report of the director of public health and in the report of the health improvement programme—they may be worth discussing.

No increase in expenditure is planned under the heading of "other health services", despite that being the main area of discussion.

The £26 million for the health promotion fund is undoubtedly welcome, but if we compare it with the money that is spent by business to promote alcohol, tobacco and our traditional diet, I suspect that there is still a significant challenge in balancing the levels of promotion.

12:00

In the public health function, and considering sensitivities around local health strategies, there is no doubt that local health care co-operatives offer great opportunity and promise, embracing local practitioners. They have a fundamental role, in conjunction with a specialist public health function.

On the objectives for patient responsiveness in "Investing in You", the consistency with the programme for government is welcome. One-stop clinics and ambulatory care centres are about ease and speed of access, especially where there is a link with inequalities. Rapid diagnosis and treatment after access, to reduce patient anxiety and improve patient outcomes, seem to be consistent with what we would all wish, not just because we live in an instant response society.

The inclusion of community care and social work grant-aided expenditure in "Investing in You" sends, in our opinion, exactly the right message. Pooling budgets across headings—to improve both quality of life and patient care in environments that are appropriate for people's needs—deserves much more investigation as we proceed. The detail could be expanded, but the inclusion of those aspects in the health budget sends the right message.

I emphasise that we value this dialogue; it will inevitably raise points of discussion, but it will develop common understanding of priorities and objectives before budgets are established.

I will draw to a close now, convener, to allow the committee to pursue its areas of interest.

The Convener: Thank you very much.

Malcolm Chisholm: Thank you for that presentation, Neil. A large chunk of the budget goes to health boards, so we thought it important to find out what happens to the money when it gets there.

Priorities have been mentioned and, in our community care inquiry, a priority is mental health. Mental health can be seen as a priority, but there is no one line in "Investing in You" that tells us how

much is spent on it. The mental illness specific grant is mentioned, but we have been told that that is not in fact part of the health budget. There is nothing to tell us how much of the health budget is spent on mental health.

I am trying to get a feel for that at a local level. To what extent do different health boards make individual decisions about how much of their big slice they spend on mental health? Do you feel driven by all the circulars and priority statements to spend a certain amount on mental health? Is there much variation between health boards in the amount that they spend on mental health?

Neil McConachie: I am not in a position to comment on whether there is much variation—there will undoubtedly be some. Health boards do not have to spend a specific percentage of their budget on mental health; it is a question of establishing priorities locally and of understanding what is required to support and improve mental health services.

I suggest that many, if not all, health boards benchmark their expenditure on mental health against other parts of the service. There are ways and means of carrying out that benchmarking, including the Scottish health services cost book. Earlier, there was discussion about whether we can get at what health boards spend their money on. There are avenues. The book is published every year, eight to nine months after the close of the accounting year, or three to four months after the close of the calendar year. There are no specifics; it is down to local priorities.

Malcolm Chisholm: The second area of concern is the shift to primary care. Everyone feels that that is right in principle, but we know that it is notoriously difficult to shift money. How does that happen when you get your budget? One split could be between the primary care trust and the acute trust, which leads us back to the vexed question of the joint investment fund. How does that work at health board level? Do you feel that you have strategic objectives when you allocate funds at local level?

Neil McConachie: There is no question about the fact that it is notoriously difficult to shift money out of the acute sector. We have a paradox. We love our hospitals. We do not really want to be in them, but we want them to be there whenever we need them. There is therefore a great deal of debate when this sort of issue comes up.

The biggest change in the past year has been the creation of the primary care trusts. Strategic primary care now has a much greater voice and will undoubtedly influence how services are developed. Historically, the NHS administered primary care as opposed to putting in managerial support. There is therefore potential for strategic planning of services, which will involve all local practitioners pulling together to increase capacity so that they can do more in the community.

I am not telling you that there is a great formula and that there will be a noticeable impact in the financial shift over the next few months. I think that what is happening is a process that will drive that change.

Malcolm Chisholm: We have talked about the new ambulatory care centres and one-stop clinics. How do health boards deal with those developments? I know that some health boards are further ahead than others, but do all health boards feel that they have to work up proposals for ambulatory care units or one-stop clinics? Would those developments be revenue neutral and would health boards get the money for capital so that they can be developed without threat to other services?

Neil McConachie: That is an easier assumption to make for one-stop clinics. The concept of a one-stop clinic tends to be seen in terms of bricks and mortar, but it is also about how services are organised inside those buildings. It may be a remapping of how patients are handled as they arrive and go through the day. That may be cost neutral and it may free up resources by moving patients through their journey more quickly.

The costs of ambulatory care centres are more difficult to envisage. I suspect that the capital requirements will be higher, although one-stop clinics may also have capital requirements from time to time, such as a new piece of diagnostic equipment or a new test machine.

Malcolm Chisholm: What have you been told about ambulatory care? Have you all been told to work up bids?

Neil McConachie: We have not been given specific targets. Provision of the service has a lot to do with geography; ambulatory care may be easier to provide in some areas than in others. When one is providing care for a whole community, one must do so holistically and consider what benefits ambulatory care might add to the existing provision.

The Convener: The objective of having one-stop clinics and ambulatory care centres is shown in one line of the budget, but then disappears into table 4.4, where it is shown within distribution of HCHS expenditure. You said that you thought it appropriate that table 4.4 was shown in that form, which seems to say, "Hands off investigating any further"—I am paraphrasing. The document is a central one, but the provision of the facilities is a local issue.

If we want to get the whole picture, we will need to know the answers to the sort of questions that

Malcolm Chisholm has been asking. We can ask you questions today, but we need a budget document that stands on its own as an investigation into health spending in Scotland. We need a document that would not require you or anyone else to elucidate the tables; it must be comprehensible to a member of the public. You said that it was appropriate that table 4.4 does not go beyond level III, but there are still very large totals for acute trusts, primary trusts and health boards. Why do you think that the document stops at that point?

Neil McConachie: I did not mean what I said quite as you suggest. I certainly did not mean to say, "Hands off." The document is appropriate at the macro level. Related data on various disease areas might also be appropriate, but they would make the document larger. That is the choice that has to be made. How much is spent on cardiovascular treatment in Argyll and Clyde Health Board area as opposed to in Grampian will have a local flavour. The summation of all the area spending plans will decide how much is spent overall on cardiovascular provision.

I was trying to explain that the breakdown below level III has a local flavour. Trying to be specific about spending on disease areas in advance of local budget setting would tend to drive priorities, appropriately or inappropriately. Nevertheless, there is a case for providing information below that level, so that people can comment on the investment in disease priority areas and the quality that we want to achieve. The timing of the document may influence the investment decisions made by health boards, although, if there is a five-year HIP, a projection of the summation of those investments may be possible.

The Convener: Do you think that, beyond the point at which the document stops, it would be appropriate to focus on the main diseases, the strategic aims and the major new policy areas, such as NHS Direct? Should more information be provided on how the department sees those things developing at local level? Perhaps the information should stop short of giving financial details, but it could give us some idea of how instructions are to be implemented throughout the system.

Neil McConachie: It makes sense for there to be clear statements of linkage. The relative weighting that will be given to any of the priorities should and increasingly will involve discussions in local communities on whether mental health has a higher weighting in one area than in another at that time. Some local discussion in supporting those expenditure priorities is important.

Irene Oldfather: I do not disagree with the point about local discussion, which is important. Local health issues and priorities are different in different geographic areas. Do you feel that enough emphasis has been placed on the prevention of ill health and the promotion of health? Do you think that there are adequate links between the national priorities and the proposed budget for health promotion? I find it difficult to ascertain from the document how much is being spent on health promotion. You mentioned that the boards shown in table 4.4 are spending a certain amount themselves, outwith the category of other health expenditure. Will you give us a little more information to help us to understand?

Neil McConachie: The expenditure I refer to is buried underneath table 4.4, where it says that £259 million is spent by health boards themselves. Health boards have budgets for health promotion and employ staff for that purpose. They have public health departments, which work on communicable diseases and with local authorities on environmental health issues. As I understand it, all that expenditure is contained in the £259 million.

12:15

Irene Oldfather: To what degree is that linked to national priorities?

Neil McConachie: Health boards' health promotion programmes would undoubtedly be aimed at national priorities. It has been said before that cardiovascular disease, mental health and cancer are, in a sense, self-evident in Scotland. Many of the health promotion programmes are about diet or smoking. A greater link is needed between those programmes and other activities that take place at local level with local authorities, through education programmes and leisure departments, which link into community plans and social inclusion. Undoubtedly, there will be links into schools, communities and work places, with an emphasis on issues such as the prevention of smoking.

Irene Oldfather: Is that adequate to tackle Scotland's very real problems of ill health, particularly heart disease and cancer? Earlier today, we spoke about the Finnish experience and the fact that cancer rates and deaths from heart disease have been cut by more than 70 per cent. Will the bitty, disjointed nature of health promotion, reflected in the health budget, be able to address such difficulties in a radical way?

Neil McConachie: The answer to part of that is that there is never enough; we could always spend more. You are right that we should identify how much we spend. I said in my presentation that I believe that this is about getting the balance right. Until we identify the spend more explicitly, it will be difficult to ascertain what that balance is. However, we need to look beyond the health budget to get the full picture of what is being done to reverse the

health profile of Scotland. We need to be cross-cutting and involve lots of other areas. Merely highlighting how much we spend on health promotion, the prevention of ill health and so on in the health budget—while that may be a good thing to do—misses the major point, which is that that is only a component of everything that needs to be done in Scotland to improve the health of our population. It is worth doing, but not if it sends the message that that takes care of that.

The Convener: I do not think that anyone on this committee would disagree with your point about the need for a cross-cutting approach. However, as we have seen, that is one of the things that the budget process does not pick up on, because it does not pick out what is being spent, for example, on drug or alcohol problems across a range of departments, yet we all agree that that is the way in which we need to go. We need to find a mechanism by which departmental budgets can isolate the areas that cross-cut other departments and we need to give some examples. The message is loud and clear that that is one of the things that this way of budgeting does not bring out.

Neil McConachie: I said that I welcomed the comments on health because there is a feeling that, if we had gone back a few years, the budget would have been much more dominated by the acute sector. The fact that spending on other areas is in the budget is a start, but we must build on that to get the balance right. It has not traditionally been accepted that health promotion should be included in the budget. There is a constant debate about how health promotion should be prioritised against the need for more sexy treatments that catch the public imagination.

Irene Oldfather: Demonstration projects offer an opportunity to examine cross-departmental health issues. Do you feel that the difficulty with validating such projects poses a problem for other health boards that are considering expanding into that area of public health and health promotion?

Neil McConachie: Such projects need patience. They take time, which is a commodity. This may be erroneous but, to use a cliché, I think that people in the health service respond much more quickly to the flashing blue light—it tends to create an aura of "We need to do something immediately here", which is easier to justify than something that takes a long time to evaluate. People on the demonstration projects have the skills to evaluate interim measures, to keep good practice alive, to spin out the good and the bad lessons as quickly as possible, to move the core forward and to transfer it to other areas. We should not be too despondent, but we need to be aware of the time that such projects take.

Mr Hamilton: The questions that the average man or woman in the street is asking are whether the health budget as a whole gets enough and what happens to the money that it gets. It strikes me that health boards could be the biggest losers, because the way in which the figures are portrayed seems to suggest that an amount is passed to the health board and then who knows what happens? Apart from new initiatives and the potential for increased expenditure on health promotion and so on, with which we agree, would not it be in your interests to have a graphical representation of, for example, the fact that 70 per cent of the health board budget goes on wages? That would allow people to see where your costs were.

That also links directly to the question whether the new initiatives will ever happen. If you are faced with a relatively static budget, on top of which you have the burden of trying to meet increases in wages, which account for 70 per cent of the total budget, your ability to key into the new initiatives will be undermined. The wage increases must be an important factor for health boards, given that no additional money was announced when the increases were announced. Which aspects of the overall expenditure of health boards could be included in, for example, a pie chart, showing where the percentages of fixed costs in health boards go?

Neil McConachie: Any pressure on costs must be taken into account; it dictates how much is free to spend on other things. The increases in the past couple of years have been affordable, but there is a knock-on consequence. It was pointed out earlier that staff and manpower in the NHS are extremely important and need to be looked after and rewarded, so wage increases are an inevitable part of running so large an organisation. That is accepted.

There are many options for the presentation of financial data. Where should we begin? We could have a document 50 ft high. I have not come here today prepared to talk about how else the data could be presented. There are a number of possibilities, such as geographic splits and so on. The list is endless.

Mr Hamilton: I do not think that we resolved this earlier, so let us be clear. Am I right in saying that the whole question of inflation is one to which we need to come back? The assumption of 2.5 per cent—which is not the case—would presumably be important to you, as it impacts on 70 per cent of your budget.

Neil McConachie: What is important is making best use of the money that we get. The health boards' responsibility is to work with partners and others to get full value from that money—that is our job.

Mary Scanlon: I return to the question I asked Mr Aldridge at the start of the meeting. I am concerned about the relationship between the Government's targets, aims and objectives and you carrying them out. How much autonomy do you have? How subservient are you?

Perhaps we could put it to the test.

The Convener: That is a bit worrying.

Neil McConachie: I am sitting up straight.

The Convener: Are you sitting up or bolting for the door?

Mary Scanlon: Let us consider JIFs. In response to Malcolm Chisholm's point, you said that it is

"notoriously difficult to shift money out of the acute sector."

Neil McConachie: That was a conventional wisdom.

Mary Scanlon: It may be conventional wisdom, but we are talking about preventive care, examining this wonderful Finnish experiment and considering moving funds out of the acute sector into primary care. If you cannot do that, are you not flexing your muscle or is it that health boards are not in control?

Neil McConachie: Well.

Mary Scanlon: Can I finish please. I have three questions lined up for you.

Is it that you are not in control or does the acute sector have such power over those funds that we cannot shift them according to our priorities, which most of us agree with?

The second point, which Malcolm Chisholm has also raised, concerns plans for ambulatory care clinics and walk-in, walk-out hospitals. You said that health boards

"have been given no specific targets."

Has the Scottish Executive not given you adequate guidance, information and instructions, or are you ignoring it? Is it not monitoring you properly?

The third point is about the Scottish health technology assessment centre, which was also mentioned earlier. We hope that it will put an end to postcode prescribing but, given your level of autonomy, you can virtually ignore anything the Scottish Executive says. It has come across clearly this morning that there are different priorities in different areas. If a drug or technology was recommended by SHTAC, could a health board pick and mix? Could you ignore that instruction, as you have done with the previous two?

Neil McConachie: Sorry, what have I ignored?

Mary Scanlon: JIF—it is notoriously difficult, so you have not pursued it.

Neil McConachie: No. Let us put some perspective on the difficulties in shifting resources. Part of the difficulty in shifting resources from the acute sector is that there are patients to be treated—there are people there—so if you shift money there must be an understanding of how those patients are going to get treated. A simple assumption says that it is about people or services; it is about providing care to patients. When people are referred to hospital, everybody in the NHS wants that service to be provided effectively.

Mary Scanlon: But we are considering a partnership that would enhance patient care, in which GPs can monitor diabetes, heart conditions and so on. We are not considering one or the other, we are examining working together.

Neil McConachie: I said earlier that I believe that the creation of the primary care trust and putting managerial support in behind local health care co-operatives and local practitioners will undoubtedly change the dynamic and the capacity to do exactly what you are talking about.

As to whether we can ignore guidance, should we choose to do so, which is an assumption in itself—I do not know that anybody would willingly choose to ignore something from the Government of the day—a range of measures to monitor health boards are currently in place. Non-executives are appointed to ensure that health boards and trusts adhere to strategy and objectives. HIPS and TIPS are examined; they are public documents that are available for scrutiny by anybody and are submitted—according to deadlines—to the Scottish Executive. Following from those are corporate contracts, which are more detailed one-year plans that we sign up to; those form part of the accountability review that takes place every year.

A raft of measures are in place to examine what health boards are doing. There will be variations according to local priorities, but they can be scrutinised and the need for a reason for any variation is clear. As has been mentioned, there is also an annual report. All those measures are mirrored in trusts. Board meetings are open to members of the public. As public involvement becomes more successful, the areas of scrutiny will increase. It will be difficult, given the raft of measures that I have described, for a health board to ignore an objective or priority that is set by the Government.

12:30

Mary Scanlon: Can I get clarification on my previous points? How can you explain that in all

health board budgets—and, indeed, in the budget that we are scrutinising today—we have to have a commitment to walk-in, walk-out hospitals to achieve this target yet you said earlier, in relation to ambulatory care, that health boards

"have been given no specific targets"?

Could you also answer the question on SHTAC?

Neil McConachie: On SHTAC and postcode prescribing, SHTAC is embryonic, but at the moment there are drug and therapeutic committees and loose associations of health boards. For example, in the west of Scotland, the predominant drug and therapeutic committee is greater Glasgow. To the best of my knowledge, all the health boards tie in to that one to look for consistency. We are well aware that an artificial border—a postcode—should not get in the way.

I believe that SHTAC will give clearer and more public guidance on what the professionals believe the value of a therapy is, so guidance will become more explicit. Many of the decisions that are taken at the moment are taken on the advice given by professionals as they examine the value of a medicine, rather than simply that it exists. Health boards tie into that.

Mary Scanlon: Can you answer my point about the walk-in-walk-out hospitals?

Neil McConachie: The document gives no specific targets for walk-in-walk-out hospitals. All the acute trusts will consider how they can improve their service to patients. The definition of a walk-in-walk-out hospital would fall into that as it is about providing more rapid access and treatment for patients. Everybody is doing that. Day surgery is a good example of that as targets are laid down. The Accounts Commission has reported on what would seem to be sensible levels for day surgery. Day surgery would be a component of a walk-in-walk-out hospital. You would find scrutiny and ideas of that type in all acute trust implementation plans.

Mary Scanlon: I am sorry, convener—

The Convener: I think that there is a target of 2002.

Mary Scanlon: Yes, there is.

Neil McConachie: What I meant was that, unlike one-stop clinics, it does not say, "We will have 30 ambulatory care hospitals or walk-in-walk-out hospitals."

The Convener: But we have the 80 one-stop clinics and we probably have an indication of the number of walk-in-walk-out hospitals.

Mary Scanlon: "Investing in You" states:

"We will launch a new generation of walk-in/walk-out hospitals"

We realise that the one-stop clinic is just a shuffling about of rooms and services in the health service.

The Convener: The reconfiguration of services.

Mary Scanlon: The reconfiguration, if you want. Is Neil McConachie saying that walk-in-walk-out hospitals are just a reconfiguration of the out-patient service?

Neil McConachie: No. I am not saying that.

Mary Scanlon: What are you saying?

Neil McConachie: The out-patient service does not, for example, cover day surgery. Walk-in-walk-out hospitals cover a range of services. Out-patients and accident and emergency would be part of that, but day surgery cases would not at the moment be classified as an accident or emergency.

Mary Scanlon: Is this a new name for something that is already happening?

The Convener: Can I stop you there. Later on in the agenda there is an item about a member of the committee going to see an ambulatory care centre in operation. Some of the questions and comments on this issue today suggest that that would be valuable. I hope that a member of the committee who has seen what is going on will be able to answer some of those questions. We might then be able to take on board some of the possibilities suggested by on-going work, as we have all heard anecdotal evidence of trusts that are examining the matter. Instead of focusing on that issue with Mr McConachie, we should bring this part of the meeting to a close and move on to those other items in our agenda.

Mr McConachie, thank you very much for your time and contribution this morning.

Organisations (Contacts)

The Convener: The next item on the agenda is consideration of contacts from outside organisations. Members will know that we have received a number of contacts from other organisations, many of which want to provide information or give presentations to the committee.

The committee's work load is such that we cannot make ourselves available in that way, but as individual members we can still meet outside organisations in a less structured way. As a result, perhaps we should write to outside organisations and make them aware of the time constraints on the committee. That said, members who are experts on community care are considering contacts from outside organisations to find out whether they fit in to our work on community care.

As I outlined last week to colleagues, the petition on the measles, mumps and rubella vaccine from Mr William Welsh is coming to us via the Public Petitions Committee. There was also a request for a committee member to take part in the Scottish Human Services Trust conference in Edinburgh. However, the conference falls on one of the days when the Parliament is meeting in Glasgow and I for one do not want to miss out on the opportunity of being in Glasgow. I suspect that committee members also feel that it would not be easy for us to take time out from Parliament meetings to attend the conference. I hope that that is acceptable to committee members. However, that said, I want to put on record that we welcome the number of outside organisations that have contacted us and the incalculable help that we have received from them. Are members agreed?

Members *indicated agreement.*

Invitation

The Convener: The third item on the agenda is the minister's invitation to visit the ambulatory care and diagnostic centre at the North West London Hospitals NHS Trust and a request that a committee member also go on the visit. I trust that colleagues think that the visit is a good idea. Perhaps I should make the committee aware of the fact that I am available to go that day.

Mary Scanlon: In light of the confusion over such hospitals and clinics, it is important for a committee member to go on this visit. Convener, you should go if you are free that day and then present a full report not just on what you saw during the visit but on what might be proposed for Scotland.

The Convener: It would be particularly useful to supplement that visit with a report on how the situation is firming up in Scotland, and I am happy to do that on the committee's behalf. Are members agreed?

Members *indicated agreement.*

Budget Process (Report)

The Convener: The fourth item on the agenda is a decision on whether our discussions on the conclusions and draft report on the budget process, during our meetings on 10 and 16 May should—as is normal with discussions on draft reports—be conducted in private.

Mary Scanlon: Given that this is an open consultation, my gut feeling is that the meetings should be in public.

Mr Hamilton: I take the opposing view. The meetings should be private to allow committee members to express themselves freely. That way, the committee can proceed without overtly party political considerations being raised.

The Convener: So far, our discussions have been very constructive and have not gone along party political lines.

Mr Hamilton: Furthermore, there is nothing sinister about private meetings, as the report will be made public.

The Convener: That is true. As we have found before in private meetings, discussions can come down to nuances such as the choice of an adjective.

Irene Oldfather: I tend to agree with Duncan. Private meetings give members the opportunity to discuss matters freely.

The Convener: Okay. I propose that part of our meetings on 10 May and 16 May—to discuss the draft report on the budget process—be held in private and that we make the report public in due course. Are members agreed?

Members *indicated agreement.*

The Convener: Thank you.

Meeting closed at 12:40.

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