HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 25 October 2000
(*Morning*)

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HEALTH AND COMMUNITY CARE COMMITTEE
23rd 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

Susan Deacon (Minister for Health and Community Care)
John Aldridge (Scottish Executive Health Department)
Gerry Marr (Scottish Executive Health Department)

THE FOLLOWING ALSO ATTENDED:

Brian Adam (North-East Scotland) (SNP)
Shona Robison (North-East Scotland) (SNP)
Nicola Sturgeon (Glasgow) (SNP)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Irene Fleming

ASSISTANT CLERK

Joanna Hardy

LOCATION

The Chamber

Scottish Parliament

Health and Community Care Committee

Wednesday 25 October 2000

(*Morning*)

[THE CONVENER *opened the meeting at 09:34*]

Item in Private

The Convener (Mrs Margaret Smith): We begin with agenda item 1, which concerns a decision to consider items 7, 8 and 9 in private. Item 7 concerns the community care inquiry. We are beginning to pull together the conclusions and the recommendations of that inquiry, and the report will be private until it is published. The same applies to item 8, which concerns the budget report. Item 9 deals with a specification for advisers on a forthcoming bill. Traditionally, we have done that in private.

Are we agreed to take those items in private?

Members *indicated agreement.*

Arbuthnott Report

The Convener: Good morning, minister. It is good to see so many of your team here, although we wondered whether you had left anybody back at the office. We are appreciative of your time and input this morning.

We should all appreciate that we have a constrained time scale today. We have only two hours in which to get through four important issues that this committee and your team have done a lot of work on. We hope to keep things moving as quickly as possible while getting all the questions answered.

The first issue that we will discuss this morning is the Arbuthnott report. Minister, if you want to make a brief statement at the beginning of any of the agenda items, I ask you to keep it tight.

The Minister for Health and Community Care (Susan Deacon): I am grateful for the opportunity to be here to address matters of interest to the committee.

I have brought with me some people from the health department. I stress that most of them are here to listen to the views of the committee on the range of issues that will be raised. It is important for the health department to hear at first hand the views of the committee. I will introduce two members whom members might like to ask to comment. John Aldridge, the director of finance, has attended the committee before. Gerry Marr is the director of performance and planning. He has recently taken up that post—previously he was the director of human resources.

I am aware that the Arbuthnott report has been subject to extensive debate in the committee and in the chamber. On 21 September, I made a full statement in Parliament setting out the Executive's proposals for implementation of the new formula. This year, we provided £12 million of additional money as a first step in implementation. The allocations for 2001-02 for each health board, based on the Arbuthnott report, were part of that announcement.

The report that was published on 7 September has been widely circulated and discussed. It has been generally welcomed as an important step towards replacing the outdated Scottish health allocation revenue equalisation, or SHARE, formula that has been in place for more than 20 years. As the committee knows, the report was the product of considerable discussion and consultation. I take the opportunity to thank the committee for its contribution to that process.

I am aware that committee members and others have continued to raise questions about this issue. I am sure that that discussion will continue—and rightly—but, as I said when I announced our plans for implementation, it is our intention to act on the proposal of Sir John Arbuthnott and his committee that there be a standing review mechanism for the formula. We will proceed with that and I hope that we can strike a balance between being willing to learn and review while ensuring stability in the funding allocation arrangements for the national health service in Scotland.

I am happy to take any specific questions that committee members may have.

The Convener: I will use my convener's privilege and kick off. Time and time again, you tell this committee and the Parliament that tackling health inequalities is one of the main priorities of the Executive's health policy. Do you believe that implementing the Arbuthnott formula will have a significant impact on the level and distribution of good health in Scotland, given that the total amount of cash that is being redistributed will remain pretty small—around 2 per cent of the overall budget?

Susan Deacon: The figure of 2.2 per cent, which is the total of what is being redistributed, is sometimes slightly misleading, as we are talking about 2.2 per cent of an overall total of some £4.5 billion, which is not an insignificant sum. When the Arbuthnott formula is applied, it will translate into

significant changes in certain areas.

Your question concerned inequalities. One of the significant elements of the formula is that it seeks to assess and quantify, for the first time, deprivation in different parts of the country. Thereafter, it allocates NHS resources accordingly. The formula goes a considerable way towards ensuring that global NHS resources are linked more effectively to need, specifically addressing the needs of deprived and remote areas.

The next stage, to which we should turn our attention, is to ensure that those resources are used effectively locally, to address health inequalities. That forms a central part of our much wider range of health policies.

Hugh Henry (Paisley South) (Lab): Chapter 15 of the Arbuthnott report talks about inequality and deprivation. Over the past few weeks, we have heard a significant restatement of the Executive's commitment to social justice. When can we expect those key issues to be addressed?

Susan Deacon: Deprivation and the wider agenda of social justice have been addressed since the Executive came into office last year. We have worked hard to put tackling health inequalities at the heart of our policy agenda. I shall give a couple of examples of that. We have targeted the allocation of the tobacco tax money in Scotland towards health improvement, specifically to address the needs of deprived communities. We have also put health inequalities centre stage in the policy framework for local health boards.

However, much more needs to be done. A major area of work that is being done at the moment is the development of the Scottish health plan—which has been discussed in the Parliament and previously in this committee—as part of our wider NHS modernisation agenda. I know that the committee will have a meeting on that next week. That plan will be published at the end of November and will set out a new performance framework for the NHS in Scotland. I expect that the need for NHS bodies throughout Scotland to tackle health inequalities effectively, innovatively and creatively will be at the heart of that performance framework. We must narrow the gap between the health of the rich and the health of the poor. It is a complex agenda, but we are serious about it.

Hugh Henry: You said that you expect bodies across Scotland to tackle health inequality. You have set out aspirations and talk about targets. Arbuthnott recognises the link between inequality, deprivation and poor health. How can you be sure that the money that you distribute will be allocated locally in a way that addresses inequalities? What criteria will you use that will indicate what level of finance there is at local level to tackle inequality?

Susan Deacon: Those are precisely the sorts of issues that are being addressed in the context of the development of the Scottish health plan, which will provide the strategic framework within which the NHS in Scotland will be required to operate from April next year and which will set out clearly a new performance framework for the service. At present, health inequalities are given significant emphasis in the priorities and planning guidance to which the service works in Scotland, but we believe that we can do much more to be clear about the outputs and outcomes that we require in this area.

09:45

Hugh Henry asked about ensuring that money is spent to address health inequalities. That is just one side of the coin. I also want to ensure that the money is spent well. To do that, the NHS must work very closely with community health organisations, the voluntary sector, local authorities and social inclusion partnerships. I am pleased that significant steps in that direction have been taken in many parts of the country. We must continue to drive the NHS in Scotland in that direction in the months and years ahead.

Dr Richard Simpson (Ochil) (Lab): I have a supplementary question on that. My area has received a very welcome £1 million for the first healthy living centre. The Stirling group, which involves health bodies, the local authority and the other groups that you mentioned, has been very active on it.

Following Arbuthnott, will you issue any guidance on the provision of support for the approach that healthy living centres represent? It is intended that they will ultimately cover 20 per cent of the population and that they will be in deprived areas. How do you link those two elements?

Susan Deacon: Richard Simpson identifies that healthy living centres have been developed in different parts of the country with funding support from the new opportunities fund. We regard them as an integral and important part of work in this area. The development of healthy living centres will be addressed in the context of the Scottish health plan and put in the wider context of the work of the NHS. In this area, as in others, we want to strike a balance between guiding, directing and setting the overall direction of travel for local NHS bodies, and leaving scope for local needs to be met effectively.

It is striking that the various bids that have been developed across the country for healthy living centres are very different from one another. Some are based on the development of a bricks-and-

mortar centre, with a particular emphasis on health-related services. Others involve a much more virtual concept, such as linking up a range of community and voluntary organisations. It is important that there should be scope for local variation and innovation if the centres are to be effective on the ground.

Mary Scanlon (Highlands and Islands) (Con): I am concerned about the Highlands and Islands in particular. I refer you to sections 4.15 to 4.19 of "Fair Shares for All: Final Report", and in particular to what is said about Argyll and Clyde Health Board. The report talks about the particular difficulties that are faced by islands and health boards that serve island communities, which require substantial adjustment. Given that the committee raised the case of Argyll and Clyde, which has 26 inhabited islands, you will understand that it is quite a shock to read in the final report that Argyll and Clyde has received nothing extra.

In the first report, Orkney was to receive a 20 per cent increase, but that has been reduced to 7 per cent. Shetland's increase has been reduced from 10 per cent to 1.4 per cent. In fact, your second report has seriously disadvantaged the islands and there is serious concern in Argyll and Clyde about the health board's ability to maintain and provide a health service for the 26 inhabited islands. In your report, you speak about roads and kilometres. Is it possible that this complex formula has not taken account of ferry and sea crossings?

Susan Deacon: Let me correct a point that Mary Scanlon makes. It is important to point out that the Arbuthnott report is not my report. The report was produced by the Arbuthnott committee and an independent review group, following widespread consultation, and the Executive has chosen to accept and implement its recommendations.

It is important to distinguish between the share of resources and the overall amount that is allocated to each health board. Mary Scanlon is correct in saying that there were changes in the relative shares between the first and second Arbuthnott reports, as I would have expected. There was widespread consultation on the first report and further adjustments were made to the methodology and the report overall as a result.

On the amounts that were allocated, it is important to stress that the Executive gave a firm commitment, from day one—which we have now translated into practical effect, through the allocations that I have announced for next year—that every health board would receive a real-terms increase alongside the new formula that was being introduced. For example, Argyll and Clyde Health Board will receive a 5.5 per cent increase on next year's allocation against this year's allocation. Highland Health Board will get a 9.8 per cent increase, reflecting the fact that, under the Arbuthnott formula, it has been assessed as requiring an even greater share. Every health board has received a real-terms increase, and some have had a greater increase than others according to the Arbuthnott formula.

We recognise that, in every health board area, to a degree, there will be real diversity between the needs of the different parts of the area—more so in an area such as Argyll and Clyde than in others. Most of the population of Argyll and Clyde live in densely populated urban areas but, as Mary Scanlon says, a significant section of the population live in island communities and more remotely. We believe that the Arbuthnott formula assesses fairly and transparently the overall needs of that health board area, but we stress that it is up to Argyll and Clyde Health Board to ensure that the needs of different parts of that area are met effectively.

The Convener: You spoke about outputs in tackling health inequalities. I presume that one output you would look for in areas such as Argyll and Clyde would be a local authority's meeting of the diversity of health needs.

Susan Deacon: Absolutely.

The Convener: Do you have a question, Duncan?

Mary Scanlon: May I finish my question, please?

The unique nature of Argyll and Clyde Health Board, with its 26 inhabited islands, was raised by this committee—vocally and responsibly—as an anomaly in the first report. You have chosen to accept and implement a final report that has not given any cognisance to the unique needs of Argyll and Clyde. You have also chosen to accept a report that reduces the amount that is allocated to Orkney, Shetland and the Western Isles. Orkney's general medical services resource has been reduced by 28.6 per cent, the Western Isles' GMS has been reduced by 22.7 per cent, and Shetland's GMS has been reduced by 19.8 per cent. Our island communities seem to have been seriously disadvantaged in the final report. Although Highland Health Board's allocation has increased by 9.8 per cent, its GMS has been reduced. I am seriously concerned about why the island communities in particular appear to have lost out in the final Arbuthnott report.

Susan Deacon: I repeat my earlier point: I am bound to say that Mary Scanlon's points are inaccurate, in the sense that—

Mary Scanlon: That information is at page 55 of the report.

Susan Deacon: With the greatest respect, I

point to the distinction that I made in response to the previous question between shifts, relative shares and the amount of resource allocated. When the Arbuthnott review group compiled the formula, it considered the different components of each health board's allocation. The Executive allocates resources to the health boards as a unified budget and it is up to each health board to take the decisions on that budget.

Mary Scanlon: My point is that the formula takes account of roads, but not sea crossings. At least, that appears to be the case, given that the island communities have seriously missed out.

Susan Deacon: Convener, Mary Scanlon raised a number of detailed points. Would it be helpful if the director of finance commented on them?

John Aldridge (Scottish Executive Health Department): May I make a couple of points, convener?

The Convener: I will stop you there for a moment, John. Duncan Hamilton had a supplementary question and I will let him ask it so that you can respond to both questions.

I remind members that they should go through the chair when they ask questions.

Mr Duncan Hamilton (Highlands and Islands) (SNP): I fully understand the point that there is a real-terms increase for each health board but, as the minister has correctly identified, the issue is the relative share of resources that is apportioned to each health board. In the context of a report of which one part was designed specifically to target remote and rural communities, it seems odd that those areas will not do as well in terms of relative share as this committee or, I am sure, the minister would like. Committee members are concerned about how robust the formula is.

Given that there was consultation and that, as a result, changes were made, it seems odd that the relative share that will go to remote and rural areas appears to have been reduced. It was interesting that the minister talked about the diversity of Argyll and Clyde, because that is the point of the exercise. The report was meant to highlight deprivation, particularly in urban areas, and remoteness and the problems of service delivery in rural communities. Surely it is obvious to the Executive that the Argyll and Clyde area, which has a preponderance of deprivation and remoteness, should have received a relative gain. We understand the point about relative shift, but we also need to understand why the formula is not achieving the specific objectives that it set out to achieve.

Susan Deacon: I will make a brief comment before John Aldridge comes in with the details.

I take this opportunity to reiterate the offer that was extended to the committee of a full briefing on the detail of the final report from officials and/or members of the Arbuthnott group. I know that that facility was taken up when the first report was published, but I am conscious that a number of the concerns that have been raised today would probably be alleviated by the detail that could be covered through such a briefing. The final report fully addresses many of the issues.

I stress that we sought to deliver a formula that is as transparent and fair as possible; we believe that the Arbuthnott review group has delivered such a formula. We are more than happy to take time, as we are doing with individual health boards, to explain further to the committee the details of those calculations. I am happy for John Aldridge to provide further details.

John Aldridge: That was the first point that I was going to make. The Arbuthnott review group, which reconsidered the recommendations of the first report in the light of the consultation exercise, sought to address each issue raised in the consultation, including the specific issues that relate to Argyll and Clyde and the islands. In doing so, the group found that the best match between the need for expenditure on health care and the available information was given by the road kilometres per 1,000 population figure, which was used as the proxy for defining deprivation. The review group could, in a briefing, provide more details about the various options that it considered before concluding that that was the best fit.

Mrs Scanlon mentioned ferries. I can assure the committee that that issue was considered. If ferry kilometrage, as well as road kilometrage, had been included in the formula, that would have resulted in a worse outcome for island communities.

10:00

The Convener: Why?

John Aldridge: Because, as the minister has explained, the formula determines relative shares, not absolute shares. An increased kilometrage would not necessarily benefit the islands. It would merely adjust the shares that the islands get.

Mr Hamilton: Does that not suggest to you that the formula may be wrong?

Mary Scanlon: Exactly.

John Aldridge: It depends. The members of the group would be in a better position to provide details on this issue, but as I understand it the health care costs that arise in island communities do not relate primarily to travelling from place to place by ferry. Services are provided either in the community, where the costs are similar to those in other communities, or in the local hospital, where

the distances are determined primarily by the road mileage or kilometrage. There are separate, additional allocations to the island health boards and to the inner isles for patient travel—when, for example, patients have to go to Aberdeen for health care. Those allocations are added in on top of the Arbuthnott formula. Those are some of the reasons why ferry kilometrage does not necessarily provide a good match.

The Convener: I would like to pick up a related point that was made in evidence from Shetland Health Board. Are you convinced that the new shares will not be detrimental to island and smaller boards and that those boards will not experience proportionately greater change than larger organisations? Are you convinced that, given the shares that have been allocated to them by Arbuthnott II—if we can call it that—all the island and smaller health boards in Scotland will still be able to proceed with their health improvement and other plans?

Susan Deacon: I confirm again that the island health boards, like other health boards, are receiving substantial real-terms increases in spend. That enables me to give you the assurance that you seek. I am, of course, aware of the specific needs not only of island health board areas but of each individual part of Scotland. Within days of the publication of the Arbuthnott report, I met the chair of Shetland Health Board and we discussed in detail how, in the light of the allocations that I had announced, Shetland would move forward with the development of services.

To move on from the SHARE formula, we had at some stage to be willing to grasp the nettle of devising an alternative formula for Scotland. Both the process by which the formula has been developed and the outcome of that process are very robust. I am sure that there is scope for refinement and development in the future. We have recognised that overtly and said that there will be a mechanism for it. However, I am not aware of any substantial or significant body of opinion that believes that the report is not the way forward. The welcome for the report and the new formula has been widespread. I am more than happy to put in place mechanisms for us to continue to discuss points of detail. However, I do not agree with the assertion that there is something inherently wrong with the approach that we have taken.

Mary Scanlon: Given the evidence that you have provided to the committee today, would you agree that there has to be something seriously wrong with the formula when taking ferry distances into account would disadvantage people living on remote and rural islands? Will you now make a commitment to talk to the island health boards, including Argyll and Clyde Health Board, to recompense them for the drastic loss in their income?

Susan Deacon: As I have indicated, I do not think that there is anything seriously wrong with the formula and I am not aware that anyone else, including those who were in the chamber when I made the announcement, has said that there is anything seriously wrong with it. I reiterate my commitment to ensure that we continue to refine and improve what is a radical and important step forward.

The Convener: I want to move on to another area. The Arbuthnott report was meant to be transparent. The methodology and how it would be put into practice were meant to be easily understood. Indeed, as you have just said, minister, the report should be as transparent and fair as possible. The final Arbuthnott report is certainly more transparent than the original report. What specific steps are being taken to disclose all the data and methods used to calculate the financial allocations within the report? Will those be subject to formal peer review?

Susan Deacon: Transparency is crucial. I know that the committee commented on that point in some detail and I am pleased that the Arbuthnott review group took on board the committee's comments. The net result is a final report and a summary report that are more accessible to a range of audiences, including the general public.

I recall that we discussed transparency in relation to other areas of policy when I last attended the Health and Community Care Committee. There is always a balance to be struck between the level of detail that is put into the short summary and the detail that underpins any policy document. On the availability of information, a far greater degree of detail is included in the final report. In addition, a series of presentations is taking place with health boards around the country to set out the details of the data and how they apply. I repeat the offer that I extended earlier, and in correspondence, that we are more than happy to do the same with the committee.

All the information is available. We are happy for it to be publicly available. I am also pleased that an attempt has been made to hone formula down to key salient points,and refine the major issues relating to the formula which the public and others can access.

The Convener: What is the timetable for making the full information—the methodology—openly available? Which sections of the final report are being rewritten for publication in peer review journals?

Susan Deacon: I doubt whether many, if any, Government policies have been as closely reviewed as the Arbuthnott proposals. As the

committee knows from the range of evidence and witnesses that it heard, the input was extensive. I therefore believe that the report has already been subject to considerable review. In addition, the two technical sub-groups appointed by the steering group provided expert advice on the further work that was done, which was fully taken on board following the consultation. I believe that the review process that is in place is robust. I am sure that there will continue to be much discussion and dialogue in a range of journals and other publications, as I would expect with such a radical change.

On the availability of information, I must point out again that the full final report contains a great deal of the information to which I think you are referring when you talk about the methodology. If the committee wants specific information to be included in the final report, I am more than happy to pursue that. An attempt has been made to include all the information in the report, precisely so that there is no need to look further for it.

Dr Simpson: As the minister says, the report has been heavily scrutinised by many people. However, the committee is interested in whether, given that this is a fairly novel approach, the methodology could be published so that there could be an international discussion—our problem is not unique. That might be part of the review system that the minister has announced; it would help us to move forward through critical analysis by other groups. That is more likely to happen if people are funded to publish the methodology as part of a research exercise, so that it can be subject to close academic scrutiny.

Susan Deacon: I note Richard Simpson's point. However, I must point out again that the report contains significant methodology and detail. I stress that we want to ensure that the issue is addressed and I hope that we can develop effective mechanisms in order to achieve that. The matter is under consideration and I will bear in mind the points that Richard Simpson has made.

Dr Simpson: Perhaps members of the committee might be sponsored to find the time to take this to the next step and to an academic journal.

Susan Deacon: We want to ensure that effective review mechanisms are in place. Our entire approach must be as open, transparent and robust as possible. I would be happy to come back to the committee as we develop the means of doing that.

Irene Oldfather (Cunninghame South) (Lab): I have a more general question. During the lifetime of the Health and Community Care Committee, it has become apparent that there are barriers to joint and effective service delivery. Is the minister satisfied that Arbuthnott facilitates joint finance and service delivery across traditional health and social service boundaries?

Susan Deacon: The fact that the Arbuthnott report results in each board receiving an allocation that more appropriately reflects its needs means that, in each part of the country, the NHS is resourced according to need, rather than simply population base. It is important that we encourage the NHS to work more closely with other bodies. The fact that remote and deprived areas have greater funding as a consequence of Arbuthnott will help to facilitate joint working.

In itself, Arbuthnott will not bring about the necessary improvements in joint working. In some parts of the country, there are good examples of different parts of the NHS working in partnership with other agencies, but good practice is by no means universal. I am determined to ensure that the steps that we are taking—to be published in the Scottish health plan—will help to make joint working a reality in every part of the country. The announcement that I made in Parliament just before the recess on services for older people set out some of the specific measures that we are implementing to ensure that effective joint planning and budgeting mechanisms are put in place at a local level across the country. We want to ensure that all the resources are used to best effect. I take on board Irene Oldfather's point.

10:15

The Convener: I would like to bring this section of the meeting to a close with a few comments. All members welcome the fact that there has been some movement on many of the issues that we raised with the Executive and with Sir John Arbuthnott. There was a significant change—the second report was far more transparent than the first report. Many of the points that were raised were taken on board, although some were not addressed to the satisfaction of all members.

The committee will consider Arbuthnott at a future date. At that point—when we have a somewhat different report to consider—we may decide to take up the minister's invitation to give us a further briefing before we finally sign off the Arbuthnott report for the time being.

No one should be in any doubt about the fact that the whole committee is committed to tackling health inequalities. We realise, in particular, that effort needs to be focused not only on areas of urban deprivation but on areas of rural deprivation and that certain parts of the country have peculiarities in terms of their locality and so on.

Winter Bed Planning

The Convener: I thank the minister for providing us with a helpful report on winter bed planning, "Lessons From Winter 1999-2000". As a result of the issues that cropped up last winter—and have a horrible habit of cropping up every winter—the committee decided that it wanted to keep an eye on planning for winter. That covers not only winter performance, which the report deals with, but flu vaccinations. The Executive has a copy of our report on flu vaccinations; it has until the beginning of December to give us its response. Minister, most of the questions that you will be asked will deal with the wider issues of winter performance rather than our report, but we might stray into that area.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Throughout what is termed the Scottish summer, the NHS in Scotland has experienced difficulties caused by the continued pressure on beds, which has meant that, occasionally, elective procedures have had to be cancelled. The winter performance group identified areas in which we might be able to alleviate the pressure during the winter months. How can we be assured that best practice, which the report identifies in various areas, will underpin the planning process for this winter? Given that no specific direction has been given nationally, how will the performance of health boards and trusts be measured?

Susan Deacon: I can assure the committee that more work has been done than ever before to ensure that best practice is followed throughout the country. For the first time, we have captured what best practice ought to look like. That is a significant step forward.

I will not go into the detail of the winter performance group report, as members have copies of it, but it is worth saying something about the background. The report was published in August, after several months of work involving a range of professional groups and perspectives in the NHS. The experience of last winter was carefully considered in an attempt to identify what worked and what did not work. It is important to note that, although emphasis is placed on what does not work in winter, many parts of the NHS have developed effective mechanisms for coping. Margaret Jamieson rightly refers to best practice; the report captures best practice so that each part of the system has the tools and the knowledge to work effectively. Similarly, reports such as the chief medical officer's report on intensive care provide guidance to local NHS organisations to help them better to prepare for winter.

Margaret Jamieson also asked how performance can be managed. I assure the committee that a number of changes have been made to monitor and performance manage the service better. I stress that it has to be down to local NHS organisations to take the operational and planning decisions to ensure that services run effectively over winter, but obviously I want to be assured that the health department is monitoring the service across the country as effectively as possible. The report made some recommendations applying to the department, and they are being taken forward. In addition, as part of the overall departmental review and reorganisation over the summer, a number of changes have been made to the department's structure and performance management processes. Gerry Marr is the director of that operation and he would be happy to comment further.

In allocating additional investment to the service this year, we have not only identified planning for winter and other peak pressures as one of the priorities, but required each health board to set out how it plans to target investment to change. As I indicated, the emphasis has been not just on how health boards spend the money, but on what they achieve through spending the additional resources. A key element that we have assessed in looking at their plans for winter is how effectively they have worked in partnership with other organisations, because, as the report highlights, one of the keys to having effective service delivery in winter, as at other times of the year, is to have the whole system working together effectively. All too often, it is where that does not happen that patients are let down.

Margaret Jamieson: On performance management, in some areas—you will forgive me if I use Ayrshire and Arran as an example—good work was undertaken with rapid response teams, but those teams have not been stood down; they have continued throughout the year. However, on occasion, elective procedures have been cancelled because of the pressure on beds. That situation is replicated throughout Scotland. To say that a board has done badly because of that pressure is not performance management. We have not identified the fundamental difficulty. Perhaps Gerry Marr has some idea up his sleeve that he has not shared with the service.

The Convener: It is time to pull out that rabbit, Gerry.

Margaret Jamieson: He is good at that.

Gerry Marr (Scottish Executive Health Department): We have taken the report of the winter performance group and created a template that will, in effect, be an action plan that each health board must submit to us. We are asking specific questions about what the boards are

doing at each level of the service—for example, in primary care and rapid response teams. What are they doing about the capacity of their intensive treatment units? What are the intended increases in the number of staff and bed capacity over the winter months? What is the planned elective reduction? In the past, there have been debates over the fact that the reduction has been unplanned. Health boards have been asked, "We accept that, at some times of the year, pressure will mean that elective admissions have to be stood down, but what will the reductions be?" More important, how are the health boards conversing with patients? Our expectation is that, within 28 days of a cancelled admission, patients will be given a guarantee of admission. Those are only some aspects, but the report is specific.

I have convened a winter planning panel, which, in the past fortnight, has assessed the action plans. We are writing to boards to ask them for more information, and in particular for quantifiable data with which we can measure their performance. In the department, we have put in place an escalating monitoring process, so that we receive information when something is going wrong. Everyone will be on weekly reporting from the beginning of December. However, if we begin to see evidence of an increase in bedblocking, failure to access intensive care units or failure to manage transfers between intensive care and other units, we will escalate the monitoring within the department. If necessary, at any point during the winter, members of the winter panel will go to local health board areas to scrutinise and try to understand better precisely what is going on.

By the end of the winter, we will want to understand what, given the pressures, is a good NHS performance in the winter for the people of Scotland and how we achieve that. By next year, we will have learned the lessons of this year, if there is anything to be learned. That will further improve the process.

Ben Wallace (North-East Scotland) (Con): Some of my questions about monitoring have already been answered. Witnesses talked about the winter pressures sub-group. Is the minister aware of pressures on beds, which have started somewhat early? Health board responses show that they are already experiencing pressures. Does the minister or the winter pressures group have any plans that will start to deal with those pressures now?

Susan Deacon: I am bound to say, almost as a common-sense statement, that pressures on the NHS in Scotland arise throughout the year. The winter performance group identified that fact. Many things happen in the winter that are not functions of winter. Margaret Jamieson's question alluded to the many special actions and efforts that are taken over the winter but are applicable 52 weeks of the year. There are always pressures and demands to be managed in a big and complex system such as the NHS. Patterns of illness and infection will impact on the system at different times of the year. That was shown particularly profoundly during last winter.

We have provided increased investment that is targeted towards meeting local needs and there is increased drive, energy and effort to put in place the policy framework to enable people to plan effectively. The winter planning report to which I referred is part of that, and monitoring processes will enable us to assess that work more effectively.

Our discussion about winter often focuses on beds—even the heading for the committee's agenda item reflects that concern. As the winter performance group's report identifies, the only way in which we can understand the effect of winter and improve services is by examining all the steps in the patient pathway. On page 9 of its report, the winter performance group identifies six steps: the prevention of illness, avoidable admission, primary care, emergency admission, critical care and discharge. In the past year, each of those steps has been the subject of considerable effort, discussion, joint working, identification of best practice and targeted investment. I am pleased that those processes have involved a range of professionals and parts of the service in a way they have not been before.

I therefore believe that there has been better planning and preparation than before. There has been significant additional targeted investment and it is now for all parts of the NHS and its partners in local authorities, the voluntary sector and elsewhere to ensure that that investment is put to good use and that policy is translated into practice to respond to the pressures effectively. Local management must do that, and do it responsively. We can provide the investment and the policy framework, but services must be responsive locally to deal with the peaks that Ben Wallace described.

Ben Wallace: I recognise that point, but given some of the good work or proposed work of the winter sub-group, including how it will be able to step in, monitor or assist, do you have centrally held funds that may be drawn on as back-up in an emergency? If so, are we allowed to know the amount of those funds and the criteria that will be applied in awarding them?

Susan Deacon: Investment in winter services requires to be made before winter, not in winter. That is the basis on which we have released resources to the health service during the financial year. First, £60 million was allocated to health boards in July, and two key priorities in the allocation of that resource were preparation for

winter and the reduction of delayed discharge, which is an important part of providing winter services.

Secondly, £10 million was released to local authorities to tackle the continuing problem of delayed discharge, and a comparable planning process has been put in place by local authorities. They have planned ahead and set out how they will channel that investment to tackle delayed discharge. Thirdly, more than £10 million has been spent on the overall flu immunisation programme, covering both the vaccine, the administration of the vaccination programme—through GPs in the communities—and a national awareness campaign.

Investment has been made throughout the year, to enable planning and preparation to be carried out. Such planning and preparation cannot be undertaken during the winter: it has to be done in advance.

10:30

Ben Wallace: Last month, Grampian Health Board tried to use its winter pressure funds early, from the money that was granted in July. It needed to access those funds due to an increase in bed pressure in October. As that health board was seeking to use some of that extra money early, it could find itself with a shortfall at the end of the winter period. How do you define the winter period, at which the money for the management of beds is specifically targeted? Where does it begin and end? Why do some health boards view it as beginning in the middle of November and ending at the end of February?

Susan Deacon: I invite Gerry Marr to address that specific point.

Gerry Marr: I am surprised by Ben Wallace's comment and I would be happy to clarify Grampian Health Board's situation on his behalf.

The £60 million allocation, which included money to ease winter pressures, was made in July. Once that money was released, it was up to local health boards to determine when and how they wanted to spend it. I reassure Ben Wallace that we have not put an arbitrary date on the beginning of the winter period.

The Convener: That would be a dangerous thing to do in Scotland.

Gerry Marr: Absolutely. I would be happy to clarify Grampian Health Board's situation outwith this committee.

Dorothy-Grace Elder (Glasgow) (SNP): I was happy to hear Gerry Marr say earlier that there will be weekly monitoring from the beginning of December. First, can he or the minister confirm that bed managers—winter pressure managers, or whatever they are called in different parts of the country—are now in place in all NHS trusts?

Secondly, are you aware that there is concern in some accident and emergency wards in Scotland—especially in ward 29 of Glasgow royal infirmary—about pressure to send patients to other types of ward, which the staff think are unsuitable for those patients, because of the expected winter problems?

Thirdly, as Richard Simpson's report points out, there is an extremely low service uptake among the high-risk group of under-65s who are vulnerable because they are bronchial or heart cases. Anecdotally, Richard said that that uptake might be as low as 20 per cent. Can you please give me your thoughts on that?

Susan Deacon: I shall address Dorothy Grace-Elder's point on the flu immunisation programme and Gerry can comment on the accident and emergency issues that she raised.

I have read Richard Simpson's report carefully, and officials are examining it at the moment. It will help to inform our work in this area. As the report recognises, we have put in place a range of measures to maximise take-up of the vaccine from those considered to be at greatest risk. As Dorothy-Grace Elder said, people under 65 but with chronic conditions are a key group. That is why the immunisation programme is carried out at local level, through GPs. Particularly with the group to which I have referred, GPs are best placed to identify which individuals would benefit and to decide whether it is clinically appropriate for them to get the vaccine.

This year we have put in place a new incentive payment arrangement for GPs, not least because of the decision to lower the age limit, which generates considerable additional pressures on them. We hope that that will generate wider benefits and increase take-up. We have agreed with representatives of the British Medical Association that we are aiming for a 60 per cent take-up. That is the target that people are working towards. National awareness raising is part of that, and so is local awareness raising. Efforts at local GP practice level to write to specific individuals with these conditions are a part of it.

The new arrangement for carrying out the immunisation programme will also deliver better monitoring and better data for the future. One of the things that became clear when we delved into this issue this year—again, this is in Richard Simpson's report—is that the data that we have for the past are quite limited. We are on a cycle of continuous improvement. I hope that after this winter, as well as having increased take-up, we will have better data to tell us what the level of

take-up has been.

Dorothy-Grace Elder: Have bed managers now been appointed in all NHS trusts?

Gerry Marr: I do not have the precise information to hand, but I can confirm that the plans that health boards have to submit must indicate precisely how they intend to undertake bed management. I have read most of the reports and many boards have confirmed that they have dedicated bed managers. If they do not, they must have something that we are satisfied will result in effective bed management.

Boards also have to confirm their plans for the management of accident and emergency. Glasgow royal infirmary, which I have visited in the past, has been mentioned. Our objective is that there should be dedicated teams on emergency call, that geriatricians should join acute receiving ward rounds, that those ward rounds should take place in the evening as well as in the morning and that early decisions should be made about triaging and treating patients in appropriate wards. Glasgow royal infirmary's scheme, which has now been in operation for a couple of years, is an example of the best practice that we are encouraging in other accident and emergency departments. That does not mean that there are not pressures on any part of the system.

Dr Simpson: I should declare an interest in this area—I am still a director of a nursing home company, albeit in England. This winter, will we use all the resources that are available to us? There are serious concerns about delayed discharges. I know that £10 million has been released to deal with delayed discharges and that that is one of the priorities in the use of the £60 million that was mentioned, but because we have had quite a bad summer, there is an impression that delayed discharges are still a big issue. Are you putting in place plans to use nursing home capacity effectively, where it exists—I know that in Lothian there is none—while you are improving the joint arrangements? Will we release those beds before we start to run into problems in the winter?

Susan Deacon: I am bound to say that that matter would be addressed at a local level. We have sought to make resources available to the local health and social care systems so that they can use investment in the most effective way.

Dr Simpson: Is there a monitoring system? We know that, inevitably, capacity in the system is limited and cannot be changed overnight. Given that fact, will we use the total capacity? As part of the monitoring system, if the bed occupancy in the nursing home sector or the residential care sector is 83 or 84 per cent, will we say that that could be pushed to 90 or 95 per cent? Will we require health boards to tell homes to use all their capacity?

Shona Robison (North-East Scotland) (SNP): The first national census on bedblocking, which I understand will be published next month, is set to show that in some areas 10 per cent of hospital beds are occupied by patients who have nowhere else to go. Local authorities are saying that the resources the Executive is allocating to them will address only about 25 per cent of the waiting list for nursing home care beds. Where do people go when they are not admitted to hospital because they are regarded as inappropriate admissions or when they are discharged although no care home place is available for them and their care needs are such that they cannot stay at home?

Susan Deacon: It is important to address the many dimensions of the complex issue of delayed discharge, which has blighted the health and social care system for many years. The Executive has targeted not just investment at this area, but significant effort to get behind the issue and identify the causes of delayed discharge. Investment and funding is only one part of the picture. Some cases are delayed while the local authority identifies the funds that are required. Some are delayed because the patient's house needs to be adapted to meet their changing needs. That is why the additional £5 million that I announced before the recess for aids and adaptations is important. Other cases occur because the patient needs to move to a ground-floor property, patient transport is an issue, or the patient and the family disagree about whether the patient should be discharged and where they should go.

Shona Robison referred to the census. The package of work that we have been doing on delayed discharge has been designed not just to quantify the scale of the problem more accurately but to identify possible solutions to the problem. We have identified 42 causes of delayed discharge. I stress that we want not just to count the causes, but to cure the problem. There is a complex tapestry of things that need to be done to achieve that. We have made an investment but we have made it clear to the health and social care systems that for that investment to be effective they have to work together and provide services that are focused on patients' needs.

The work that has been done by the joint futures group and the joint meetings that we have held with local leaders and managers of the NHS and local authorities are all a part of that. Effective planning, discharge management and communication between different parts of the system are just as important as investment. I take Shona Robison's point about the significance of delayed discharge. It is a profound problem, not

just for the system, but crucially for the individuals who suffer as a consequence of it. In addition to extra investment in the system, we need step changes in ways of working to resolve this issue. This is a 25-year-old issue; we reckon that the solution will take between two and five years. We have embarked on that course and will continue to tackle the issue.

The Convener: I will take one final question on this section, but I am aware that there are several members who have a series of questions for which we have not had time today. Is it acceptable that we send you those questions in writing for—hopefully—a speedy response before the winter sets in?

Susan Deacon: Certainly.

Mary Scanlon: Are you satisfied that there are adequate supplies of the flu vaccine for everyone in the recommended category and all those who request it?

Susan Deacon: I am satisfied that the total number of vaccine doses that have been ordered and made available for Scotland is more than sufficient to meet total need and am concerned that there have been suggestions to the contrary in the press. That said, I should stress that, in a very large and complex immunisation programme, there will always be logistical issues at a local level. For example, supplies might not reach GP practices precisely when they were expecting them and we are very actively monitoring such distribution and supply arrangements.

However, our confidence that sufficient overall supplies of vaccine are available has been reinforced by representatives of the pharmaceutical profession. We continue to monitor the situation closely.

10:45

The Convener: If members have any questions on this matter that they have not been able to ask, they can e-mail them to the clerks for tomorrow so that they can be sent to the minister's office as quickly as possible.

Minister, I am aware that I did not allow you to have an opening statement on that section. That was an oversight; however, I think that we managed to cover many areas of continuing concern. In light of Dr Richard Simpson's work and the winter planning that has already been undertaken, the committee will also acknowledge that, although this is a very big issue, the Executive has started to find ways through it. The issue is complex and involves a range of people across the health and social services sectors, from community pharmacists to people on the wards. I am quite keen for staff to be immunised and hope that the minister, as a key front-line worker, will do the same.

Hepatitis C

The Convener: We will move on to the next item. Minister, do you want to make a statement on hepatitis C, or do you wish to go directly to questions?

Susan Deacon: I am happy to go directly to questions.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): Although I am persuaded that there has been no negligence on this issue, people have fastened on to the September 1986 preliminary report from England that indicated that heat treatment of blood products might prevent transmission of the disease. I can advance several answers on that issue myself; however, as I am here to ask the questions, I will give you the opportunity to respond to that point. As far as I am concerned, that is the only section of your report on hepatitis C and heat treatment of blood products that requires to be questioned.

Susan Deacon: I am grateful to Malcolm Chisholm for his question. He has rightly focused on one of the key elements of our report and the investigation that I commissioned. Although I have waived my right to an opening statement, I would like to make a few wider points in answer to Malcolm Chisholm.

First, I am profoundly aware of the impact of this experience on individuals and their families and have enormous concern and sympathy for those who have been affected. That is precisely why I wanted to investigate this issue carefully and examine the facts fully. Our report seeks to address the specific question raised with me last year—whether the Scottish National Blood Transfusion Service could have or ought to have done anything else in the mid to late 1980s to reduce the risk of hepatitis C infection to haemophiliacs in Scotland. As the committee might recall, it has been suggested that the SNBTS could have or should have introduced heat treatment procedures for factor VIII at an earlier stage, which could have rendered that blood product safe.

The report gives the detailed chronology. During that period, work was going on in different laboratories—not only in the United Kingdom but right across the world—to make blood and blood products safer in a range of ways. HIV was isolated in 1983 and, as we all recall, extensive investigation and research followed as a consequence. Each laboratory made progress at different rates. The hepatitis C virus was not recognised or isolated until 1989. Prior to that, there had been developments that subsequently turned out to be effective in dealing with the hepatitis C virus in blood.

Our findings, which are fully set out in the report, tell us that as soon as action to make factor VIII safe was possible, it was taken. In 1988, Scotland became the first country to have that process fully in place, although we recognise that England started in this area before Scotland. We do not believe that SNBTS could have done anything more than it did, given the level of scientific and medical knowledge at that time.

Malcolm Chisholm: I note in the report that Scotland produced trial batches of factor VIII that had been treated at 80 deg C before September 1986. Would clinical trials have had to be done, meaning that early 1987 would have been the earliest possible time for its use?

Susan Deacon: Absolutely—that is why we have set out the chronology of events in some detail in the report. A development process goes on, in research and clinical trials, for different treatments for blood and blood products. That is not just about finding a treatment that kills a particular virus; it is also about ensuring that the blood product is still safe and effective. There were clinical trials during that period.

The Convener: As you say, different laboratories and different scientists were working on different strands of the same issue. To some extent, they concentrated on HIV. Did the SNBTS have its eye on the HIV ball—if you like—rather than the hepatitis C ball? In doing that, and in using pasteurisation and wet heat rather than dry heat, did it commit itself to going down that route while others were doing other things? When it changed to using dry heat, did it have to move away from a course of action in which it had invested time and effort? How do different laboratories across the world talk to each other about their developing work?

Susan Deacon: I do not agree that SNBTS focused simply on HIV. When we consider the history of this—and we must bear in mind the fact that we are going back 15 or 20 years—the medical and scientific research community was spurred on by the drive to eliminate HIV. That resulted in a far greater investment of skills, expertise and resources during that period to examine how scientific knowledge, technical expertise and treatment and testing methods could be developed most effectively.

Throughout that period, there was an awareness of the existence of another unknown virus, which was known as non-A, non-B hepatitis, which was not recognised or isolated until 1989. In retrospect, it became apparent that various heat treatments that had been tested and developed for other reasons at that time could be effective in killing that particular virus. Subsequently, arrangements

were put in place.

The Convener: There is a barrage of hands. I want to stay on the technicalities of the issue before we move on. Members must stick to the technicalities.

Dr Simpson: In that case, I hope that I will be allowed in again to ask my other question.

Minister, will you confirm that the 68 deg C heating, which was the technology that was proved, was not proven to be effective against HIV until after the new 80 deg C technology became effective? People did not know whether the 68 deg C technology would work—that was the problem. The whole industry, across the world, was driving to get higher temperatures with longer periods of heating to ensure that whatever was there was killed. That is why there was such a significant difficulty.

The Convener: Are you happy to agree with that, minister?

Susan Deacon: Yes.

Dorothy-Grace Elder: I lived through the 1980s—

The Convener: I think we all did—even Duncan Hamilton.

Dorothy-Grace Elder: I clearly remember being involved with the people who were clamouring for a heat treatment centre in Scotland. The concern was HIV, not hep C, which, as the minister correctly says, was not recognised until 1989. However, people realised that they had something exceedingly dangerous on their hands and that, often, another virus was involved. I also remember that the sums of money involved came to only a few hundred thousand pounds and that Scots pleaded with the Conservative Government to give them that to conduct the heat treatment. How can the Government today body swerve the tragedy that has occurred due to hep C subsequent to the HIV tragedy? Will the minister at least consider ex gratia payments to the families?

The Convener: Would those be technical ex gratia payments, Dorothy-Grace? I really do not think that that was a technical question. Other people are waiting to ask non-technical questions.

Dorothy-Grace Elder: People are suffering, Margaret.

The Convener: I know. The minister may answer the question.

Susan Deacon: Do you want me to answer Dorothy-Grace Elder's question now, convener?

The Convener: Yes.

Susan Deacon: Members are asking a range of technical questions, many of which, I hope, are addressed in the report. If the committee wants to take it up, the offer remains for one of our medical advisers or perhaps the deputy chief medical officer, who was involved in the report, to come along to discuss the matter further.

Dorothy-Grace Elder referred to ex gratia payments. Compensation has been discussed quite fully. Let me differentiate between negligent and non-negligent harm. The essence of the report was to investigate whether there had been negligence during the period in question, which would require the NHS to pay compensation on the ground of harm having resulted as a consequence of negligence.

Having examined the information carefully, we have found no evidence to suggest that there was negligence, for the reasons that we have outlined and, as Richard Simpson indicated, because of the chronology of events and when medical and scientific knowledge advanced.

11:00

There is also the question of non-negligent harm. The NHS not paying compensation for non-negligent harm has been a generally held principle. That was revisited in these cases, two years ago by the UK Government, by previous Conservative Governments and now by the Scottish Executive.

Having examined the issue we do not see there being a case to change that principle in this instance. I am bound to say that all medical treatment carries a degree of risk. The issue is about the balance of risk and how we deal with it.

Dorothy-Grace Elder: We are not talking about treatment.

The Convener: Let the minister finish.

Susan Deacon: I am happy to take a further point from Dorothy-Grace Elder.

The Convener: But I am not. Nicola Sturgeon also has points to make on this issue.

Nicola Sturgeon (Glasgow) (SNP): I have two points. First, the report that is before us today is, in effect, an internal report by the Scottish Executive into one of its agencies. Considerable disquiet and controversy surround its findings. In light of that, will the minister consider the case for a public inquiry, which has been supported by a significant number of members of this Parliament, so that evidence can be taken and conclusions formulated independently and openly?

Secondly, I will return to Dorothy-Grace Elder's point. I am sure that all of us who have read the report are aware of the distinction between negligent and non-negligent harm. If we can put the issue of negligence aside for the moment, will

you reconsider awarding no-fault compensation, perhaps along the lines of that announced for CJD victims in England? If you are not prepared to do that, can you outline the distinction between people who have been infected with hepatitis C through infected blood products and the CJD victims—why does one group deserve no-fault compensation while the other does not?

Susan Deacon: There has been no formal announcement on variant CJD cases in England. The report of the Phillips inquiry into BSE is due for publication tomorrow. None of us can comment, either on that report or on any of the Government—

Nicola Sturgeon: If it is the case—

Susan Deacon: I do not think that we can deal with conjecture, speculation and hypothetical situations. We must deal with the facts in every case. As we know, the cases of variant CJD are also enormous human tragedies. The BSE issue has been examined in the detail that it has been to inform us better why the situation occurred. We will need to examine that report when it is published. We must examine every case on the basis of the facts and the circumstances.

Nicola Sturgeon asked whether I would change my view, or whether I would respond to calls for a full public inquiry. Several members, including Nicola Sturgeon, have called repeatedly for me to order full public inquiries on several issues. I understand why people want that to happen on complex issues, but I must reach a judgment about the appropriate level of investigation, inquiry, examination and intervention that is required in any case.

I gave a commitment to the Haemophilia Society and others that, as a new Executive and as the new Minister for Health and Community Care, we would take a fresh look at the facts of this case. I have done that thoroughly. The report that has been published sets that out openly. That indicates, as does the fact that we are discussing the matter at this meeting, that in a devolved Scotland we have far greater opportunity to do such things openly. I do not believe that it would be appropriate to have further investigation of what happened 10, 15 or 20 years ago. We have set out the facts.

I am not aware of anybody challenging the substantive facts in this case. What is crucial is that we all think about what we can do in future, not just for the haemophiliacs who have been infected with hepatitis C, but for the growing number of Scots who are infected with it.

Nicola Sturgeon: Haemophiliacs who have been infected by hepatitis C desperately want to look to the future. Do you accept that an inquiry that has, in effect, been carried out by your department into one of your agencies does not inspire the full confidence that an independent inquiry would? I had a call on the matter from someone this morning—perhaps you can answer their questions. Was evidence taken from immunologists, liver specialists and so on? Exactly what evidence was taken and what weight was given to it?

I return to my original point: there will always be difficulty with the findings of a report that has been carried out in such circumstances. Would not it be better for all concerned—your department included—if a genuinely open and independent inquiry could be held?

Susan Deacon: The inquiries were initiated to establish the facts. How those facts were found and who was asked to provide information is set out fully in the report. All the submissions—apart from those where the people who submitted them said that they did not want them to be made public—are available for scrutiny. I am unaware of anyone having challenged the substantive facts in the report.

Of course it is open to people to continue to discuss the issue. It is open to the committee to do that and to take further evidence. I state to you candidly that a judgment that I have to make regularly—and have made in this case—concerns the extent to which we take lessons from the past and apply them to the future. We have struck an appropriate balance in this case.

The Convener: The minister is correct. We have two petitions, one on the factor VIII blood products situation as it affects haemophiliacs in Scotland, and one on the wider issue of compensation for people who have been infected by hepatitis C as a result of other NHS treatment. The committee has an on-going job in both regards. It is for us to decide what further work we do on hepatitis C. We can do all sorts of different things—committee members are well aware of our abilities in that respect. We will return to the issue in the near future and decide what action we should take and whether we should take further evidence from other groups on the report and the wider issue of hepatitis C.

Ben Wallace: First, will you consider expanding the Macfarlane Trust to encompass hepatitis C? I know that you did not want to hypothesise on CJD, but the trust, which was set up under the Conservatives, was intended to help people with HIV. Secondly, will you assure us that the inquiry was independent and tell us whether any officials who were involved in the inquiry were also involved in the decisions that were made in the early 1980s?

Susan Deacon: On Ben Wallace's first question, I adhere to the view that has been held

by successive Governments—Labour and Conservative. Having considered the issue and the cases, I do not see an argument for veering from the general principle of not offering compensation in the case of non-negligent harm. I recognise that a previous decision was taken on the Macfarlane Trust.

On the second point, I stress that the report was a fact-finding exercise. To the best of my knowledge—and not least because of the time that had elapsed—the officials who were most closely involved in carrying out that exercise for me were not directly involved in the details of that earlier period.

I emphasise that we were gathering the facts and, as I said in response to Nicola Sturgeon's questions, all that information is available for the committee to scrutinise.

Ben Wallace: Do you think that the Macfarlane Trust should not exist because it does not adhere to the principle that has been followed by successive Governments?

I would also like a stronger assurance—

The Convener: The first question is not one that I would want the minister to be asked—it is not relevant to the discussion. The minister has answered a question on the relevant points.

We are running over time and five other members want to ask questions. You can ask your second question, Ben.

Ben Wallace: Will the minister investigate whether the officials who were involved in the fact-finding inquiry were involved in the original process? Will she write to the committee on that point, so that we can satisfy ourselves that they were not?

Susan Deacon: I repeat: it was a fact-finding exercise. Only if someone were to question the validity of the facts would I have grounds to call into question the process by which the facts were gathered. On the basis of the information that has been presented to me, I have no reason to do that. All that information is available to committee members and others.

Hugh Henry: Can I ask about compensation?

The Convener: No.

Dr Simpson: I want to move on. I hope that any member of the public who listens to today's meeting or reads the *Official Report* will examine the full evidence, including the supplementary report, which contains all the evidence apart from letters from the haemophiliacs—which they did not want to be published—so that any questions can be posed to the Health and Community Care Committee as part of its work on the petitions. Unless there are direct questions about that evidence, I agree with the minister that, at this stage, there is no purpose in spending public money on a public inquiry.

Keith Raffan has questioned the minister closely on several occasions on the whole issue of hepatitis C. Has it been decided whether a Scottish needs assessment programme—SNAP—report on hepatitis C will be undertaken? If the minister feels that such a report is appropriate, will she try to ensure that it is produced on a broader basis, to examine the social and support issues that relate to the management of hepatitis C, both for haemophiliacs and others? That might be an alternative to the Macfarlane Trust or compensation, both of which seem to have been ruled out.

Susan Deacon: It is important to look to the future and, where we can, to learn lessons from the past. The incidence of hepatitis C has been rising steadily in Scotland and that is an enormous cause for concern. Various members have raised the issue with me. That is why SNAP was commissioned to carry out a comprehensive piece of work to investigate how the needs of people with hepatitis C could be met more effectively and to address issues of infection and prevention. The report was published at the end of last month and is being given careful consideration. SNAP reports are issued routinely to health boards. However, because of the level of incidence of hepatitis C in Scotland, I want to ensure that we consider the report thoroughly to ascertain what further steps we can take to improve services in the future.

The Convener: I am minded to extend our time on this item a little, as I am aware that it is important. A number of members have indicated that they wish to ask questions.

Mary Scanlon: Given that this is an emotive issue that has had a tragic effect on people's lives, it is not surprising that the Haemophilia Society has said that your report contradicts its evidence and is thin and incomplete. I have looked through the report—not as thoroughly as I would have liked to, as I was preparing my speech for this afternoon's debate—and it seems to me to be a substantive piece of evidence. Would any further inquiry be likely to yield more information that would contradict empirically anything that was said in the report that was issued yesterday?

11:15

Susan Deacon: Of all the evidence that I have seen, nothing leads me to conclude that further examination of this period would reveal substantial additional information or would enable us to do anything differently.

As Mary Scanlon said, this is an emotive subject. I have met people who have been

affected by what has happened, just as on a regular basis I meet people who are affected by a range of conditions. We are looking to do the best we can to assist people. We cannot turn the clock back to avoid the tragic cases occurring but, as Richard Simpson's previous question indicated, I hope we can at least attempt to support people with hepatitis C more effectively in the future. We will also continue to ensure that blood and blood products that are offered in Scotland are made as safe as possible, to prevent the transmission not just of viruses that are known now but of viruses that may be identified in future.

The Convener: I want to pick up on one of the issues that the Haemophilia Society is still unhappy about and that Mary Scanlon touched on. You have outlined the time scale for certain scientific discoveries and changes. However, there is a wider issue of whether patients were given appropriate information, which is much more difficult to pin down. We all know that during the 1970s scientists knew that hepatitis C existed, but did not know what to call it. In the 1980s, patients and patient groups had access to a certain amount of information. However, that is not the same as saying that each patient and their family were given all the information that they required to make the best judgment. Are you convinced that patients were given all the information that they could have been given in the circumstances?

Susan Deacon: That was the second part of the question that this exercise was designed to answer, as haemophiliacs and their families had raised the issue of provision of information with us. We found it particularly difficult to access information about that, but in the latter part of the report we have detailed what we were able to find out about the amount of information that was issued to patients and their families, based on the knowledge of the condition that existed at the time.

From the facts that we have been able to establish and the information that we have been able to uncover, it would seem that substantial efforts were made to make available to people information about the risks that existed. It is important that we seek continually to ensure that patients, now and in the future, are given as much information as possible, to enable them to make informed choices. There can be no absolute guarantees or certainty.

As I said earlier, medical treatment always carries a degree of risk. It is important that we identify that risk and communicate it as effectively as possible to patients.

Brian Adam (North-East Scotland) (SNP): I welcome the fact that we have access to a lot of information that did not appear to be in the public domain previously. However, many people are still unhappy that there will be no public inquiry into the matter. In light of that, is the minister prepared to meet the Haemophilia Society to address the outstanding concerns that it might have following publication of the report? Could the minister tell us why publication of the report was delayed?

On compensation, I understand that the minister cannot take hepatitis C away from sufferers, but can she explain the logic of the distinction that has been drawn between people who have been infected, as a result of contaminated blood products, with HIV and hepatitis C?

Both HIV and hepatitis C are emotive subjects, but when HIV first arose, the life expectancy of sufferers was significantly shorter than is the case today. Hepatitis C might have a similar effect to HIV on morbidity and mortality.

Susan Deacon: I know that Brian Adam has taken a close interest in this issue. I think that his last point partly answered itself.

When the Macfarlane Trust was established, the distinction that was made for those with HIV was based on a judgment call made by the Administration at that time, for which I cannot answer. Brian Adam touched on a number of points. HIV was an extremely emotive issue during that period; the life expectancy of people with HIV was considered to be very short and that was a material factor in the judgment that was arrived at by the Government of the day. Of course, that same Government also chose to make a different judgment call in relation to other conditions, including haemophiliacs who contracted hepatitis C.

Completing and publishing the report took much longer than I thought it would take when we set out on this exercise, partly because it proved difficult to access information that went back 10, 15 or 20 years. We worked hard to obtain that information, and I hope that it is helpful that the information is now available in the public domain.

I wanted to satisfy myself on the contents of the report before I put it in the public domain. When I received the report, I asked a range of further questions and for further information and details on the chronology of events to be included, as I wanted to be sure that we had considered all the facts and that the report was robust.

Publication of the report took longer than we hoped because we wanted to get it right and to ensure that the report was reliable, so that people could depend on its accuracy.

I met the Haemophilia Society previously and I am happy to meet it again to discuss either outstanding issues arising from the report or wider issues that the society may wish to raise.

The Deputy Convener (Malcolm Chisholm): We are overrunning, but I have only Hugh Henry's

question left. Hugh, has your question been answered?

Hugh Henry: Yes.

Budget 2001-02

The Deputy Convener: The budget is the final agenda item that involves the minister. Do you want to make an opening statement, minister?

Susan Deacon: I am happy to go straight to questions.

The Deputy Convener: In that case, I will kick off. One of the issues in the committee's report on the budget was transparency. The question concerns the total budget figure, which confused me when I first saw the comprehensive spending review. Our baseline is the figure for this year in "Investing in You"—£5,416.5 million. In the comprehensive spending review, the figure is £5,587 million. Is that difference a result of resource accounting, or something else? If it is because of resource accounting, I expect that John Aldridge is desperate to explain—briefly—how that impacts on the health budget.

Susan Deacon: I expect that John is indeed desperate to explain.

John Aldridge: It is because of the change to resource accounting. The actual amount of money that is available to the health service to spend has not changed as a result of the change in the figures. The figure that was published in the comprehensive spending review outcome is known as the total managed expenditure figure. That comprises two elements: a departmental expenditure limit, which is broadly similar to the cash figure that was announced earlier, and the figure for what is known as annually managed expenditure, which is a consequence of resource accounting and which represents money or resources that are more subject to fluctuation than those that are included within the departmental expenditure limit.

For example, the UK figures for unemployment benefit and so on come under annually managed expenditure, because they fluctuate, depending on the level of unemployment.

I understand that the Minister for Finance wrote a letter to every MSP in September, explaining the move to resource accounting and budgeting. An annexe was attached to the letter, with a table showing the changes that had been made from the cash figure to arrive at the resource figure, as published in the document.

Mary Scanlon: I refer to "Investing in You" and the definition of one-stop clinics and walk-in-walk-out hospitals. How much do those hospitals cost? Are any at the planning stage?

My other question came up when Mr Aldridge was speaking: given our commitment to public health, is there a means in the budget by which we

can see the resources that are being channelled towards the future public health budget?

Susan Deacon: There is no single definition of a one-stop clinic because different parts of the service in different parts of the country work in different conditions, and they will design their clinics slightly differently. The general principle is that someone can be referred to a clinic in which they can get diagnosis and treatment quickly. There should be people there who specialise in, and are skilled in, the condition in question.

Where the one-stop clinic approach has been developed, there have been dramatic improvements in the overall patient journey, and the approach has enabled diagnosis and treatment to be offered more quickly. We made a commitment at the start of this parliamentary session to double the number of one-stop clinics by 2002. There were 80 such clinics, and I am pleased that we have now met that commitment: more than 160 one-stop clinics are in place across the country. Having seen several of them in operation, I am very pleased about the benefits that patients have derived from them.

With the concept of walk-in-walk-out hospitals, we must recognise that, in the future development and configuration of hospital services, more and more treatment—specifically surgery—can be, and is being, delivered on a day-case basis. Currently, that applies to about 60 per cent of all non-emergency surgery, and that is a consequence of advances in treatment and medicine.

Experience elsewhere provides strong evidence that a better targeted, more effective and more responsive service can be given where emergency and non-emergency surgery are kept separate, as that allows patients to be booked in for certain more routine non-emergency procedures, examples of which would be operations involving hernias and cataracts. Patients undergoing such surgery can be treated and sent home quickly, which makes that treatment different from the much wider range of emergency surgery that is generally provided.

No facility of that nature is currently at the planning stage. A number of parts of the country are considering whether such facilities—often described as ambulatory care and diagnostic units—could be developed. That forms part of a number of local acute services reviews.

As members are aware, the Executive has targeted significant additional resources specifically to public health, notably the £26 million that is the Scottish share of the tobacco tax. A separate issue that will be of interest to the committee is how such targeting of resources is shown in the budget documents. That was one of a number of issues that was raised during last year's budget process and I expect fully that it will be taken on board in future. I also expect that the Scottish health plan, which will be published at the end of November, will give further details of how our investment strategy for the next few years will be linked to our priorities for public health and to wider reform in the NHS.

11:30

Irene Oldfather: The minister will be aware that the committee is keen to develop the health promotion aspect of the public health service. We have spoken to the minister about that in previous discussions. One of our difficulties with the budget was that activity in relation to health promotion was disaggregated. There are central elements, such as the £26 million from tobacco tax, but other elements are contained in health board budgets. To enable us to tackle the matter strategically, we need to have that wider perspective. Will the minister assure us that, to allow the performance of health promotion to be monitored across Scotland, we will be able to get such details in the budget?

Susan Deacon: We have talked about monitoring and performance measurement today. Those subjects are dear to my heart and we have spent a lot of time working on them in the department. Ultimately, however, I am interested in results. I do not want to spend so long measuring and monitoring, or ensuring that others do so, that we cannot deliver results. I hope that we can strike a balance between those elements in the new performance management framework for the service.

That said, I am supportive of the principle that underlies Irene Oldfather's question, which is the idea that there must be better and more effective co-operation across the country on health promotion among a whole range of areas. It does not make sense for national health promotion activity not to be reinforced effectively at a local level through local health promotion activities.

The work that we have done on the public health agenda has started to address that. The Health Education Board for Scotland has a key role to play, as do a number of local health promotion organisations. We have recently established the public health institute and Phil Hanlon has been appointed as its director. I am keen to continue to improve that area and would welcome comments and feedback from the committee on those points.

Hugh Henry: I will take up one of the points that the minister made about results, not only in relation to health promotion. We indicated that one of our principal concerns was that information on spending should be transparent, so that the public can enter the debate about how money is spent on health care. When the minister talked about

Arbuthnott, she mentioned what she expects to happen and the measures that she is putting in place. I am sure, however, that the minister is aware that MSPs and the general public are concerned that, despite all the announcements in recent years of record levels of expenditure in the health service, they are not seeing results. How long is the minister prepared to give health agencies to produce results and improvements before she takes action?

Susan Deacon: Hugh Henry's point has been at the core of discussions that have taken place over many months and which will come to fruition with the publication of the Scottish health plan in November. He is right to make the point—I have identified it myself and many people throughout the health service have raised it with me—that although substantial additional investment is going in to the NHS, it does not always reach its target or benefit the patients that it ought to benefit. There are a number of reasons for that, some of which require action at a national level, including the performance management framework and so on that we discussed earlier, and the systems and structures of the NHS in Scotland.

Under a previous Conservative Administration, a range of local NHS bodies was established under the internal market, each of which developed its own decision-making structures and infrastructures. Although we have taken away the contracting mechanisms of the internal market, there is still over-complexity and over-fragmentation in the NHS in Scotland, which all too often militates against not only effective spending, but effective service delivery. That has been at the heart of our discussions on NHS modernisation. We want to get better at measuring and monitoring local health systems, but in doing so I do not want to look only at where health boards are spending the money.

For example, two health boards might each spend an extra £3 million on mental health services, but one might deliver massive improvements while the other makes barely any difference to the services that are provided. Unless health boards spend their money well and effectively and unless they also tackle bureaucracies, demarcations, old working practices, inefficient systems, professional mistrust and poor communication—the list goes on—people will not get the improvements that they need and deserve. I want all those problems to be tackled. In measuring the service more effectively, I want to measure not only where money is spent, but the results that that spending achieves and the standards of service that local health providers deliver to local communities.

Mr Hamilton: "Investing in You" was supposed to be about contacting people directly and involving the public, as Hugh Henry said. On information access for the public and the committee, I wish to take the minister back to one of the more heated and less instructive evidence-taking sessions—the debate on private finance initiatives, during which the committee took evidence from the minister and John Aldridge, the director of finance. There was a contradiction about what information was available. When the minister gave evidence on 10 May, she told the committee that she would give a more detailed submission on the information that was available and where that information could be accessed by the committee and the public. It is now 24 October. Does the minister have any thoughts on that?

Susan Deacon: I am not aware that there were any contradictions at that meeting between the director of finance and me, but I am sure that if Duncan Hamilton thinks that there were, he will tell me. I regret that the additional information that was requested was not provided sooner. It was submitted to the committee during the past two days.

Mr Hamilton: It was not submitted to the Health and Community Care Committee. I do not know which committee it went to, but it did not come here.

Susan Deacon: I have seen the paper and signed the letter. The matter was identified when the committee clerk liaised with the health department about any outstanding issues.

Mr Hamilton: We look forward to receiving that submission. Some substantial issues about which there was serious concern are involved. We needed to know—for the full budget process—whether the PFI projects that were being pursued represented value for money and whether public money was being spent appropriately. The minister could give the committee a commitment today—as she has in the letter that we have not seen—that enough information will be provided to allow the committee to make that judgment.

Susan Deacon: A detailed paper accompanies the letter, which I have signed. I regret that members have not received it sooner, but I hope that it will answer Duncan Hamilton's questions.

Mr Hamilton: Will we able to access information on value for money?

Susan Deacon: I think that that information is set out in the paper in some detail. If, after members have read the paper, they decide that they want further information, we will be happy to deal with any such request. As part of the internal reorganisation of the department, we have introduced new arrangements for committee liaison and we have been working closely with the committee clerks on that. I hope that such matters

will not fall through the net in future.

Dr Simpson: The messages that the minister gives about quality, performance management and outcomes rather than inputs are extremely welcome. However, a concern that is specifically related to the budget is the way in which level III expenditure is laid out. It does not help very much to have an aggregated amount—£4.3 billion—for health boards. That does not allow members or the public to understand what is going on. MSPs see what is happening at a micro level—such as the recent proposal in Tayside to cut a paediatric epilepsy nurse position, which is of enormous value—and can raise issues with local health boards and so on. What we cannot get to grips with is the process of disaggregation and reaggregation at national level. Will the minister and her department examine the possibility of saying how much is being spent on, for example, mental health issues, cardiovascular care and diabetic care in each health board and then reaggregating those amounts at national level? That would give us information about level IV, which is equally important, and would allow us to benchmark health boards so that MSPs can question them.

For example, we could ask a health board whether it is spending less on diabetes because it is more efficient. It might be argued that a health board does not need to spend so much on diabetes because it is dealing with it more cost-effectively. However, it might be that a health board has not prioritised diabetes, although the Executive has made it a priority. We cannot help the Executive as we would like to, because the budgetary system is archaic.

Susan Deacon: It is always welcome to hear members of the Health and Community Care Committee offering to help the Executive. The key question is how best to do that. What questions do we ask? What information is reported and at what level is it reported? Some of the detail to which Richard Simpson alluded is available in the accounts of local health boards and NHS trusts. Therefore, it is possible for members to ask questions locally. Given that we all operate with finite time, energy and resources, I question the value of massively expanding the amount of information that we ask to be reported back to the centre to be aggregated at a national level. There are fundamental issues relating to how resources are allocated, how they are spent and how much reporting there is about how they have been spent. In Scotland we operate rightly on the basis that the lion's share of health resources and NHS spend is allocated to local health boards, which they decide how to spend.

I would be extremely wary of moving dramatically from that position. Having said that, I recognise that we can consider more effectively how to act more cohesively throughout the country on several issues. However, we must consider how spending decisions are taken locally. I point again to the performance management framework. I do not want that to say simply, "Thou shalt spend £X million." I want to set out the standard of service that we expect every part of the NHS in Scotland to deliver on such matters as diabetes or mental health and I want us to focus our energies on assessing that.

I will be frank with the committee. I am resistant to going much further down the road of a big data collection and financial monitoring exercise that would disaggregate the line that I described in the way that was suggested. However, we are always happy to consider the system as it evolves. When the committee discusses NHS modernisation and the health plan next week, I am sure that questions on performance management will arise. The committee might then wish to discuss further such issues.

11:45

The Convener: One point that has cropped up in our discussions is the fact that we are investigating not only what a health authority is spending on a programme, such as on diabetes or coronary heart care, but whether there is a trend of change from acute to community or intermediary care, which the committee needs to see. If the Executive, at the centre, decides that an issue is a priority and that it wants to take forward a move towards change that the committee wants to support, the committee should see such change. At the moment, it is difficult for all committee members to see those changes.

Margaret Jamieson: Although some of the moneys that have been allocated are welcome, it is difficult for committee members to follow the health pound through to the point of delivery by local health boards. Some health board employees deliberately make that task difficult and remove any chance of having the transparency that the minister is trying to introduce into the health service. That gives us a political problem, because the message is not available locally.

I had discussions with Ayrshire and Arran Health Board this week about the money that was allocated for Arbuthnott. I tried to find out where that money would be spent, but was stymied at every opportunity. I accept that the minister does not want to continue to hold centralised data. I am an opponent of health boards continuing in their present form and I do not think that my view will change, but we need to ensure that health boards make available the information that we need, without Parliament or patients having to ask for it. That is how the accounts of health trusts and—

need I mention them—independent contractors, general practitioners and out-of-hours GP services should be handled. We need to see what public funds are delivering, whatever the services are called. I think that that is the point that Richard Simpson makes. John Aldridge might not require that information, but it is definitely required at the point of delivery.

Susan Deacon: Margaret Jamieson raises several important issues, which she has put to me several times before. I agree with some of her general points and I share some of her frustrations. The Government faces some real issues.

The Government is pumping an extra £400 million to £500 million into the health service this year, next year, the following year and the year after that. We feel that, in some cases, that money is not getting through to deliver the improvements in services that we are investing in and that people demand. Those services are greatly needed and the solution to the problem lies not in our financial monitoring processes or budget reporting mechanisms, but in resolving some of the fundamental weaknesses in the governance and accountability mechanisms of the NHS in Scotland.

I have said explicitly, from the very beginning of the wide-ranging package of work and discussions on NHS modernisation that we have undertaken this year, that resolving those problems must be at the core of our work. We want to address that directly and specifically in the Scottish health plan in November. We cannot allow patients to suffer as a consequence of weaknesses in the system or because of the absence of effective decision-making and accountability processes.

The Convener: I pay tribute again, as I constantly do, to the hard work of committee members. The Health and Community Care Committee was one of the few subject committees that made suggestions about where the Executive might like to spend some of those hundreds of millions of pounds of extra resources. I know that Dorothy-Grace Elder wants to pick up on one of those suggestions.

Dorothy-Grace Elder: I have a question about the role of the voluntary sector in health and community care. The minister has paid tribute to the voluntary sector's vital role. In the past 15 months, every member of the committee has heard evidence—officially or individually—that there are issues other than budget levels to consider. As Margaret Jamieson said, some things are not apparent from the general budget. Insecurity of funding is a significant problem for voluntary organisations.

As the minister said, there is a danger of monitoring to such an extent that there is no time left to do anything else. The work of voluntary organisations can be considerably diluted by a constant battle for funds. Sometimes, a full-time officer is needed to do that and voluntary organisations often cannot exist for more than six months or a year at a time. Could the minister give the committee a pledge on security of funding for voluntary projects?

My second point is about raw cash. The Executive managed to obtain £26 million from the increase in tobacco tax, not from the overall tobacco tax. That was an innovative way of dipping into funds. However, in view of the fact that the Scottish tobacco tax haul is about £1 billion, of which £10 million is contributed, it is believed, by child smokers, can the minister assure the committee that she will try again to get more of the tobacco tax to fund health and community care?

Susan Deacon: I shall answer the point about voluntary organisations first. I share the view that the voluntary sector will have an immense role to play in the delivery of effective health and community care services in future. The tragedy is that, all too often, insecurity and uncertainty about funding stands in the way of effective delivery of voluntary sector services and can, in the worst cases, lead to organisations folding.

To the extent that we can address that problem at national level, we are doing so through the voluntary sector compact. We have increased the grants that are available to voluntary organisations by £1.5 million, as set out in our spending review commitments for next year. We must also ensure that local funders—health boards and local authorities, in the main—give local voluntary sector bodies the attention and priority that they deserve. A number of developments that are under way, such as community planning, can help them to do that. That will create cohesion between different agencies under the leadership of local authorities, so that agencies can come together and make a better assessment of the needs of local communities.

I hope that, thereafter, the statutory bodies will work more closely together than has sometimes been the case, on how those needs can be met most effectively. If a broader perspective is taken, needs can often be met as effectively or more effectively by a voluntary organisation. I repeat that the Scottish health plan is where we want to make explicit the role that the voluntary sector ought to have in the future development of health and social care services. I see that sector's role as central.

Dorothy-Grace Elder asked about financial issues. The £26 million that we have identified for public health is part of a much wider increase in

the resource that has flowed to Scotland, not only for health, but for the entire Scottish block. As I said a moment ago, that has resulted in an increase of between £400 million and £500 million not just this year, but for the next three years. Without wanting to go into the constitutional issues, which I think Dorothy-Grace Elder touched on, I believe that Scotland has benefited enormously from the fact that the UK economy is in good shape and is being managed effectively. Substantial additional resources are available to us to spend as we see fit. We will continue to ensure that the health budget and budgets and activities across the Executive keep working to improve the health of Scotland. We are active in that respect.

The Convener: In bringing this item to a conclusion, I ask for clarification on the two specific issues that the committee asked about—grants to voluntary organisations and the uprating of the mental illness specific grant. What have you decided to do?

Susan Deacon: I breathed a sigh of relief there. When you emphasised that you had specific points, I was sure that I would not have the details to hand, but I can say that those two issues are specifically identified as having been addressed in the publication "Making a Difference for Scotland: Spending Plans for Scotland 2001-02 to 2003-04", which the Minister for Finance published a few weeks ago.

As I mentioned, we are increasing the grants that are available to voluntary organisations by £1.5 million. Similar increases are taking place in budgets for voluntary organisations in specific areas, such as drugs. We have also given a commitment to increase the mental illness specific grant by £1 million a year, while at the same time considering how to make that grant more effective.

The final point that I want to make, which I did not mention earlier, is that we have not provided further level III figures to the committee as requested, because we want to ensure that spending and investment planning is linked to our policy development process. We see the health plan, which is to be published next month, as the point at which the two things will come together. I am sure that the committee will want to ask further questions and have further discussions on that, and I hope that the committee will contribute to the process between now and publication of the plan.

The Convener: We will conclude our discussion on the budget later this morning, after we have released you, minister.

I bring this item to a close. I thank the minister and her officials for attending. We have covered a fairly sweeping range of items of business, some of which we have done a lot of work on. I thank colleagues for the work that they have undertaken to date. We will do further work on some of those areas. We will return, for example, to hepatitis C, as well as to the Arbuthnott report, on which the committee will take a final position. As I said, we will examine the budget further this morning. Thank you, minister, for your input.

Subordinate Legislation

The Convener: The final agenda item in public concerns the Food Irradiation Provisions (Scotland) Regulations 2000. Members will recall that we considered the regulations on 26 September. We had two main concerns about defective drafting and ambiguity of specific parts of the regulations, which had been picked up by the Subordinate Legislation Committee. The Executive did not allay the concerns of the Subordinate Legislation Committee and we agreed to ask the Executive for further explanation of its position.

We have received a response, which has been circulated to members, from the Food Standards Agency Scotland. That agency intends to introduce amending legislation to address the points that were raised by both committees. I suggest that that resolves the issues satisfactorily. No motion to annul has been lodged. I therefore recommend that the committee make no recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement.*

The Convener: That brings our public business to an end.

12:00

Meeting continued in private until 12:37.

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