HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 9 May 2001
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
14th Meeting 2001, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
*Janis Hughes (Glasgow Rutherglen) (Lab)
Mr John McAllion (Dundee East) (Lab)
*Shona Robison (North-East Scotland) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Ochil) (Lab)
Nicola Sturgeon (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Andrew Wilson (Central Scotland) (SNP)

WITNESSES

Michael Bews (Lomond and Argyll Primary Care NHS Trust)
Malcolm Chisholm (Deputy Minister for Health and Community Care)
Jim Devine (Unison)
Eddie Egan (Unison)
John Gallacher (Unison)
Judith Illsley (Argyll and Clyde Health Board)
Dr Erik Jespersen (Argyll and Bute Local Health Care Co-operative)
Mr Paul Martin (Renfrewshire and Inverclyde Primary Care NHS Trust)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERKS

Irene Fleming
Peter McGrath

ASSISTANT CLERK

Joanna Hardy

LOCATION

Committee Room 2

Scottish Parliament

Health and Community Care Committee

Wednesday 9 May 2001

(*Morning*)

[THE CONVENER *opened the meeting at 09:29*]

Budget Process 2002-03

The Convener (Mrs Margaret Smith): Good morning. I welcome representatives from the Argyll and Clyde health care system to the meeting. I am sorry that we are missing David Sillito, who has decided to opt for the dentist's chair rather than to face the Health and Community Care Committee. Let us hope that the idea does not spread and that other witnesses do not see that as a way out of appearing before the committee.

We want this morning to talk to the witnesses to gain some idea of the pressures under which they work. Periodically, we hear from people who work at the sharp end about the constraints and pressures, highs and lows and difficulties of knitting together central diktat and local circumstances, as well as of managing a budget that cannot do everything that needs to be done. We wanted to hear evidence from several people who work in an area in which no member of the committee has a particular constituency interest. Mary Scanlon tips into the area slightly, because she is a Highland region list MSP. We want to hear the witnesses' perspectives on the different parts of the jigsaw puzzle. We want to consider this year's Scottish budget, particularly the health budget, to find out whether the Executive's proposals will deliver what we want to see on the ground.

Please make a short introduction. I will then open up the meeting to questions from members.

Judith Illsley (Argyll and Clyde Health Board): Thank you for the opportunity to come and talk to the committee. I will outline briefly the process that we use in Argyll and Clyde Health Board. The process is unique to us—other health boards use different processes—but it might help to focus the committee's questions. The resource allocation process is not a one-off—it is a cycle over twelve months. We would like to think that this year we have a process that is more open and transparent than that which we have used previously. Each year we try to put in place something better than the year before, although there are always issues on which we can improve.

The key planning document is our health improvement programme—or HIP—which covers five years. We identify our programmes by colours and last year's is the pink HIP in the papers. Recently, we produced a health improvement programme for the next five years, from this year onwards. The programme sets out the resource allocation and our key aims for the five years and will be published at the end of May.

The key point in the yearly cycle is the publication of our director of public health's annual report. That report sets out the key messages on the health status of the population of Argyll and Clyde. That is done on the basis of local authority areas so that we can pick out key health issues in Argyll and Bute, as opposed to those in Inverclyde or Renfrewshire. We take that document as our starting point. The other key document that we have been using this year focuses on inequalities. We have a multi-agency inequalities steering group that has drawn up a paper on the key inequalities in health in Argyll and Clyde and how we might tackle them.

The national priorities, together with those documents, create the backdrop to our planning and resource allocation process. The key strategic route is our multi-agency health improvement forum, which involves the trusts, the health board, local authorities, social inclusion partnerships, Scottish Homes, voluntary organisations and the area partnership forum. That key group meets monthly to discuss strategic issues. The minutes of the group's meetings are circulated widely and can be accessed through the health board's website.

This year, building on the work of previous years, we made the process of considering how new moneys would be allocated more open. We asked the trusts and the specialist groups—such as the cancer steering group and the mental health steering group—to propose ways in which the new moneys could best be used to benefit their area in Argyll and Clyde. We have used various methods to prioritise—no one way is correct—and to work out what would be the best way in which to spend those moneys. We had a full-day meeting of the health improvement forum, at which we listened to what those groups and the trusts had to say about the priorities. We came to a conclusion on how those needs could best be met. That is reflected in our most recent health improvement programme, which we submitted to the Scottish Executive at the end of March.

We have some areas of concern on which we need to work. We are all struggling with the principle of genuine public involvement. We have tended to take public involvement as involvement either in developing a strategy—having patients,

users and carers on the strategic groups as we develop the strategy—or in one-off exercises, such as citizens juries and panels. Trusts are doing a great deal to facilitate public involvement, although that tends to be through one-off activities. We carry out end-stage consultation. We are trying to develop an overarching approach in Argyll and Clyde towards public involvement, working with local authority colleagues as well as the whole national health service in Argyll and Clyde. Public involvement is ripe for development because it is particularly difficult to engage with the public, rather than just with the usual suspects. We are implementing various measures to achieve that.

We know that the committee is interested in historic moneys and we would be happy to answer questions on that too.

Shona Robison (North-East Scotland) (SNP): You have helpfully answered many questions that I wanted to ask about the process. Perhaps I could dig a little deeper. What local discretion is possible, given that £25 million of new money has been allocated for 2002-03, most of which will be used for inflationary pay and price increases?

Judith Illsley: There is an element of local discretion. However, Shona Robison is right to say that although the money is called new money it is already earmarked to meet various demands before it hits the desk—there are unavoidable commitments. Part of the financial planning process is to identify how to mitigate some of the problems. If there is a demand—as there is—for a large sum to be paid for junior doctors' hours, we must consider how changes in rotas, for example, might reduce that demand. Some things just come in and out and we have no choice about them. By the time we get the trickle-down effect, it does not feel as though there is much local discretion. By the time the money has been top-sliced at the Scottish Executive for recombinant factor VIII or IX and so on—and top-sliced at various other points along the way—it does not feel as though there is a lot left at the bottom of the pile.

Michael Bews (Lomond and Argyll Primary Health Care Trust): Confidence that future moneys will come in allows us to adjust timing on the issues. There are significant pressures of which everybody is aware, such as junior doctors' hours. As a health system, we will receive a 5.5 per cent increase in funding this year. However, with the confidence that future moneys will come in, we are able to plan for developments and to address issues in-year; we can start some of the developments a bit later, knowing that the money will come through the following year. Some developments might start towards the latter end of the year, rather than during the early part of the year.

Shona Robison: You talked about the public involvement and the interest groups that are involved in the process. Are those people surprised when they find out the levels of resources that are being discussed in relation to the priorities? Do you find that they assume that there is a global figure and that they are surprised that, when the money is whittled down, there is not much flexibility?

Judith Illsley: Interest groups find it quite difficult to grasp the large amounts that are involved. For instance, Argyll and Clyde Health Board deals with £390 million, of which a great amount is already committed on a year-to-year basis before it comes in. It is hard for interest groups to get a handle on what we mean when we tell them, for instance, how much discretion there is at local level in relation to £25 million of new money. Most interest groups are focused on their specific area and they want investment in those areas. The difficulty that we face is in engaging the public in strategic decision making.

Shona Robison: Can the interest groups in local areas affect the decision-making process? Have changes been made in response to what they have been lobbying for?

Dr Erik Jespersen (Argyll and Bute Local Health Care Co-operative): Public involvement only works at a level below the local authority level, because people understand the spend on their local hospital and their community services. It is difficult for Argyll and Clyde Health Board to have a sense of community because it encompasses, for example, the deprived population in Inverclyde and the rural population of Argyll and Bute. Only at the level of, for example, north Argyll or Inverclyde do people care about services. That is where local health care co-operatives offer added value. The LHCC best practice report shows that the vast majority of LHCCs involve the public. The question is whether, once we have listened to the public's priorities, we are able to change the health system's direction. That is the challenge that we face.

Mr Paul Martin (Renfrewshire and Inverclyde Primary Care NHS Trust): I will give a specific practical example of a case in which public involvement has clearly influenced the direction in which the local services have been delivered daily. Renfrewshire and Inverclyde Primary Care NHS Trust has made the relatives and carers of patients who have learning difficulties in Merchiston hospital an integral part of the group that is considering the types of services that can be put in place as the hospital retracts. That group is also considering the level of support and provision that can be made available to support the sons, daughters, brothers and sisters of those

people, as they move into the community. That has meant that we have slowed the programme down a little to enable people to have more influence over placement of their relatives.

Michael Bews: Over the past year, there has been quite a change in attitude in relation to public involvement. From a time when consultation used often to be done after the process, we have moved to a different situation, as is illustrated by the on-going service developments in Dunoon. We are starting with a blank page and there are no project groups and so on. We are involving the public, patients, users of services, local clinicians and so on to shape how we begin the process. That is a fundamental change and we are dealing with new concepts and an exciting agenda. As Mr Martin said, the process might be slower, but it will be much more effective in the long term.

Mary Scanlon (Highlands and Islands) (Con): The committee received from Oban a petition—that had more than 9,000 signatures—on the threatened closure of the Nelson ward in Lorne and Islands district general hospital. That petition did not highlight wonderful consultation—people had no idea what was going on. A couple of weeks ago I received a paper on the closure of the Nelson ward, from which it was not crystal clear that some patients would go into the community and some would go into the Malcie Fleming ward. On the eve of a general election, I can see that many elderly people could be worried about the proposals.

09:45

The Convener: I am not convinced that that has much to do with the budget that we are meant to be discussing. The question should be about the consultation that is involved in that kind of closure, rather than the specifics, if I may guide the witnesses in that manner.

Dr Jespersen: We have rescued the situation in north Argyll. I agree that it was handled poorly at the beginning, but with Lomond and Argyll Primary Care NHS Trust, the local authority social work department, the local hospital and the public working together, we have set up a local forum. People have been much more involved in decisions and the reasoning behind them. Once they get an understanding of the pressures on the service—they want to see better community-based services—they are much more supportive. We have recovered from the days of the petition to which Mary Scanlon referred and the marches on the hospital.

Mary Scanlon: The situation was badly handled in the early stages.

The Convener: Can I move back to the budget? Your initial remarks were good—they were about the component parts of the process that you go through in deciding how to prioritise new money. Does that mean that the other £390 million—or whatever it is—that you already have sitting there goes unchallenged? How do you examine that again during the HIP process?

Judith Illsley: One of the difficulties is that a huge amount of the focus goes on the new money—it is the 80:20 rule—because people see an opportunity to gain something out of it, but they see the large bulk of the money as merely flowing through. We do not feel that that is the case, because that large sum of money must be re-examined every year.

The culture has got much more involved in looking at redesign within resources—bending the spend, in the terminology—and in examining what value and use is made of that vast amount of money that goes into health and health care in Argyll and Clyde. The culture is such that people are thinking much more along those lines, rather than trying to bid for the £0.5 million or £1 million or whatever it is on top of that large resource.

We have not quite got the balance right between the attention that we give to prioritising and bidding for new moneys, and dealing with the existing moneys. However, as we move towards a locality-based approach and local health plans—we will have to develop five plans, because we cover five local authorities in Argyll and Clyde—that will bear down on what we get and what the residents of each area get for the money that is spent on their health care.

Mr Martin: There is a process that I describe as needs-to-resource profiling. Judith Illsley touched on the annual report by the director of public health. This is the first year in which that report has been built around identification of the public health needs of localities. As we get better at that science, we are identifying the true needs of localities—with good and robust public involvement—and we are getting better at analysing the spend. We are beginning to match the two. We must be careful, as was touched on, not to fall into the trap of looking only at how we invest any additional uplifts in our budget. We must take a whole-system approach.

A good local example is the approach to providing children's services. At the moment, community child health services are provided by Lomond and Argyll Primary Care NHS Trust and Renfrewshire and Inverclyde Primary Care NHS Trust, and acute paediatrics are provided by the Argyll and Clyde Acute Hospitals NHS Trust. That division in itself creates some—one would think—diseconomies. We have been working, over the last year, to move towards what is described as a combined child health service, in line with the template that the Scottish Executive's child health

support group produced.

We hope to do that over the next year and to bring all the strands of child health care clinically and managerially under one umbrella. We would thereby create a managed clinical network that would allow us to identify and design services that are more responsive to how modern children's services and paediatrics should be provided, as opposed to how they were provided in the past. In that context, we consider the total spend on children's services, not just any development moneys that we get.

Shona Robison: Many of my questions about cost pressures have been answered. Clearly, you recognise those pressures and the limitations that they impose. Is it impossible to balance national priorities, local priorities, staff aspirations, interest groups and the public? I presume that in an ideal world, you would want fewer constraints. How could that be done manageably?

Mr Martin: We need to recognise that, given the demographics and deprivation profile of Argyll and Clyde Health Board's area, many of our local priorities are the national priorities. Forty one per cent of deaths in the area are the result of coronary artery disease or stroke. Those are national, Scottish Executive health priorities and we need to do something about them to improve that statistic. I am not trying to dampen the housing market with this statement, but somebody who lives in the Argyll and Clyde Health Board area is 10 per cent more likely to have a stroke, and 7 per cent more likely to have a heart attack, than somebody who lives anywhere else in Scotland.

Those are significant health improvement priorities for any health system to tackle. Having a steer from the centre that says that coronary heart disease and strokes are among the national health priorities reinforces and adds weight to the local health system's efforts. A central steer does not necessarily compromise a local initiative if the local initiative is focused in the same direction.

Michael Bews: The general issue of planning processes is important. Those processes go from the bottom up and from the top down, as the classic expression goes. The reality is that the LHCC planning processes match top-down planning quite well. As Paul Martin emphasised, the priorities that come from the LHCC are very similar to the national priorities—Erik Jespersen might want to comment on that. There might be additional local pressures.

The key issue for balance is in devolving decision making—there is no question about that. We are trying hard to devolve as much decision making as we possibly can and we are doing that where there are diverse localities, in particular in Argyll. However, the philosophy applies throughout the area. It is important that local clinicians, in conjunction with local staff and populations, can be involved in the decision-making processes.

The Convener: That takes us on sweetly to our next line of questioning, so perhaps Dr Jespersen can say what he was about to say after he has heard Mary Scanlon's next round of questions.

Mary Scanlon: My question is specifically for Dr Jespersen. Given that you have £25 million and that we are looking for best health practice, from your experience, what difference will the new money make at LHCC level? Is greater devolution of budgets to LHCC level the way to address local priorities? Could you mention commissioning in your answer? General practitioners in England and Wales have commissioning powers and I understand that, in Wales, the LHCCs are funded directly by the National Assembly for Wales.

Dr Jespersen: Last year, James Dunbar came to speak to the committee about the budget process. He emphasised the role of primary care and prevention. I will not repeat much of that.

It might be helpful to give members a little background about Argyll and Bute LHCC, because many co-operatives are very different. We cover a geographical area that stretches from Dunoon to Tiree, and the population of 65,000 is served by 30 practices and five community hospitals. Anybody who suffers a stroke or a heart attack, or who gives birth to a baby, will be treated in a local community hospital in Argyll, which makes the service there different from that in many other parts of Scotland. We have decided on a locality structure, because we want to devolve as much decision making as we can to the localities. We have relatively small localities such as Kintyre, mid-Argyll and Cowal, and through time more decisions will be made in those areas.

Our budget is about £25 million: £8 million is for GP-prescribed drugs; £16 million is for the hospitals and community health services budget, which covers community hospitals, community nursing services, therapists and the like; and a further £1.3 million is for what is called general medical services cash-limited, which pays for practice staff, computers and so on. It might be interesting to take each of those elements to examine how the uplifts have applied to us.

Because prescribing is one of the largest elements, we thought that we might have been able to shift investment from it into primary care. Members will be aware from previous budget discussions that the expected annual inflation figure is 8 to 10 per cent. The first problem that we faced this year was the generics crisis, which caused us to lose control of the budget. Many

years of good work in encouraging GPs to be responsible about their prescribing were lost, and practices were left with a budget that was overspent no matter what they did. Furthermore, there was no rescue package.

Secondly, we experienced problems in getting information about current drugs spend. We had to go back to last October for high-level information—which meant that it was six months out of date—and then to last June for detailed practice level statements. That makes it very difficult to encourage GPs to manage that important aspect of the budget.

As for the GMS cash-limited aspect of our budget, last year's rise was 2.3 per cent and it was 3.1 per cent this year. At a time when pay rises are running at 3.7 per cent, it is clear that we must begin by making efficiency savings, rather than developing more practice nurses. The situation has led to much of the frustration that is being voiced by GPs.

However, it has not been all bad news; we have had many capital developments. For example, there was the announcement about the Mid Argyll hospital last week, and new surgeries have been established in Tiree, Dalmally and Tarbert. In the past year, we managed to increase the number of repairs to community hospitals, which were in quite a dilapidated state. Furthermore, we received winter pressure money, with which we have been able to improve our work with the social work department for better community care provision. We also used some of that funding to uplift the practice budgets by making every practice aware of what every other practice had in its budget. By doing that, we managed to show that there was gross inequity across the practices, because with the previous system, he who bid best got most. All the money was aimed towards practices that had the lowest staff allocations, in order to bring everybody up to the same level, which was a much more open and transparent process. However, the problem is that, without any new funding, we cannot finish the process in the short term.

Mary Scanlon: I feel like a teacher now, because I want you to answer my specific questions about commissioning in Scotland and direct funding.

Do you feel that the funding of LHCCs encourages initiative and best practice? Furthermore, the Audit Scotland document "Paying dividends: Local Healthcare Co-operatives bulletin" says that LHCCs'

"involvement in the local planning process"

is very limited. Can more be done at the local level?

Dr Jespersen: As some committee members may know, my background is that I was a GP fundholder. I managed a budget of £2.5 million for a population of 10,000. By investing in our local services and our primary care services, we managed to reinvest or change the way that that money was used. I admit that I imagined I would be able to spread what I had done for one practice to the 30 practices in the local health care co-operative. However, the opportunities to do that have not existed. The lack of commissioning in Scotland is a drawback and means that we have no mechanism for managing the rise in demand for acute services. Primary care and acute services would benefit jointly from some mechanism to address that interface.

The situation in England is interesting, as health authority layers are being cut rapidly. In Wales, health authorities will go in two years and the local health groups that will take over much of their role will have a commissioning role. In Northern Ireland, the health and social care groups will also have a commissioning role. At the moment, Scotland stands apart. When we have large rises in health spending of 6.5 per cent or more a year, it is perhaps easy for commissioning to be absent. That will not always be the case and commissioning is one mechanism that could be used to manage demand in future.

10:00

Mary Scanlon: Does the funding process encourage initiatives by clinical directors such as you?

Dr Jespersen: If Mary Scanlon means that some things are ring-fenced, I would say that we have enough flexibility. Our trust devolves decisions about the whole of our hospital and community health services and GMS budgets down to the LHCC. That is not happening all over Scotland but, where it is, it encourages us to address our local priorities with quite a lot of freedom.

Mary Scanlon: You mentioned the example of the Welsh health authorities. Are you saying that a lot of money in Scotland is spent on bureaucracies, such as health authorities, and that it may be better directed elsewhere?

Dr Jespersen: It would be wrong to plan to have management savings. Sometimes the health service is undermanaged but overadministered. Taking out layers might not save a lot of money; it might just put the managers in places where they might be able to effect more change.

Michael Bews: Dr Jespersen has made the point, but I want to ensure that the committee understands that the hospital and community health services budget in the primary care trust is

already devolved to the LHCC. When Dr Jespersen talked about commissioning, he was talking not about community services, for which he is already operationally responsible, but about acute services.

Dr Jespersen: Yes.

Michael Bews: I want to add an observation. Many of the primary care trusts in England have relatively small commissioning budgets. The committee might want to be aware of the potential to destabilise some large services. It is not my job to say what is right or wrong, but that issue needs to be considered along with the benefits.

Dr Richard Simpson (Ochil) (Lab): I am interested in the devolution of budgets, as that is fundamental. The figure that Dr Jespersen gave us was 3.1 per cent. On a 5.5 per cent uplift, how do the LHCCs get into the share of the remaining 2.4 per cent? Is that devolved? We have heard about the complex process that is involved in managing those budgets, but if the 2.4 per cent is taken with the managed clinical network concept and with the shift from secondary to primary care, the reduction in acute beds and the increased turnover—and the resulting increased pressures on primary care—what is he getting for that?

Dr Jespersen: We must mention again that the 5.5 per cent uplift from Argyll and Clyde Health Board creates a difficult situation; the board is an Arbuthnott loser. The degree of deprivation and rurality that exists in the Argyll and Clyde area suggests that there is something wrong with the formula.

If we got into the health improvement programme, we would get that 3.1 per cent uplift. This year's HIP includes provision of £500,000 for primary care development. The problem is that that tends to come in further down the line—acute pressures tend to come into play beforehand. The GMS cash uplift is generally decided at Scottish Executive level. It is a new thing for health boards to have a unified health budget and to understand that they can invest more in primary care if they so choose.

Judith Illsley: The total amount of money that comes into Argyll and Clyde Health Board is devolved through the process that the committee has heard about and is not retained at health board level.

Some of the pressures that we face—from European working time directives, junior doctors' hours, the inexorable increase in demand in people coming through our doors—eat into our allocation. In particular, the pressures in the acute sector are in your face and are perhaps not seen in quite the same way as those in the primary care sector, but they all eat into the allocation. We are struggling to understand that too, because of the specific pressures that we face in Argyll and Clyde.

Michael Bews: We have been trying to encourage both the LHCCs in the trust not to consider the GMS budget in isolation, but to consider the total money that they control. They are well aware of that. If one budget is a bit limited, we do not restrict the Argyll and Clyde Health Board budget to purely ACHB funding if the service benefits from other developments. If we are considering coronary heart disease or developments in the localities, the LHCCs will come up with the best way to deal with the issue. If that happens to be development in the GMS budget, so be it. We do not try to restrict between budgets.

Mary Scanlon: Various people—including the British Medical Association and the committee—responded to the first Arbuthnott report by saying that no recognition had been taken of the 26 inhabited islands in Argyll and Bute.

When the second Arbuthnott report was produced, Argyll and Clyde Health Board got nothing in comparison with the Highlands, which benefitted greatly. Why was that? Is something wrong with the formula? Have you made representations about additional funding to finance the most inaccessible part of Scotland, which includes more islands than the Highland Council area? What is happening to tackle issues such as rurality and inaccessibility to services that are specific to your area?

Michael Bews: One example is the Kintyre peninsula, which is not an island geographically, but is an island when it comes to the reality of providing services. The peninsula has a population of up to 8,000 people who are, in effect, three hours away from Glasgow or from a district hospital. The peninsula should be treated as an island, but the figures do not treat it as such. It is treated as a rural area—that is one disadvantage in the Argyll area.

The trust is conducting an exercise on the Arbuthnott formula and its effect on different areas. We are considering the formula's effect on learning disabilities and community hospitals, for example, and how our funding compares with the formula.

In addition, the board—the whole system—is benchmarking all its services using the Arbuthnott formula as the base. We will make a comparison with ourselves and with others in respect of all our services. That will give us an idea about the issue that we talked about earlier—what we do with the existing £390 million—and will help us to shape where we put that money and to know whether it is being spent in the right areas.

Dr Simpson: I will move on to accountability up

the way. We have looked at accountability down the way—you have described that in great detail.

One of our concerns is the ability of Parliament to hold the Executive—and of the Executive to hold the health boards and trusts—to account. How will the accountability review change things? Will it make things better? Does it, or should it, involve public accountability? The committee is concerned about the process and would welcome your comments on the accountability review system or performance management.

Judith Illsley: We are slightly hampered, in that only Mr Bews has attended an accountability review. The rest of us do not go—we do the preparatory work beforehand.

The Convener: Should you go?

Judith Illsley: That is an interesting question.

The Convener: That is what I am here for.

Judith Illsley: The one element that I feel is missing at board level in Argyll and Clyde, among the three trusts and the health board, is that the director of public health for Argyll and Clyde Health Board should attend the reviews. Currently, the health board chairman and the trust chief executives attend. If the director of public health were to attend, that would provide the health element, as opposed to the clinical element, and perhaps we need that extra dimension to help focus on health, as opposed to health care. That would be my plea; I do not know whether my colleagues agree. That would give a different slant to considering overall accountability for health, rather than just for the delivery of services.

The review has moved on. There is a different chief executive, who has run this year's accountability review. The review for Argyll and Clyde Health Board went through on 1 May. Different chief executives' styles are reflected in the reviews. The comments that I received show that the approach taken by—and the response received from—Argyll and Clyde is much more corporate. In the past, it was a straightforward matter of the accountability of the health board, through the accountability review process. The new approach is a great development for engendering a much more corporate, collaborative feel.

I have not attended a review, so I will leave it to my colleagues to feed back on how the review in question went.

The Convener: That was neatly sidestepped.

Michael Bews: The actual accountability review—when we meet representatives of the Executive—is only one aspect of the whole accountability process. As health service deliverers, we are accountable to Parliament—there is no question about that. That is firmly understood by people in the service.

There are also local issues of accountability. We have local annual reports, which are made public, and we have annual public meetings, at which there is an element of accountability. In addition to that, there is the whole audit process. There is, therefore, an accountability process at board level, whereby the non-executives on the board put the executives through a process of accountability to ensure that they are spending the money properly. That covers the internal audit committees and clinical governance committees. There are many levels of accountability in the system.

Dr Simpson: Is your health improvement plan subject to discussion with the Executive? I am aware that you have to submit it.

Judith Illsley: Yes.

Dr Simpson: Are you monitored against specific targets? I am referring not just to financial targets, but to health or health management targets.

I will give you an example. During a previous meeting, we discussed multiple sclerosis. Argyll and Clyde is one of the areas that appear not to have any MS nurses. You may deal with the treatment of MS in a different way, but would such a question arise? In other words, is there benchmarking not just for national priorities, but for conditions such as MS, for which—as far as we can judge—there is postcode provision? Certain areas have one MS nurse for every 500 sufferers; Argyll and Clyde appears to have none, although we may have got the figures wrong.

There is wide variation in care for quite a number of different patient groups. Are you benchmarked? Are you given targets and, if so, are those targets questioned?

Judith Illsley: We are expected to meet a whole set of national targets for improvements in health. Those targets cover morbidity and mortality in relation to cancer, coronary heart disease and stroke. They cover a whole range of other things including teenage pregnancies, low-birth-weight babies and dental health. Some of the targets are, one could say, picked out for the accountability review process, which covers a range of targets. They might relate to the financial side, to clinical outcomes, to the efficiency with which we deliver services, to access or to waiting times. They relate to a raft of things.

We are looking forward to the new performance accountability framework that is to be produced. We await the details of that framework, which should give a much more structured feel to accountability in specific areas. Currently, the various structures are not always subjected in the way that they might be to accountability review;

they are sometimes cherry-picked.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): You talked about the way in which you involve the public when you work on your strategies. You indicated that one of the ways in which you were accountable to the public of Argyll and Clyde was through your annual meetings. Are you accountable in other ways, which you have not mentioned, to the people that you serve in Argyll and Clyde?

Does the accountability review process that is undertaken by the health department place sufficient emphasis on what you will do in future, rather what has been done in the past?

10:15

Mr Martin: One main theme in that question was whether the process aims to hold to account the defined accountable officers or the system. Margaret Jamieson touched on holding the system to account, which requires a different approach. That is what the performance assessment framework, which has been developed through the health department, aims to do. I understand that the framework aims to produce real evidence through a self-awareness approach.

We must produce the evidence locally that demonstrates public involvement. That is not just about having a citizens jury, but about a whole range of matters. We are doing some work with Scottish Health Feedback, which culminates in a workshop tomorrow. As a trust, we are saying that we have done the community conference and the locality conferences and we still do not think that we have got it right. The message that we are getting is that things are better than they were, but that we have not quite got it right. Part of tomorrow's workshop will consider a work plan for meaningful, informed public involvement, which—as Judy Illsley said—does not mean wheeling in the public to rubber stamp something. We must set out the situation clearly over the next couple of years. We can say what we expect to happen, but set out the process that we will use to introduce public involvement when something unexpected arises.

Margaret Jamieson: Will that cement a corporate accountability approach? The committee is not looking to blame individuals—we want to move away from the blame culture. If corporate accountability flows through the process, the spin-off is that the staff, as well as the public, will buy into the system.

Mr Martin: The new structure for the unified arrangements, as defined in the health plan, sets out clearly the template that is designed to support that approach. The proposal is that the local authority employee director and the conveners of social work will be representatives on the unified board. Further clarity is required. With clinical representation on the unified board, a wider system is being created for both strategic involvement and accountability in governance.

Janis Hughes (Glasgow Rutherglen) (Lab): An area of concern for the committee, which emerged as we questioned previous witnesses, is that the spending plans in the budget do not appear to be directly linked to the NHS plan, which was published at the end of last year. What is the correlation between the budget, as it is laid out, and the NHS plan?

Judith Illsley: The timing was difficult. The plan, which was produced at the end of last year, is an enormous document that contains a huge amount of information. It was out of sync with the process that we had embarked on and the targets for completion that had been set by the Scottish Executive.

Having said that, the board has an exercise under way to map out what is in the health plan, to ask whether we are already doing anything about that plan, and to decide what the action plan will be for this year, next year, or whatever time scale is indicated in the health plan. We hope to develop a matrix that lists all those things and indicates what is happening. When we went through the health plan, it was interesting to find out how much we had in train, how much we had planned—perhaps using slightly different words from those in the plan—and how much was happening at trust level. Of the slightly daunting 249 recommendations—or whatever the figure was—we were under way with quite a number of them.

The five local health plans may need to make those links more explicit and it is probably easier to do that at a local level. As we have heard, people in Oban do not have a special interest in what is happening in Paisley—that is the span that Argyll and Clyde Health Board covers. If we have a local health plan that considers the Renfrewshire area, the Inverclyde area or wherever, we may be able to pick out the specific ways in which the issues in the health plan—and the local community plans—link in. That will be easier to do on a local basis than on a wider basis.

Michael Bews: At the accountability review—at which I was the only one of the four of us who was present—we were remitted to produce an action plan by the end of June. That is under way. Judith Illsley is right about the timing, but the health plan must be regarded as a continuing, and accelerating, process. There is a heck of a lot in the plan. We have to look at the specific targets for this year, add targets that we think we can achieve in the longer term, and produce an action plan. We will be doing that for the whole system and as individual trusts.

Janis Hughes: I accept your point that there is a definite correlation between local plans and the NHS plan, but are the budgetary proposals linked to the health plan? Can you deliver on the issues in the health plan with the budget as it is at the moment?

Judith Illsley: That is the $64,000 question.

Dr Jespersen: And the only answer is that it would be very difficult to do so. However, that does not mean that we will not attempt it. It would be wrong of the Scottish Executive to decide to give lots of pocketed, ring-fenced money to allow the ticking-off of the actions in the health plan. There needs to be a balance between central decision making and local devolved decision making. Getting that balance right is extremely difficult for anyone.

Mr Martin: We should not regard the health plan as being delivered only by the NHS. To be delivered, the health plan demands partnership working at local level. Much as we need to apply rigour—as the committee is rightly doing—to the allocation of budgets through the health system, equally we need to apply rigour to the allocation of budgets through the local authority system. The challenge is to identify where the two systems can work in partnership to get the best value for local money. That should be based not only on locality health planning, but on integrated community planning in which robust locality plans reflect the needs of the communities. We will not be able to deal with some of the health issues that have been mentioned unless we are also dealing with unemployment, housing and access to leisure. Problems in those areas are all impediments to improving health care.

Shona Robison: I want to follow up on the point that Janis Hughes made. How do you fund a proposal in an action point in the national plan that has a cost implication but for which no money is coming to you from the Scottish Executive?

Judith Illsley: That is part of our prioritisation process. We look at all the demands that we face and all the resources that are available. To a greater or lesser extent, things can be programmed in according to how much money is available. It is not an easy process. Of course, we still have £390 million of existing resources and we also have opportunities for joint commissioning with local authorities, whereby we might get better use of the existing moneys by pooling and applying them.

There are ways of bending the spend or using the existing resources if you do not have that slug of money. Having said that, there are some areas in which it is extremely difficult to create a pool or an opportunity and some prescriptive moneys from the centre can be very helpful. I am thinking particularly of the funds known as the tobacco tax moneys, which could be used for things that health boards have found it difficult to create a resource for, because most of the money goes out directly to services rather than into the promotion of good health. That is true of a lot of public health areas. A prescriptive allocation for public health nurses is something that, as a health community, we would probably have found impossible in the face of competing demands of service delivery.

Shona Robison: Are you saying that, in terms of prioritisation, there may be elements of the national health plan that cannot be met because of resource issues?

Judith Illsley: We have not been through the process of putting sums of money next to each of the requirements in the plan. That is something that we will be doing as part of the action plan. Then we will get an idea of whether we require new moneys or whether we feel that we can do it within an existing base budget. If we require new money, we will need to decide where that stacks up and how it can be introduced over a period of time. If the question is whether the health plan will cost us money and whether we can afford it, the answer is that, at the moment, we do not know.

Michael Bews: It is worth adding that a lot of the priorities in the health plan are the existing priorities. I therefore do not see a conflict there; I see a matching. As Judith Illsley said, the action plan will identify specifics much more rigorously, which is what I think you are after, but we do not have that information at the moment. However, we will have that sort of rigour within the next months to six weeks.

Dorothy-Grace Elder (Glasgow) (SNP): We are interested in the possibility of health boards informing us at some stage of how much they spend on various major diseases, such as cancer, heart disease, diabetes and mental illness. It might be difficult to work out, but it cannot be impossible. Do you think that that would be technically possible in an area such as yours? Do you think that that would be useful in comparing what happens in Argyll and Clyde Health Board area with what happens in other health board areas?

I have another question. I shall remind you of this question again, because it is not fair to give you three questions in one go. Someone referred earlier to the postcode provision of MS nurses. I would like to ask you whether you have any chronic pain clinics. I also want to know whether we can get a reasonably precise figure for how much new money you have to spend out of the £25 million, after you have paid wages and taken inflation into account. We have still not got down to the hard facts. If you ignore staff costs, how much do you have to spend directly on the health service?

I ask you kindly to address yourselves to my first question about how to catalogue and inform about how much you are spending on the major diseases.

Judith Illsley: It is possible to identify those figures for certain groupings, such as mental health, learning disabilities and the elderly, partly because those are the areas in which we are entering into joint commissioning with local authorities. Each side is required to identify what they are putting into the joint commissioning pot, so to speak. Having said that, the picture is not complete. We can probably identify what we spend in hospitals on mental health and what we spend on community mental health. However, the amount of money that we spend on mental health in primary care, for example, is not separately identified, and it might be extremely difficult to pull that out.

Doing that would not be impossible, but it would have to be undertaken on the basis of assumptions. I am not sure whether such an exercise would have value, because we do not have the national costing systems that would allow us to do that regularly and establishing them would require investment. I am not sure about the value of the information that would be obtained. However, it is possible to identify broadly the money that is spent.

Health boards have an interest—I am not sure whether that interest is invidious—in making comparisons even within an area such as Argyll and Clyde, where there are questions about equality of spending, given the diversity of the area, and with other health boards. For our Arbuthnott work, we are considering how much we spend on some matters, how much other health boards spend and whether that tells us anything. The problem with a snapshot is that it does not tell us much. Knowing that we spend the national average on cancer, for example, does not tell us whether that money is being spent in the best way. We simply know that an amount of money is being spent. We must link spending with some of the outcomes and useful indicators that make sense of what we are doing with the money.

10:30

Dorothy-Grace Elder: So the proposal may not be cost-effective. I will move on to postcode medicine, which was referred to in relation to MS-trained nurses. Does your area have any chronic pain clinics?

The Convener: What has that to do with the budget?

Dorothy-Grace Elder: It relates to the budget because there are proportionately more patients for such clinics than for heart disease and cancer treatment together. Richard Simpson referred to a gap in MS-trained nurses; chronic pain clinics are another gap area. Am I wrong in thinking that there are no MS-trained nurses in Argyll and Clyde and that there is no specialist chronic pain service in the area?

Dr Jespersen: There is a chronic pain clinic in Inverclyde, but most of our patients go to the Western general or the Southern general in Glasgow, where they have access to clinics.

Dorothy-Grace Elder: Those people in extreme pain would have a very long journey.

Dr Jespersen: It is difficult to provide such services throughout remote Argyll and Bute. I agree with you that it is difficult to provide outreach specialist services.

The Convener: Please make your final point, Dorothy-Grace, as I want to let Margaret Jamieson ask some questions and we are already over time.

Dorothy-Grace Elder: I ask the witnesses to try to answer the next question with specifics. How much of the £25 million of new money do you estimate, even roughly, is in your hands for improvements in health care or new provision, leaving aside the considerable sum for wage increases, inflation and other matters?

Judith Illsley: In our most recent health improvement programme—Andrew Walker probably has a copy of its financial schedules—the amount is £20 million.

Dorothy-Grace Elder: Do you have £20 million of new money?

Michael Bews: That question relates to the point that I made earlier. The intention is to spend £20 million on a recurring basis by the end of the year. We will not spend £20 million this year, because we will not start with all elements on 1 April. Slippage has occurred. We need to create some slippage in the system to deal with some in-house pressures, but by the end of the year, the intention is to spend £20 million on developments. That depends on our achieving all our targets.

Dorothy-Grace Elder: So roughly £5 million is to cover wage increases, inflation and the costs of goods that you buy. After that, are you saying that you will have £20 million clear?

Dr Jespersen: The way in which we use the existing money is changing to release money.

Michael Bews: We intend to spend that money on developments—for example, if something is redesigned. We have quite an involved plan to try to achieve the target. That was the intention and that is the plan. It is ambitious.

Dorothy-Grace Elder: A bit of old money is being shifted around as well as new money.

The Convener: The thinking behind Dorothy-Grace Elder's question concerns the 5.5 per cent uplift, which is your headline figure. Once pay, inflation and other such matters are accounted for, what is a ballpark figure of the amount that you have left?

Judith Illsley: It is intended that, by the end of the year, we will have invested the equivalent of £20 million, which will come into full play next year. For example, recruiting consultant staff may take a considerable time, and you do not start to pay for them until they are in post. Once they are in post, you pay for them permanently. The £20 million of developments that will take place in cancer and stroke treatment and in primary care, for example, will not all happen on 1 April.

Shona Robison: After all the pay awards and everything else has been dealt with, how much new money from the Scottish Executive—not reshifted money—will be available for new services?

Dr Jespersen: I think that we can give the committee that information on paper, from our finance department. It would be difficult for us to give it to you.

The Convener: We are happy for you to do that.

Margaret Jamieson: Has the introduction of three-year indicative budgets enabled the health service to adopt the spend-to-save philosophy that it was previously denied by the year-on-year budgeting process? Has that granted greater autonomy for general practitioners in prescribing high-cost drugs in the initial stages of illness, which may allow a better quality of life for patients in the long term?

Dr Jespersen: The move to three-year budgets is a welcome development, as it allows us to take a long-term view. The mad March spend in the NHS has always horrified me. Moving towards three-year allocation will allow us to think a little differently. If we have three years in which to spend money, we will be able to adopt a better approach and involve the public more. It is a welcome development, and I do not think that anyone would speak against it.

Mr Martin: Although we previously had a five-year planning process in terms of the HIP, we were constrained in what we could commit to that. For example, we were not sure whether we could start the recruitment process in December to begin the service on 1 April. Under the previous arrangements, we were not sure whether we could hold to that kind of commitment. With the projection of a three-year allocation, we are able to plan more sensibly over those three years and consider the phasing in of new services over that time scale, instead of having to jiggle it within 12 months. We also look forward to receiving the revised financial arrangements that are being developed, which should give us additional flexibility at the end of the year, so that there will not be the usual mad dash.

Margaret Jamieson: I was interested to hear that the three-year indicative budgets allow you to think differently. You are obviously talking about a huge spectrum of services in which you would have to think differently. Are you ensuring that individuals are thinking differently and working out what can be achieved with the money that is coming in? Have we managed to join all that up?

Dr Jespersen: The question was asked whether we can deal with mental health services below health board level. We are moving towards joint commissioning boards within each of the health board areas, for example, within Argyll and Bute. There is a common understanding and the local authority knows how much it spends on in-patient care, on community mental health nurses and on drugs. A three-year planning process will allow us to make much bigger changes in the type of provision that we have. At the moment, we are stuck with paying for institutional care with 90 per cent of that money.

Judith Illsley: The most important factor, which was mentioned earlier, is that three-year budgeting gives confidence not only to managers, who can plan ahead, but to clinicians and assistants. If they see their place in the queue for money not this year but next year, they have greater confidence that their turn will come without their having to enter into the traditional shroud-waving or shouting louder than anyone else. Three-year budgeting allows them to put forward much more measured and reasonable proposals for services, which is a key benefit.

The Convener: We will have to close the questioning, as we have overrun. Thank you very much for your evidence this morning.

10:38

Meeting adjourned.

10:47

On resuming—

The Convener: Okay, back to work. I reconvene the meeting.

Margaret Jamieson: I declare an interest as a member of Unison.

Janis Hughes: I declare a similar interest as a member of Unison.

The Convener: The recruitment policy has been working.

Margaret Jamieson: Some of us have been

members of the union for more years than we would want to declare.

The Convener: I welcome the representatives from Unison. You represent a work force that is incredibly important to the health service in Scotland and therefore to the members of this committee. We are here today to talk, ask questions and take evidence specifically on the budget. As I explained, we will ask questions along those lines, rather than including some of the more expansive questions that we might ask you at future meetings. We have all read your paper. I ask you to make a short introduction.

Eddie Egan (Unison): I am chair of the Unison health committee in Scotland. With me are Jim Devine, head of health for Scotland, and John Gallacher, lead officer for staff governance. I thank you for giving us the opportunity to come before the committee today. I shall leave most of the replies to my colleagues, but I shall respond when appropriate.

Janis Hughes: In your submission, you identify a number of concerns, such as pay, morale and work load. Is it possible to quantify the effect that those have on the service's ability to achieve targets?

Jim Devine (Unison): The ethos of the Scottish health committee of Unison is equality, care, dignity and accountability, not only for the staff, but for the patients and clients to whom we provide a service. The problems that you mentioned are difficult. Our members are committed to the service, but we have major difficulties in recruiting and retaining staff for the salaries that are being paid, which start at around £4.05 an hour for the ancillary sector. Medical secretaries in Scotland are currently in dispute. The maximum salary for medical secretaries is around £12,000, although they have clear and crucial responsibilities. For example, they are essential to the Government's waiting list initiative. At any given time in North Glasgow University Hospitals NHS Trust, one in three of those posts is vacant, and it takes 20 weeks to fill the vacancy. Across Scotland, the ability to recruit and retain those staff is a major problem.

Janis Hughes: Your submission raises a number of important concerns for Unison and for anyone involved in the health sector. In questioning witnesses about the budget process, however, we are trying to elicit information about the correlation between the budget process and the national health service plan. Can you quantify more specifically how you think the budget and the plan correlate? Do you think that there are areas in the NHS plan that it will not be possible to fulfil because of what is in the budget? How will that affect your members?

Jim Devine: In fairness to the Government, I should say that we have record investment in the Scottish health service. This year, there has been an increase of more than 6 per cent, which we welcome. However, our proposals are about improvements and that is what we want to debate with the committee. We do not want slogans or scams; we want solutions. We have major concerns about the morale of the work force and about the blame culture in the Scottish health service.

We want to talk about fully funding the pay deals. The Scottish Government allocated a funding increase of 3.4 per cent. The pay increase this year for NHS workers was 3.7 per cent, but on the pay bill that means around 4 or 4.1 per cent. That 0.6 per cent difference may not seem much, but in a trust such as North Glasgow University Hospitals NHS Trust, £300 million of the £400 million budget is spent on salaries, so 0.6 per cent represents an immediate loss of £1.5 million. On top of that, you must recognise that inflation in the NHS is a lot higher than the inflation that you and I enjoy on the streets. That factor is not always taken into consideration.

Legislation, such as the working time directive, can also have an impact. An additional £20 million was allocated to the service by the Scottish Government. However, the Scottish Ambulance Service has calculated that it would cost in the region of £15 million for that service alone to implement the working time directive. We would therefore like pay deals to be fully funded. We would also like requirements arising from new legislation to be centrally funded.

Another concern about the budget is new Government initiatives. For example, a waiting list initiative may be announced without us having the practical costings or knowing the staffing implications. As Janis Hughes will know, we held emergency sessions on a Saturday morning, for which consultants were being paid in excess of £400, some nurses were getting additional money and some were not, and there was a mishmash with portering and domestic staff. We are concerned about the costing and funding of new legislation, pay and central initiatives.

Dr Simpson: The committee has been trying to tease out what is actually new money for new developments, which is an issue that you have been emphasising. Would you like the budget document to contain figures for meeting the working time directive, which was agreed in October 1998? The directive is not new—it has not just arisen out of nowhere—so the costs that are involved should be planned costs. Would you like that to be spelt out in the budget, showing the amount that is to be used specifically to implement the working time directive? If the costs were drawn

in from all areas, such as the Scottish Ambulance Service, and put into the budget, would there be greater clarity?

Jim Devine: The health section of Unison has been debating that issue, and we are getting to the stage at which we may even want to separate the staff costs from all other costs. That would be exactly the scenario that you are painting, which would make the responsibility for staff very clear.

People do not fully appreciate that 78 per cent of the costs in the Scottish health service are tied up in staffing. We did not come to a conclusion on that matter, but initiatives from the centre, such as new legislation, the working time directive and the junior doctors' pay deal, will have a major impact on the Scottish health service. The problem is that, although new money is coming in, expectations are constantly being raised. If those expectations are not met, staff and patients will become disillusioned.

Dr Simpson: I am in the Manufacturing, Science, Finance union, which has been fighting for increased pay for laboratory staff. This year, we secured an 11 per cent increase, but that money cannot be used again.

Jim Devine: Absolutely. I totally agree.

Margaret Jamieson: In your responses to Richard Simpson and Janis Hughes, you seemed to indicate that there should be greater central control on the money for initiatives such as the working time directive and the junior doctors' pay deal. Do you think that there is a danger that too much central control would lead to the ring fencing of funds and the cessation of the creative work that many health boards and health trusts are doing, using their flexibility to redesign services?

Jim Devine: You mention progressive work, Margaret. You know probably better than anyone around the table the impact that Unison had on the issue of local pay bargaining. Since the reduction in the number of trusts from 47 to 28, a doctor can be in the ludicrous position of working in Monklands hospital, Law hospital and Hairmyres hospital, which are all within the same trust, on differing terms and conditions. Our submission highlights the need to consider the harmonisation of terms and conditions throughout Scotland.

We are keen that the NHS should use its flexibility in service delivery to make the developments that you are talking about. That is why Unison is central to the job evaluation scheme that will take place in advance of agenda for change, which will give local flexibility for service delivery while ensuring minimum standards of terms and conditions throughout Scotland. We are keen on that, but it does not take us away from the central issue of fully funding the pay deals or of ensuring that the requirements of new legislation are fully met.

Margaret Jamieson: How would a one-off payment make any difference to the standardisation of the terms and conditions, which would involve an annual cost?

Jim Devine: We are concerned that the introduction of agenda for change will hit the NHS financially. If agenda for change is implemented next year, any job evaluation scheme that has been introduced anywhere will lead to an immediate 4 or 4.5 per cent increase on the pay bill, because the people who are on a higher grade but who might not meet the evaluation for that grade are given protection and those people who should be on a higher grade go on to that higher grade. It is in anticipation of that that we are suggesting that we standardise all terms and conditions throughout Scotland.

Margaret Jamieson: How does that correlate with the budget that we are discussing?

Jim Devine: You are talking about the budget for 2002-03. Agenda for change is due to be operational by next April, potentially.

Margaret Jamieson: Potentially?

Jim Devine: The trade unions in Scotland take the view that, if we are to implement agenda for change, it should not be phased in and we should not end up with advance trusts or hospitals. We want the whole country to adopt agenda for change simultaneously. If that does not happen, an early implementation scheme in Lanarkshire Health Board, for example, will create problems for Glasgow Health Board, Forth Valley Health Board and surrounding areas, especially with regard to staff such as physiotherapists. Scotland is far too small to have early implementation in just some areas. The whole of the country must implement agenda for change simultaneously, which is why Unison is pushing for its implementation next year.

Margaret Jamieson: Have you examined the budgets that are being proposed for specific health boards? As one of the local MSPs, I have been involved in the budget process in the Ayrshire and Arran Health Board area and I am aware that money has been set aside for the standardisation of terms and conditions. Given that that health board has managed to retain its flexibility as it moves towards standardisation and that there is an accountability review process, does the money have to come from the centre?

11:00

Jim Devine: Quite rightly, you are telling us where the new money is going, but we are trying to tell you where we think difficulties will arise. Everyone, including our members, wants service delivery to improve and wants our clients to

receive quality care. The difficulty is with the potential gaps in the system. You describe the situation that Ayrshire and Arran Health Board is in. We do not know about that. We have raised the issue recently through the Scottish partnership forum and through the Scottish pay reference information group, but we have not received the information from the health board that you mention.

Shona Robison: I should perhaps have declared earlier my 10-year membership of Unison.

I have a question for Jim Devine. Did you say that the pay deal would deliver a 3.6 per cent increase?

Jim Devine: The vast majority of staff have received a 3.7 per cent increase.

Shona Robison: Average earnings across Scotland have risen by 4.5 per cent in a comparable period. Would it be fair to say that health sector workers are not keeping pace with average earnings?

Jim Devine: For the first time in three years, we have had above-inflation pay rises, which we welcome. Unison's policy, as you will be aware, is for a minimum salary of £5 an hour and we will continue to campaign for that, as we view it as a sensible investment. I spoke about medical secretaries earlier. A high turnover of such staff means that, although they are being invested in and trained to a specialist level, they are moving on to other positions in the public sector or the private sector. We need to think in the short, medium and long terms on issues such as pay.

Margaret Jamieson: One way to link spending with better pay and conditions would be through the accountability review process that is held by the Scottish Executive health department and the local health boards and trusts. Do you know whether any of those topics are covered under the present arrangements? Has the health department discussed including pay and conditions in future accountability reviews?

Eddie Egan: What is discussed in the accountability review meetings is kept from us. The process is almost secret; it is certainly not open and transparent. At this stage, we have partnership working in the basement but a different type of partnership working on the top floor. Our position on the accountability review is that we should wait and see. However, we do not trust the current process.

Margaret Jamieson: Would it make a difference if there were staff involvement in the accountability review process and if the discussions were about how this year's budget was to be spent rather than about how last year's budget was spent? Discussions about last year's budget usually take the form of having a nice cup of tea and patting everyone on the back to congratulate them on how good they have been.

Eddie Egan: Yes, that would make a difference. Since the establishment of the Scottish Parliament, the situation has improved and there is some discussion about budget allocation and spend. Historically, we had already spent the money by the time someone told us how much we were getting and we did not know whether we would find ourselves underfunded, overspent or under budget.

John Gallacher (Unison): A lot of work is being done to deliver a new performance assessment framework in the health service. We welcome the guidance by Trevor Jones, which was published yesterday. It outlines the health service financial management framework, which in our recent experience has been a closed book and has mainly involved talks behind closed doors between the chief executives and managing directors of boards.

Committee members will be aware of the budget-setting process in local authorities in which, year on year, the trade unions and other interested groups are brought into an open and public debate about the annual allocation of resources; more recently, that debate has been about the allocation of resources over a three-year period. Trevor Jones's guidance talks about broadening the financial management framework to allow such flexibility over three years. Furthermore, having an employee director on the new unified boards will give us unprecedented access to financial information and the financial planning of service delivery.

The committee is struggling to unravel how that money is spent; indeed where the money goes is largely a mystery. We welcome any guidance that opens up and shines a light on the process, as well as the involvement of the trade unions from day one. It is vital that we know which services are receiving money and which are not.

Margaret Jamieson: Your membership and the members of other organisations will obviously be involved in deciding whether the money is spent on a, b, c or d. By having such ownership, you will be able to address the issues that Mr Devine raised about which aspects of the service have a claim on funding. That will make the system much fairer. I do not think that in my lifetime we will have the money to meet all the expectations of the Scottish public.

John Gallacher: In the context of the strategic planning of investment in services, we must also consider issues connected with terms and conditions. However, that is being put on the back

burner. We need to examine the new costs associated with those issues, but that discussion is being excluded from the partnership agenda. Our membership wants us to use the partnership process to deliver real improvements in pay and conditions, but we are still being told that such improvements need to be met through efficiency savings from existing budgets. For example, at the Inverclyde royal hospital in Greenock, one group of catering staff is on bonus while another is not. It will probably cost less than £50,000 to rationalise the situation, but the trust has said that it cannot afford to do so, even though its pay bill is about £12 million. It is ridiculous to claim that that money has to be found from cuts made elsewhere. Such issues must be identified clearly and the costs of their standardisation written into the bottom line of the budget, so that year on year we know that staff costs are a given and that there are no variations between board areas and trusts.

Mary Scanlon: I should declare that I am not a member of Unison.

The Convener: We had guessed that.

Dr Simpson: You can get an application form afterwards.

John Gallacher: I thought that we had a quorum at the meeting today.

Mary Scanlon: I think that I am the only committee member who is not a member.

In your submission, you criticise the Scottish Executive health department by suggesting that all central initiatives should be costed. However, you do not seem to have costed some of your proposals. For example, you have not costed fully funded pay deals, the financial implications on the NHS of legislation such as the working time directive and the one-off payment to the health service to standardise terms and conditions. Moreover, you have not provided the costs of removing private contractors from the NHS and re-establishing salaried nurses. You have written your own agenda for change, but how much would it cost to implement your proposals?

Jim Devine: We do not want to come to the Parliament and be negative about the situation; instead, we want to establish a partnership with the Parliament and this committee, because they play a crucial role and their decisions have an impact on health service workers. The costs that you ask about will depend on the differential between what the Scottish Government allows for a pay increase and the actual pay increase. This year, that figure is about £18 million. Furthermore, the money to implement the working time directive will probably fall about £16 million short this year. We believe that on-going costs should be met.

You raised the issue of private contractors. This year, it is costing us £21 million more to treat individuals who have contracted hospital-acquired infections. It is no coincidence that there has been an increase in hospital-borne infections at the same time as there has been a dramatic fall in the number of domestic staff working in the wards and support services have been privatised. According to figures released last week by the Executive, 70,000 people a year were suffering injuries and contracting infections in hospital. That situation could be avoided and money could be saved.

Likewise, the establishment of salaried student nurses would be an efficient and cost-effective measure. It costs £35,000 to train a student nurse but, depending on the university, 25 to 35 per cent of student nurses leave before they complete their training. The main reason for that is that many of them are living in poverty. We pay student nurses bursaries. They also differ from other students because, in the summer, they have to work in the health service to make up their hours instead of simply working in a hospital, factory or whatever to earn money. If they were salaried, they would be employed by the health board and would have employment protection rights. Furthermore, the many female student nurses would also qualify for maternity rights. If we introduced that measure, there would not be such a high turnover in that group. The strategies and initiatives that we have proposed will save money.

Mary Scanlon: None of us would disagree with some of your points, particularly on hospital-acquired infections, which I understand affects about 10 to 11 per cent of beds.

I have two questions about what you have just said. Although I am not an expert on the private finance initiative, I understand that public-private partnerships have to be costed and that the contracts are awarded on the basis that they represent the best-value option compared to the public sector. Are the costs of PFI therefore higher than public sector costs? Surely that suggestion goes against the basic belief about PFI.

Margaret Jamieson: Did you get that message from central office this morning? You will be signing up to the Labour party as well as to Unison.

Mary Scanlon: I was referring to the suggestion that had been made. However, the proposal to save money by removing private contractors from the NHS does not fit in with existing contractual arrangements.

Secondly, on the connection between the number of domestic staff and hospital-acquired infections, your submission says that

"the throughput of patients"

rose

"from 60 in 1985 to 301 per domestic".

There should be minimum standards to ensure that cleanliness and hygiene are implemented throughout the NHS.

Eddie Egan: We are not saying that PFI is always a more expensive option, but we are saying that it is a demonstrably more expensive way of building new facilities, from the very small to the very large. Did we compare like with like? If the comparison is between an apple and a pear, all we can say is that we have two different fruits. However, in this case, as we are comparing an apple with an apple, PFI is significantly more expensive. We have much evidence that the PFI schemes in Scotland are more expensive than the amount of money that we receive in revenue and capital from other sources—we would be happy to furnish the committee with that data.

Mary Scanlon: Are you saying that the system for scrutinising and checking the contracts is wrong? It is supposed to save more money.

Eddie Egan: The system and the principle are wrong.

Dorothy-Grace Elder: Can I ask a supplementary on that point?

The Convener: Hold on a minute. I understand that the Finance Committee is undertaking a full inquiry on PFI.

Dr Simpson: Yes. That is the subject of our next inquiry.

The Convener: No doubt that committee will be asking for submissions. I am sure that we will be happy to see any copies of Unison's submission on the issue.

I am aware that PFI was one of Shona Robison's lines of questioning. I do not want the committee to have a complete free-for-all, so I ask Shona to put specific questions on the subject.

Shona Robison: On PFI, for the record, it would be useful if you could give us a ball-park figure for the significantly higher costs to which you refer and the implications of those higher costs for the budget. Is it fair to say that there will be a knock-on revenue cost? If so, are we talking about a knock-on effect of fewer employees or worse pay and conditions?

11:15

Jim Devine: We are opposed to PFI because every scheme has privatised the poached staff, reduced the number of beds, cut the number of nurses and diluted the skills mix to make profit for private companies. The scheme that we have identified here was a £4 million one with a profit margin of around £200,000. It is fair to say that the profit margins of PFI schemes are, on average, around 5 per cent. The PFI strategy runs contrary to statements of the Health and Community Care Committee on ensuring that we have model employers and on creating an NHS family. We have carried out a lot of good work on partnership information network guidance, working in partnership with the Government and management on a Scottish basis.

Eddie Egan: In answer to the first question, the cost of PFI could be measured in tens of millions of pounds per annum by the time the PFI is finished. I am not an accountant; I am a charge nurse who is also involved in Unison, so I am at the sharp end and see what PFI does.

Secondly, of course PFI will have a knock-on effect. All the PFI schemes will be guaranteed their money. When it comes to planning budgets and identifying which bit of the budget is for which particular element, one of the first boxes to be filled will have to be the money for the PFI projects, as they are guaranteed it. Even if there is less money available or more is required, their chunk of the cake is guaranteed. That means that the rest of the service may have to subsidise the PFI schemes—not just next year, but for the next 30 years. That is like someone buying a house that they never own and which they can be told to leave after 30 years when it is returned to its owner.

Therefore, PFI has potentially significant implications for future revenue. If whoever owns the new royal infirmary, for example, says after 30 years, "We can now get more money for that building to spend on something else," this committee or its successors will have to find a new royal infirmary or a new Tippetthill hospital. The figures that Jim Devine talked about are an additional £200,000 on top of the figures that were demonstrated for the new Tippetthill hospital, which was a £2.2 million project. Such figures can be significant if they are multiplied throughout Scotland.

Shona Robison: Would you support an alternative to PFI such as the Scottish Government having borrowing powers?

Jim Devine: We welcome the fact that the Finance Committee will investigate that possibility, as we have been campaigning for it. We will make submissions stating our opposition to PFI. As we state in our paper, we are open-minded about a broad range of options, but we think that PFI is not a good option.

The Convener: I have a final question, to which I hope that you will provide a brief answer. Proposal 10 of your paper is:

"Extend the role of the Scottish and Local Partnership Forums to include financial planning and management."

What kind of involvement do health service staff have in the budget process?

Jim Devine: They have none at present. However, as John Gallacher mentioned, Trevor Jones's paper has been very helpful. John has undertaken much work on staff governance, and we are considering putting a staff member on the new, unified board. We are looking forward to being involved in the decision-making process. The Scottish Partnership Forum is a new concept in industrial relations and ways of working. Our argument has always been that economic partnership is necessary for proper partnership. Trevor Jones's paper from yesterday points us clearly in that direction, and we welcome it.

The Convener: Thank you very much for your evidence.

Mary Scanlon: I did not get an answer on hospital-acquired infections and the minimum standards.

The Convener: We can ask for a written answer on that. The clerks will write to the witnesses with that question.

Dorothy-Grace Elder: May I also have a written answer? When you were talking about PFI, you—

The Convener: No, Dorothy-Grace. Mary Scanlon asked a question that was not answered, but we have now run out of time. The Finance Committee will investigate PFI in detail, with a lot more back-up from the finance side than is available to us—I mean no disrespect to Andrew Wilson. Andrew sits on the Finance Committee, and I am sure that he can ask any questions that you may have on PFI.

Andrew Wilson has joined us today as the reporter from the Finance Committee on the budget process. The Finance Committee has commissioned a report, which Andrew would like to bring to our attention. It contains some interesting points on the health budget that relate to some of the work that we undertook last year on the budget. I am afraid that we have only a few minutes in which to address the matter.

Andrew Wilson (Central Scotland) (SNP): I shall be brief. As a reporter, I do not have a hands-on role. I shall read about your activities and report back to the Finance Committee. Richard Simpson knows what we are doing anyway. You have received a guidance note from the Finance Committee, convener. The fundamental questions are whether the health budget is adequate and whether it is being allocated properly.

We commissioned research from Arthur Midwinter and Jim Stephens—who are known to some members—on two important issues that are unique to the health budget. The first issue is the fact that 71 per cent of expenditure is spent on labour, which incurs a specific type of cost inflation. To what extent do increases in the health budget—every year sets a new record in health spending—buy new things in terms of outcomes? We must focus on the outcomes. Over the past 30 years, labour costs in the health budget have risen nearly twice as fast as inflation in the economy as a whole. Therefore, just to stand still and buy the same things, health budgets must increase faster than inflation.

I ask members to drill into the Finance Committee report to see what outcomes will be bought for the new increases that the health budget is getting. Over the past 10 years, health inflation was 4.8 per cent on average. If the health budget had not increased by 4.8 per cent over the past 10 years, it would not have stood still—it would have gone backwards. That is significant. The committee's inquiry last year included a lot of work on the health budget, which was very useful to the Finance Committee.

The second important issue is the scope for change in the budget. Arthur Midwinter and Jim Stephens conclude that there is limited scope for change in budgets that have already been allocated. Nevertheless, the health budget will receive £460 million of new money this year. If the committee identifies the proportion of that new money that has already been claimed, through pay increases, the effects of the working time directive and so on, it will have a better idea of the scope that it has for suggesting changes.

That should not be the limit of the committee's ambitions. The guidance is different this year, and the committee is asked to consider whether the overall health budget is adequate. We can consider whether other aspects of the Scottish budget might be less important than health. The intention is to engender a slightly more animated debate about the budget than we have had over the past year, when the debate has been compartmentalised and restricted. The committee should not set any limits on its ambitions for the health budget. We all know that there are reality constraints, but the committee should define its ambitions in terms of outcomes and tell us whether the health budget is adequate. We can then investigate how health requirements might be met.

I hope that that introduction has been helpful. Those points should be drawn to the attention of your adviser, and the Finance Committee will be happy to help. I shall leave it at that, unless members have any specific points to raise.

The Convener: I like to think that there is no limit to this committee's ambitions. Thank you for sharing that information with us. If any members of the committee want a copy of the report, they can

get one from the clerks.

Mary Scanlon: A significant part—about 10 per cent—of the budget that we discussed last year was the drugs budget.

The Convener: There is some information on the drugs budget in the report.

Andrew Wilson: The drugs budget is significant. Interestingly, the report states that, if wages are taken out of the equation, inflation in health procurement is not increasing faster than general inflation. The drugs budget may be, but overall health procurement is not. I do not know why—we have not managed to drill into that. The key finding is that health inflation in wages is far and away the most important factor. Drugs is an interesting specific aspect but, as it is such a small part of the budget, whereas wages constitute 71 per cent of the budget, we suggest that the committee should look more closely at the wage position first. Richard Simpson knows about all this, and he can feed back on the budget as well.

Subordinate Legislation

The Convener: The next agenda item is subordinate legislation. The first instrument for consideration is the National Assistance (Assessment of Resources) Amendment (No 3) (Scotland) Regulations 2001 (SSI 2001/138), which was circulated to members on 25 April 2001. No comments from members have been received. The Subordinate Legislation Committee has no comments to make. No motion to annul has been lodged, so I recommend that the committee make no recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement*.

The Convener: The NHS 24 (Scotland) Order 2001 (SSI 2001/137) was circulated to members on 25 April 2001. The Subordinate Legislation Committee has no comments to make. No motion to annul has been lodged.

Mary Scanlon: The order means an enormous change in the NHS. Three days were given for the committee to consider the order between its being placed in Parliament and its implementation.

Given the enormity of the order, the Parliament or the Health and Community Care Committee should have been able to have at least some input into the debate. In contrast, there was considerable discussion about the Food Standards Agency and I want to put down a marker. When there is such a huge change in the NHS, Parliament should be given more than three days' notice.

The Convener: If the committee agrees, I am happy to write to the Executive to say so. Otherwise, I recommend that the committee make no recommendation in relation to the instrument.

Members *indicated agreement*.

Regulation of Care (Scotland) Bill: Stage 2

The Convener: Agenda item 3 is stage 2 of the Regulation of Care (Scotland) Bill. I welcome Malcolm Chisholm and the bill team.

After section 27

The Convener: Amendments 68, 70, 71, 72, 73, 74, 75, 133, 69 and 77 are all in the name of the minister and have previously been debated with amendment 62. Does any member object to a single question being put on the amendments?

Members: No.

Amendments 68, 70 to 75, 133, 69 and 77 moved—[Malcolm Chisholm]—and agreed to.

Section 28—Constitution of Scottish Social Services Council

The Convener: Amendment 220 is grouped with amendment 221.

Janis Hughes: Amendments 220 and 221 are in the spirit of previous amendments that Kate MacLean and I lodged to encourage equal opportunities in the bill and necessitate the observance of equal opportunity requirements in legislation.

I move amendment 220.

11:30

The Deputy Minister for Health and Community Care (Malcolm Chisholm): Members will recall that we discussed amendment 123, which was lodged by Kate MacLean, at the committee's first meeting at stage 2, together with amendment 99, which introduced equal opportunities provisions for the Scottish commission for the regulation of care. We accepted the equal opportunities provisions for the commission and it follows that equivalent provisions should also be inserted for the Scottish social services council. However, it is better to include the necessary provisions in section 28(2) rather than subsection (1) where amendment 123 would have placed them. Subsection (2) is about the functions of the council. Janis Hughes has recognised that by lodging amendment 220, which I am happy to accept.

Amendment 221 will require Scottish ministers to have regard to equal opportunities policy when deciding on appointments to the council. We support that principle and I am happy to accept the amendment. Amendment 102, which Janis Hughes also lodged, added a similar provision to schedule 1 on commission appointments.

The Scottish Executive is committed to promoting equality of opportunity for all. In support of that commitment, the Scottish Executive is taking a new strategic approach to ensure that equality of opportunity is at the heart of policy making. I am happy to accept amendments 220 and 221.

Amendment 220 agreed to.

Section 28, as amended, agreed to.

Schedule 2

Amendment 221 moved—[Janis Hughes]—and agreed to.

The Convener: Amendment 21 is grouped with amendments 22, 23, 24 and 25.

Malcolm Chisholm: The committee will recall that I lodged a series of amendments at our first stage 2 session to adjust the composition of the board of the commission. Amendments 21, 22, 23, 24 and 25 make similar provision for the board of the council.

Schedule 2 to the bill makes provision as to the constitution of the council. It specifies the groups that should be represented on the board and enables ministers to make regulations for the appointment of the convener and members of the council.

Amendments 21, 22, 23 and 24 will alter the proposed membership of the council's board. As it stands, schedule 2 requires appointments to balance the interests of various stakeholder groups. We now consider that such an approach would not provide the most effective model of management for the council. We therefore propose that the board should be relatively small and that members should be selected on the basis of their management abilities.

The requirement for a balance of interests creates a tendency towards a large board and makes it more difficult for ministers to appoint on the basis of individual ability. However, we want to ensure that those registered with the council and the users of services and their carers have a direct voice at the heart of the council.

To that end, the amendments provide that at least two places on the board will be reserved for users and carers and two for those registered with the council. Other members of the board will be appointed on the basis of their managerial abilities rather than as representatives of particular stakeholder groups.

Amendment 25 will enable the council—like the commission—to pay pensions, allowances and gratuities to its employees. As it stands, schedule 2 makes provision for the appointment of the council's staff, but does not allow the council to

make those payments.

We expect about 16 staff who are currently employed by the Central Council for Education and Training in Social Work to transfer to the council and we have given an undertaking that they will do so on terms and conditions that are no less favourable than those they currently enjoy. That cannot happen unless we amend the bill to allow the council to pay pensions, allowances and gratuities. The council will also employ new staff and will need to be able to make such payments to them too.

In summary, amendments 21, 22, 23 and 24 are designed to ensure effective management and operation of the Scottish social services council. At the same time, they allow users of services and their carers and those registered with the council to have a direct say in the operation of the body.

Amendment 25 will give the council the powers necessary to pay pensions, allowances and gratuities to all of its employees.

I move amendment 21.

Shona Robison: I have a question about user and carer involvement, which has been a contentious issue. User and carer organisations were concerned that they were not going to get the required level of representation. Is it fair to say that user and carer organisations are more satisfied with this new arrangement for representation?

Malcolm Chisholm: I have not had any representations to say that they are dissatisfied with what is proposed—that is all that I can go by. I am not aware that they have been making that point to other members. My understanding is that they are satisfied with the proposals.

Shona Robison: The selection process is not laid down; how will it work?

Malcolm Chisholm: The positions will be advertised.

Amendment 21 agreed to.

Amendments 22, 23, 24 and 25 moved—[Malcolm Chisholm]—and agreed to.

Schedule 2, as amended, agreed to.

Section 29 agreed to.

Section 30—Applications for registration

Amendment 134 moved—[Malcolm Chisholm]—and agreed to.

Section 30, as amended, agreed to.

Section 31—Grant or refusal of registration

The Convener: Amendment 78 is grouped with amendments 79 to 82.

Malcolm Chisholm: Section 31(1) lists the conditions that an applicant must satisfy in order to be registered with the social services council. Once the application has been considered against those conditions, the council has the option of granting the application unconditionally, or subject to conditions. Otherwise, the application is refused.

Amendments 78 and 79 will ensure that the options that are open to the social services council for granting applications for registration are stated clearly at the start of section 31 and in a way that leads logically to the decision making and appeal process. That would improve the clarity of the bill.

Section 32 allows the social services council to give notice to a registered person that it proposes to vary or remove an existing condition of registration. Alternatively, the council could impose a new condition. No such notice is needed when the council completes its initial assessment of an application and decides to grant an application subject to conditions, or to refuse an application. We think that such notice is desirable.

Amendment 80 will require the social services council to give notice to an applicant of a proposal not to grant an application unconditionally, and so require the same of the council at the outset under section 31 and later under section 32.

We are committed to openness and transparency in all aspects of the work of the social services council. It is therefore important that the council gives reasons to applicants and registered people for proposals to refuse an application for registration, impose conditions on registration or vary or remove such conditions. Amendments 81 and 82 would require the council to provide reasons for such proposals.

Amendment 82 would also remove section 32(2), which requires the social services council to set out in rules how procedures under section 32 will operate. That is to allow the provision to be clarified and strengthened. The next group of amendments that we will discuss—amendments 83, 84 and 85—replace section 32(2) and place appeal procedures in the bill for applicants and registered people who are given notice under sections 31 and 32.

Each of amendments in the group will strengthen the bill and, accordingly, I urge the committee to accept them.

I move amendment 78.

Amendment 78 agreed to.

Amendments 79, 80 and 81 moved—[Malcolm Chisholm]—and agreed to.

Section 31, as amended, agreed to.

Section 32—Variation etc. of conditions in relation to registration under this Part

Amendment 82 moved—[Malcolm Chisholm]—and agreed to.

Section 32, as amended, agreed to.

After section 32

The Convener: Amendment 83 is grouped with amendments 84 and 85.

Malcolm Chisholm: As I said when we discussed the previous group, the amendments in this group clarify and strengthen the provisions that were in section 32(2), which we have just agreed should be removed.

Amendments 83 and 84 would provide an applicant with a right to make written representations against a decision by the social services council to refuse an application or to grant an application subject to conditions. The amendments would also provide a registered person with a right to make written representations to the council about a proposal to vary or remove a condition of registration, or to impose a further condition, or about a decision to remove, suspend, alter or restore an entry in part of the register.

The amendments would provide a staged process for an applicant or a registered person to appeal to the social services council against its decisions. They would allow the council to reconsider its decisions on the basis of written representations from an applicant or registered person.

The amendments would avoid the need for matters that could be resolved between an individual and the social services council to be referred unnecessarily to the sheriff. They would relieve the courts from being burdened with cases that should rightly be considered by the council in the first instance. The inclusion of deadlines for representations and appeals should ensure that matters are dealt with promptly and that final decisions are not delayed.

Amendment 85 follows from amendments 83 and 84. It clarifies the circumstances in which an applicant or a registered person can appeal against the decisions of the social services council to the sheriff, and provides a time scale. A staged process of appeal is beneficial and cost effective for all involved. The amendments will strengthen the bill.

I move amendment 83.

Amendment 83 agreed to.

Section 33 agreed to.

After section 33

Amendment 84 moved—[Malcolm Chisholm]—and agreed to.

Section 34—Appeal against decision of Council

Amendment 85 moved—[Malcolm Chisholm]—and agreed to.

Section 34, as amended, agreed to.

Section 35 agreed to.

Section 36—Codes of practice

The Convener: Amendment 216 is grouped with amendment 217.

Dr Simpson: I make a declaration that I work for Nursing Home Management, which is a company that operates nursing homes in England and Wales.

Amendment 216 seeks to provide a guarantee of consultation to care service providers. That is of particular importance to providers in the voluntary sector, under the terms of the Scottish compact. The voluntary sector has suggested to me that the amendment should be moved to guarantee their rights of consultation.

Amendment 217 makes a similar amendment to section 40.

I move amendment 216.

11:45

Malcolm Chisholm: Section 36 requires the social services council to prepare and publish codes of practice for social services workers and employers of such staff. Before publishing any codes the council must have the approval of ministers and consult the commission and any other persons that the council or ministers consider appropriate. Section 40 deals with the council's powers to make rules about registration. That includes powers to require particular groups of registered staff to undertake additional education and training. Before making or varying rules about such education and training, the council must consult staff who are likely to be affected by the rules, and other persons as appropriate.

Amendment 216 would require the council to consult employers and potential employers of social services workers before publishing a code of practice. Amendment 217 would require the council to consult employers of people on the relevant part of the register before making or varying rules about additional training and education. Although consultation will almost certainly include employers or potential employers,

it might also include for example, registrants, training providers or—in the case of the codes—service users. It might include training providers in the case of the rules that are outlined in section 40(3).

It would be inappropriate, therefore, to single out employers or potential employers in the bill as if they were the most important group but, as I said several times during stage 2, we will consider all the consultation provisions in the bill to ensure that they are appropriate and consistent, before we reach stage 3. I will bear in mind what Richard Simpson said about the compact with the voluntary sector as we do that. The provisions will be included in the general review of the consultation procedures. On that basis, I ask Richard Simpson to withdraw amendment 216.

Dr Simpson: Given the minister's assurances, I am happy to withdraw the amendment.

Amendment 216, by agreement, withdrawn.

The Convener: Amendment 185, in the name of John McAllion, is in a group of its own. John is in Westminster today. Does anyone else wish to speak to and move his amendment?

Margaret Jamieson: John McAllion has raised the issue the amendment concerns with the minister on several occasions.

I move amendment 185.

Malcolm Chisholm: Section 36, to which the amendment relates, requires the council to prepare and publish codes of practice for social services workers and for employers of such staff. The purpose of the codes is to increase the professionalism of the work force and improve public protection. In the case of care services that are regulated by the Scottish commission for the regulation of care, adherence to the codes will be enforced through inspections that are carried out by the commission, as provided for in section 5(3). For local authorities employing field social workers, the social work services inspectorate, as part of its normal inspection programme, will review—alongside other issues—local authorities' performance against the code for employers and their methods of assuring that fieldworkers adhere to the code for staff.

Amendment 185 would place a particular responsibility on chief social work officers in local authorities to ensure that local authorities comply with any code that is published by the council. It is not appropriate to single out local authorities or to tie their hands in that way. They will require to adhere to any code in the same way as all other employers of social services workers. It should be for employers to determine how to ensure compliance with the codes within their own organisations. In the case of local authorities, chief executives should be able to delegate that responsibility to the appropriate officer or officers. The appropriate person will not always be the chief social work officer. In the case of early-years provision in schools, the appropriate person will be in the education department. For housing support services, they will be part of the housing department.

I invite Margaret Jamieson, on behalf of John McAllion, to withdraw amendment 185.

Margaret Jamieson: John McAllion did not give me any instructions, but I am happy to withdraw the amendment.

Amendment 185, by agreement, withdrawn.

Sections 36 agreed to.

Sections 37 to 39 agreed to.

Section 40—Power of Council to make rules

Amendment 217 not moved.

Section 40 agreed to.

Section 41—Functions of the Scottish Ministers under this Part

The Convener: Amendment 186, in the name of John McAllion, is grouped with amendment 187.

Margaret Jamieson: Amendment 186 would underpin some of the work-force planning issues that have been raised in the consultation on the bill. It would allow that proper cognisance be given to work-force planning and that training and staff development was in place. The belief behind the amendment is that it will result in a better-trained and better-qualified work force, which would assist in bringing about confidence in the social care work force and among the public.

Amendment 187 would block a potential loophole whereby unqualified social workers could be employed to undertake inappropriate tasks. There are areas where only qualified social workers are required to provide reports, especially in relation to the courts and the Adults with Incapacity (Scotland) Act 2000 and for the children's hearing system.

I move amendment 186.

Malcolm Chisholm: Section 41(1) lists the functions of the Scottish ministers with regard to work-force planning for the social services. The intention is to delegate all those functions to the social services council, as provided for in section 41(4). The functions are central to the work of the council. Ministers will be kept informed of progress through the council's annual report and corporate plan, and through its regular contact with the sponsor division in the Executive.

Amendment 186 would add promotion of the work done by social services workers to the list of functions. That promotional work, however, needs to be a shared responsibility. Employers, professional bodies, unions, national training organisations—including the NTO for the personal social services—the Scottish ministers and the council all need to be involved. It would therefore not be appropriate to legislate for ministers to carry that responsibility alone.

Accordingly, I ask Margaret Jamieson to withdraw amendment 186.

We acknowledge that the council will need to undertake work to clarify the functions of social workers, as background to its activities in relation to registration, education and training. We do not agree, however, that it is appropriate for the functions to be set out in regulations, as is suggested in amendment 187. Service users and employers increasingly require a flexible response from social workers. To set out their functions in regulations would inhibit what must be a dynamic service. The functions will undoubtedly develop and change over time. Regulations would also present a barrier to multi-professional working, which is crucial to the sector.

It would be difficult to determine functions that could be carried out only by social workers. Many of their activities are quite properly also carried out by other social services employees and other professionals. Counselling, for example, is often a major part of the work of social workers, but they do not have a monopoly on counselling skills. Another example is care assessment. Joint working means that social workers often share assessment work with nurses, occupational therapists and others. While the social worker brings particular skills and perspectives to that work, it would be inappropriate to specify in regulations that care assessment is an activity that is exclusive to social workers. A flexible approach that encourages joint working is required.

In trying to describe functions that are exclusive to social workers, it is likely that any regulations would lead to a very narrow definition of social workers. That could lead to individuals with appropriate qualifications and experience being unable to call themselves social workers. I should add that I see protection of title as a different issue. While the regulations proposed by the amendment would hinder the profession, protection of title—as provided for in section 35—is an important way of increasing professionalism and raising standards. Protection of title can be achieved through allowing only individuals who hold an appropriate qualification—a diploma in social work or its equivalent—to call themselves social workers.

I invite Margaret Jamieson not to move amendment 187.

Amendment 186, by agreement, withdrawn.

Amendment 187 not moved.

Section 41 agreed to.

Meeting closed at 11:55.

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