HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 31 October 2001
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
24th 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

WITNESSES

John Aldridge (Scottish Executive Finance Department)
Malcolm Chisholm (Deputy Minister for Health and Community Care)
Jim Devine (Unison)
Jim Dickie (Convention of Scottish Local Authorities)
Sandra Dickson (Convention of Scottish Local Authorities)
Joe Di Paola (Unison)
Eddie Egan (Unison)
Trevor Jones (NHS Scotland)
Councillor Ronnie McColl (Convention of Scottish Local Authorities)
Neil McConachie (Association of Health Boards' Chief Executives)
Lorna McGregor (Convention of Scottish Local Authorities)
Douglas Philips (Association of Health Boards' Chief Executives)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

ASSISTANT CLERK

Graeme Elliott

LOCATION

The Chamber

Scottish Parliament

Health and Community Care Committee

Wednesday 31 October 2001

(*Morning*)

[THE CONVENER *opened the meeting at 09:43*]

Budget 2002-03

The Convener (Mrs Margaret Smith): Good morning everybody, and welcome to this morning's Health and Community Care Committee. The Minister for Health and Community Care is not with us this morning; we send her our best wishes for a speedy recovery. Malcolm Chisholm is here to answer questions on the budget in her stead. I am sure that he is looking forward to that. We also have John Aldridge—I think that this is all part of a plot by John to be the person who has attended more meetings of the Health and Community Care Committee than anybody else. We look forward to hearing his answers to our questions.

However, before we get into those questions, I want on behalf of my committee colleagues and myself to put on record our concern about the fact that answers from the Scottish Executive health department to questions that we asked in advance of this meeting were received only at about half-past 4 yesterday afternoon; I received those answers and then circulated them to committee members and our budget adviser Andrew Walker. As a result, Andrew was still working on those answers and on his work for the committee at 10 o'clock last night; he was unable to circulate his work to committee members until this morning. That is why we have started a little late.

Had this been the first occasion on which such a thing had happened, committee members might just have accepted it because our request went to the department only on 18 October and we appreciate that the department is very busy. However, on every other occasion on which we have asked for information from the department in advance of a budget meeting, the response has arrived at the very last minute. We do not have squads of staff behind the scenes to assist us in our work; it is very much up to members to formulate their opinions after having seen information and answers that we receive. When information that I request does not come in until half an hour before the end of the previous working day, I must say that I feel as if I am working with one hand tied behind my back.

I could go on more about this—perhaps it is just as well that I am talking to you this morning and that I did not do so at half-past 4 yesterday afternoon. I have made my views known to the deputy minister and, indeed, to the minister at a meeting I had with her last night. I have been urged by colleagues to put these views on record. That should be taken as an indication of how unhappy we are.

We are happy to accept the offer that the minister made in a letter, for senior officials from the Scottish Executive health department to meet members of the committee to explore the options for mutually acceptable future improvements to the budget document and the budget process. The committee would like to be as helpful as it can. When we ask questions, we genuinely just want the answers; we are not trying to trick anybody. Committee members want information so that we can give a reasonable response to the Finance Committee on a complex and important issue. Malcolm Chisholm knows, and we know, that the health department is a significant spending department. We must ensure that our scrutiny of the budget is as good as it can be, bearing in mind the limited numbers of committee staff.

The committee does not find the amount of information that we receive or the time when we receive it to be acceptable. We would be happy to work with the health department in future to improve the situation. However, the same thing has happened in October 2000, May 2001, August 2001 and now October 2001. That should be viewed against the backdrop of the committee having an incredibly heavy load in terms of legislation and other work. I hope that what has happened will not happen again.

The Deputy Minister for Health and Community Care (Malcolm Chisholm): I would like to respond to what you have said, convener. First, I pass on Susan Deacon's apologies. She has been unwell through the night and regrets that she cannot be here. I would also like to give an apology on behalf of the department. I am not going to try to justify the fact that you did not receive a reply until yesterday afternoon—I have noted the points that you made and I will ensure that it does not happen again.

I am glad that you have welcomed the health department's response about dialogue with the committee. I understand that the committee would like to address outstanding issues on the information and format of the budget document. We will be pleased to discuss those issues with you.

By way of self-protection, I would like to apologise in advance. I did not know that I would

be coming to the committee until less than an hour ago, so I am perhaps not quite as well prepared as usual.

The Convener: Members have been instructed to treat you gently—not too gently, but a little. We all appreciate that you have been drafted in at very short notice and that you have not had the same amount of time to prepare as your colleague would have had.

Nicola Sturgeon (Glasgow) (SNP): I do not remember any agreement to treat Mr Chisholm gently. He will forgive me if I break that agreement.

My first question relates to the decision-making processes in the health department. One of the questions that the committee asked was how you reach decisions about the allocation of new money. The answer that we received last night at half-past 4 gave a valid justification for each of the five areas to which the new money that was announced in June was allocated. Nobody in the committee is denying that any of those areas represent worthy causes. However, the point that the committee was making is that they are five out of dozens or perhaps hundreds of worthy causes. We would like you to talk us through the decision-making process that leads to the selection of one worthy cause over another. On what evidence do you base decisions that spending money in one area will have greater benefit than spending it in another area?

Malcolm Chisholm: I will begin by answering most of the questions and will then pass them to others for further comment.

The questions go to the heart of decision making in the health department, the Executive and the Parliament. So much of what we do is about relative priorities. We ranged over many important areas in the months before the decisions were made. At the end of the day, a judgment must be made.

Examples such as the cancer strategy leap out; it represents one of our three clinical priorities. We published the strategy during the summer. That was an easy decision to make, in a sense, because we must assign money to that. Susan Deacon will make an announcement next week about how the extra money for the first year of the cancer strategy is being allocated.

We are aware of the amount of interest and activity that there has been in work-force issues in general in the Parliament and particularly in nurses and their recent campaign. Given the importance of nurses and of recruitment and retention issues, nurse bursaries is clearly an important area.

The third area that I want to flag up is primary care. We are committed to a primary-care led NHS, so it is vital that there are developments in primary care, particularly in some of the key priority areas.

We are not saying that there are not many other areas in which money could be spent but, after long consideration of the various issues, it was not too difficult to decide that we had to put extra resources into those three priority areas. The extra money that came through from the Westminster budget arrived in good time to meet those demands.

Trevor Jones (NHS Scotland): We should stand back a wee bit. We must consider two issues when we are allocating funds to the NHS. The first is the cost of maintaining the existing level of service. We must take into account forecasts of inflation and the potential costs of pay awards. We need to get that cash out to NHS boards as quickly as possible. We must allocate funds to NHS boards to allow them to progress with local developments. We are increasing allocations at more than the basic rate of inflation to allow NHS boards to address local priorities.

As the minister said, we must then consider how we will fund national key priorities. The decision-making process is about striking a balance between centrally-funded national priorities and allowing NHS boards to address local issues and fund the cost of maintaining their existing levels of service.

On evidence, as we develop national policies we take into account clinical evidence about different forms of treatment and that sets the direction for services such as cancer treatment. As we allocate development funding, that determines the rate of change towards the new provision of service.

Mr John McAllion (Dundee East) (Lab): I want to pursue the point about getting right the balance between national and local priorities. Obviously only one—cancer—of the three national priorities is mentioned in the five priorities on which money is being spent. There is no mention of coronary care, stroke treatment or mental health.

In my area, the local primary care trust has been asked to find £600,000 of savings from mental health services this year. It seems strange to make mental health a national priority at the same time as mental health services are being cut back locally. Why is that happening?

Malcolm Chisholm: Historically there has been an issue about mental health not being given the same priority as the other areas to which John McAllion referred. NHS health board spending on mental health has increased significantly over the past two or three years. Last year there was an increase of about 7 per cent in NHS spending on mental health. We are moving in the right

direction. The issue that the member raises is one that we will consider as part of the new performance assessment framework.

Mr McAllion: Having moved in the right direction, spending on mental health in Tayside is now moving back the other way.

Malcolm Chisholm: Mr McAllion is giving the example of only one health board.

Mr McAllion: I live and work in Tayside and represent a constituency there, so what is spent there is important to me.

Malcolm Chisholm: The importance that is attached to mental health in Tayside will be considered when Tayside is assessed under the performance assessment framework. We are mindful of the issue that the member raises and recently we have taken a considerable number of new initiatives on mental health. Our determination to make it a real priority is firm. The money that is being spent reflects that.

Mr McAllion: Should the new spending that has been allocated across the country be aligned in some way with the national priorities?

Malcolm Chisholm: It certainly should.

Mr McAllion: The problem is that that is not happening. The money is not aligned with the priorities of coronary care, stroke treatment and mental health.

Malcolm Chisholm: The member has cited the example of Tayside Health Board. However, a great deal of activity has gone on in relation to coronary heart disease. There has been a task force report. The first Clinical Standards Board for Scotland standards were issued two weeks ago; I will refer to those again in response to questions about the performance assessment framework. That is evidence of a determination to have high standards throughout the country for the treatment of coronary heart disease. The general strategy for coronary heart disease will be launched next year.

Much is happening in relation to both CHD and mental health. The way in which they are prioritised and the money that is spent on them will be considered as part of the performance assessment framework.

Mary Scanlon (Highlands and Islands) (Con): John McAllion mentioned the reduction in spending on mental health in Tayside. Although mental health is one of the Executive's top three clinical priorities, the recent publication of the Scottish community care statistics confirmed that local authorities have reduced by £8 million spending on adult mental health in 2000 compared with 1997. You call mental health a clinical priority, but it is not recognised as such by local authorities throughout Scotland. The statistics do not confirm that it is a clinical priority.

Malcolm Chisholm: Some spending on mental health comes from local authorities, but the bulk of it still comes from the NHS. As I said, NHS spending on mental health has recently increased significantly. Some mental health spending comes through the mental illness specific grant, which has also been increased recently. Two years ago, the committee made a recommendation on that, which the Executive took up. However, I accept that in some local authorities there are problems relating to spending on mental health.

Dr Richard Simpson (Ochil) (Lab): I have a specific question relating to the priorities. I know that the £30 million that has been made available over three years—£6 million, followed by £12 million, followed by £12 million—has been welcomed as a good start. Can the minister guarantee that that money will get to the local health care co-operatives? There are already disturbing reports from at least two health boards that the money either is not being used easily by LHCCs or, in one case, is being used to prop up a deficit.

Malcolm Chisholm: I would welcome being given information about those cases after the meeting, if that is what is happening. We have been very clear that NHS boards must feed through the new money to LHCCs. As Susan Deacon's letter to the committee indicates, we are flagging up the needs of specific groups. More generally, greater access to primary care is the priority that is being emphasised. In practice, the money will probably be spent on additional staff, to diversify the primary care teams in LHCCs.

Trevor Jones: We require each NHS board to give us a detailed statement of how the additional funding for primary care has been spent. We expect to see in those returns a demonstration that LHCCs have figured as the key players in the decision-making process locally. Spending of the additional money is being monitored nationally.

10:00

Dorothy-Grace Elder (Glasgow) (SNP): The east end of Glasgow is in a position that is similar to that in Dundee, as described by John McAllion. The east end of Glasgow has the highest incidence of mental health problems in the city, yet there have been cutbacks; for example, in Auchinlee day hospital, which is a modern hospital. I add that as a point of information, because mental health was supposed to be one of the Executive's top priorities.

Malcolm Chisholm: Members can give various local examples and I am interested in them all. However, I do not know the details of that example, so I cannot comment. Sometimes, there

are issues about money being diverted. At other times money might be being spent differently in the same area. However, I do not know what the case is in Dorothy-Grace Elder's example.

The Convener: Dorothy-Grace Elder can write to the minister with more information and enter into discussion on that matter.

Dorothy-Grace Elder: The situation has been going on for a while. I gave that example as a point of information to add to what John McAllion and other members said.

Shona Robison (North-East Scotland) (SNP): I turn to the reply to question 2 in the letter from the Executive, about the end-of-financial-year underspends. We accept the point that that does not relate to 2002-3 and beyond, but that information has raised other questions. We want clarification on a particular issue. The helpful table shows that £135 million was underspent and there is a description of how £90 million of that was distributed. However, that begs a question: what happened to the other £45 million? Can you outline what it was used for?

Malcolm Chisholm: I will flag up one issue and John Aldridge will, perhaps, flag up others.

As you know, we are discussing fees for care homes with Scottish Care and others. Indeed, Shona Robison asked me several questions about that matter during the passage of the Regulation of Care (Scotland) Bill. As part of our commitment to sorting that difficulty we put up £18 million to go at least some way toward meeting the cost of whatever settlement is arrived at. That is one item of spending that I am sure members of the committee will welcome.

The other general point is that the underspends that sit in health boards and trusts remain with them to be spent later. As members know, that is a much better arrangement than that which pertained in the past.

Those are two distinct areas that cover some of Shona Robison's question. I do not know whether John Aldridge wants to add anything.

John Aldridge (Scottish Executive Finance Department): I can add a little, if members will find that helpful.

The £90 million is the resources that were distributed to area health boards. In addition, some resources went to help special health boards with capital slippage. That amount was not large—it was about £7 million. Because the clinical negligence and other risks indemnity scheme that we run—CNORIS—operates as a fund and pays out only for the claims that come in in a year, there was more in the fund at the end of last year than was needed, so that was carried forward to this year as well.

Those are the main items that were funded, and they include the care home settlement that Mr Chisholm mentioned.

Malcolm Chisholm: I suppose the other point to make, which I know committee members are aware of, is that the underspend figure was more than £135 million, because we gained through the redistribution across the Executive. We actually had £159 million from the end-year flexibility settlement.

Nicola Sturgeon: You provided a table that details the underspend and breaks it down into—I think—seven general headings, which is helpful. Is it possible to break down the underspend to a level beneath those headings? For example, we know that health boards underspent to the tune of £41.7 million. Is information available about the areas in which that underspend occurred? For example, I have heard that £10 million of that underspend was money that had been given to health boards to help with the problem of bedblocking. I think that most people would be confused about why health boards underspent, given the seemingly intractable problem of bedblocking.

My general question, however, is whether we can break the underspend down further to see where health boards, for example, are not spending all their allocated funds.

Malcolm Chisholm: I will ask Trevor Jones to deal with the point about health boards. An example about the minor underspends—which is, in fact, the largest item of all—has been given. The underspend is quite typical; it might be that the money for new initiatives such as demonstration projects is not being spent as quickly as was expected, although the same overall sum of money will still be spent on them.

My only other general remark is to point out that there is some capital slippage. That has always been the case, as we know. There is nothing unusual about it. I ask Trevor Jones to give some detail in response to the question about health boards.

Trevor Jones: The first thing to bear in mind is the level of the underspend, which is just over 2 per cent of the budget. Overall, that is not a huge amount for managing such an organisation. The second point relates to what the minister has just said. Generally, the underspend is committed to new developments. If, however, a member of staff is not appointed on 1 April in a given year, money needs to be carried forward into the new financial year so that the member of staff can be fully funded. The health boards are generally fully committed. We are dealing with non-recurrent underspending, which is brought about because of delays in recruiting staff and in implementing

capital schemes.

I do not have more detail on underspending with me, but we could get the breakdown of the figure from NHS boards and details of the commitments against that sum. If it would be helpful, we could supply that information to the committee later.

The Convener: It might be worth the small group of officials and committee members discussing what information on the underspend might be useful. The minister's letter states:

"The 2000-01 underspend has not affected planned progress towards targets."

Are you sure that that is the case, minister?

Nicola Sturgeon: If I may come in on that point, convener, I raised the example of the money that is allocated for bedblocking. I have heard it said that that money formed part of the underspend. Is that the case? It alarms me that such a huge problem is being dealt with using money that, although it has been given to health boards and health trusts, is not finding its way to dealing with the problem.

Malcolm Chisholm: I would be very surprised if that were the case, although John might be able to provide more detail.

John Aldridge: There was a final amount; money had been issued earlier to help with bedblocking in the last financial year, and it was all committed and spent. Very late in the financial year, £10 million was issued, which had become available from underspends elsewhere in the programme. That money was released to local authorities through the health boards to deal with bedblocking. I stress that that was late in the last financial year, and authorities were not able to spend all the money in that year. As Trevor Jones said, the money was already committed and the plans for how the money was to be used to help with bedblocking were in place. It was not all spent by 31 March, however.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): A great deal of discussion has taken place about the performance assessment framework, particularly with regard to how it is failing the accountability process in certain areas of Scotland. The Minister for Health and Community Care has provided us with her views about how that can be linked to the work of the Clinical Standards Board for Scotland and so on. However, there is nothing in her response that links the performance assessment framework to public accountability in such a way that individuals can question or influence it. Can you provide the committee with any more information on that?

Malcolm Chisholm: In general, the performance assessment framework is an exciting and important development, and performance assessment involves a far broader range of areas than was the case in the past. The main areas that will be covered are these: first, health improvement and the reduction of inequalities; secondly, fair access to health care services; thirdly, clinical governance and the quality and effectiveness of health care; fourthly—and crucially—patients' experience, including their experiences of service quality; fifthly, staff governance; and sixthly, organisational and financial performance and efficiency.

Performance assessment will be public, in the sense that the letter that we send to the NHS board following the assessment will be a public document. We are also asking boards to produce factual information about the assessment in their annual reports.

That information will be generally available and if boards are failing in some areas, that will become broadly known. This is a big step forward and I would be interested in hearing of the ways in which people think that that can be developed. We are in the early stages of the process, starting with the inception of the new NHS boards this month.

Margaret Jamieson: Obviously, people who have a problem with the old process want to influence the process. I therefore declare an interest. To date, the system has operated like a secret society in that the organisation advises the centre of how it thinks it has complied with the instructions. How can we influence that at a local level? You talked about the involvement of patients, but how are you going to ensure that the information that you receive is true and accurate and has involved patients and staff outwith the local delivery area? Without those elements, we will not be sure that the information is robust.

Malcolm Chisholm: We are strongly committed to patient and public involvement. The department will shortly produce a paper on that matter. Equally, we are strongly committed to staff involvement, which is demonstrated by the composition of the new NHS board and the various clinical committees. As part of the performance assessment framework, we will be examining the extent to which the clinical committees have been consulted and involved by the NHS board in its decision-making processes. You are asking whether the NHS boards will be able to pull the wool over our eyes.

Margaret Jamieson: As they have done for many years.

Malcolm Chisholm: We will make sure that that does not happen. Trevor Jones may wish to speak in more detail about that.

Trevor Jones: We are bringing in a new accountability review process between the department and the boards. Those involved in the

review will, in theory, meet annually but they might meet more often to deal with problems with certain boards. We will have before us a range of hard data on the areas that the minister has talked about. National data will be collected to support all areas. That will be hard, published data that we will collect rather than data that are submitted by the NHS boards. We will also have reports from key stakeholders, the Clinical Standards Board, the Mental Welfare Commission and the staff partnership forum that will act as external views. Based on that information, we will have a structured discussion with the NHS board about its performance. Whereas in the past that meeting would have concentrated on financial performance, it will now deal with all of the core business. An action plan will be agreed at that meeting and it will be sent out in a public letter to the NHS board.

We will expect the annual reports of NHS boards to use the data set to show how they are serving their public. That will result in a much more balanced annual report that will not simply concentrate on what is going well. It will enable us to examine relative performance across Scotland.

Margaret Jamieson: I welcome your saying that that will be a public document, but we have found that it has taken six months for such documents to become available to the public and their elected representatives. What is the time scale for the publication of the document?

Trevor Jones: We have not yet set a formal time scale, but I would not expect it to take six months. I would expect the letter to be produced within a couple of weeks of the meeting. I would also expect it to appear at the next public meeting of the NHS board.

Margaret Jamieson: I wait with interest to see that happening.

Mary Scanlon: I would like to continue the theme of the secret society.

In response to our questions about the determinants of the size of the health care budget, the minister said that data that are already in the public domain were used, such as activity costs and outcomes and an assessment of pressures. That raises the question of how you define a pressure. For example, on the news this morning there was a story about the rise in the incidence of type 2 diabetes. Would that be included as a pressure? Would evidence of unmet need for health care or 10 per cent of hospital beds being taken up by people with hospital-acquired infections be included as pressures? How do you decide or measure what is a pressure on the NHS?

10:15

Malcolm Chisholm: There are two ways of looking at this. I thought that your question in the letter was about health in relation to other parts of Scottish Executive spending—that is one area that must be considered across the Executive, particularly at each spending review. Perhaps you are also touching on the subject that was mentioned before, which is the relative priorities within the health budget once the overall budget has been allocated.

Mary Scanlon: I am asking about the size of the budget given the pressures and how you measure the pressures and the priorities within that budget.

Malcolm Chisholm: In a way, the care development group was part of the process. It considered spending in community care. The process is not terribly dissimilar to that for the health budget. For example, one of the main things that the care development group examined was demography, which is a fundamental factor that we must consider as we examine the needs of the health budget over the coming years. We must consider health trends—an increasing number of elderly people is a significant factor for health budgets. That is a general area of which we must be mindful.

Trends in illness and disease are also taken into account in planning. It is quite difficult to factor in disease trends in the long term. We hope that our health improvement measures will make a big difference, but we cannot predict that with absolute certainty. We have to keep track of the trends in diseases and illnesses as well. It is a fairly complicated process. We have to keep our eye on several balls at once.

Mary Scanlon: Given the huge and increasing incidence of diabetes, which can lead to heart disease and so on, are you not concerned that at Raigmore hospital a first-time diagnosed diabetic would have to wait 11 months to see a consultant? There is a feeling that many illnesses have fallen off the agenda. Are you not concerned about increases in waiting lists and waiting times and the fact that more than 10 per cent of beds are taken up with hospital-acquired infections? I would have thought that such matters would be a top priority in order to utilise the beds and ensure that more people are cared for.

Malcolm Chisholm: We have taken several steps in relation to hospital-acquired infections. We are determined to deal with that particular issue. The comment on diabetes is absolutely true and diabetes is what features in the news today. From week to week, we will read about different disease profiles—one illness may be increasing and another may be in decline. We have to keep our eye on those details.

The other central factor is staff. I am sure that members will not forget that about 70 per cent of the health budget is allocated to staff costs. Clearly we have to be mindful of the number of staff that are required. A high level group led by Professor Temple is considering work force planning and will make a preliminary report before Christmas. We must consider the different staff positions that are required as well as wage demands and other issues relating to staff development that have arisen recently. That is a major part of the calculation of the health budget.

Mary Scanlon: Are you saying that it is very difficult to change priorities in the health budget because staff costs take up so much of it? Are you saying that, should diabetes become the primary concern in Scotland, it would be very difficult to change the current set-up in the NHS to deal with that urgent need?

Malcolm Chisholm: I am sure that that is not the case. We have flagged up three clinical priorities, one of which is heart disease—where there is considerable overlap with diabetes—but those could change over time. As members know, cancer and coronary heart disease are now priorities, whereas 50 years ago the priorities would have been various infectious diseases.

Dorothy-Grace Elder: You were right to refer to the vital role of staff. I hope that when you shift the waiting list for diabetes and many other conditions you will take into consideration the shortage of medical secretaries in Scotland, which is due largely to the low wages that are paid to these very highly skilled people. Can you assure us that you wish to increase the number of medical secretaries and to fill the vacancies that exist? That is one of the reasons for the bottlenecks that appear in some specialties.

Malcolm Chisholm: It is clear that there are issues relating to particular staff positions. Over the summer, medical secretaries have been in the news quite a lot and I am sure that we are all pleased that an agreement about their position has been reached in all trusts. Later, the committee will hear from representatives of Unison, which was involved in the negotiations with trusts that led to that agreement. We now have a way forward for the important position that the member mentioned.

The Convener: The general issue that Dorothy-Grace Elder raises concerns us all. We may be straying slightly from the budget, but as staff costs are such a phenomenally large part of the budget it is important that we consider problems of recruitment and retention. Do you feel that, because of national pay bargaining and so on, you are in a financial straitjacket that prevents you from giving people extra incentives that would encourage them to take up positions? We can all see that there is a shortage of, for example, consultants and medical secretaries. Do you feel that you have sufficient powers to offer people the inducements that would attract them into the health service? We all know that there are problems of recruitment and retention.

Malcolm Chisholm: We are mindful of those issues. As members know, in three weeks' time we will hold a convention at which the full range of recruitment and retention issues relating to nursing will be considered. Nearly all the powers that can be used to deal with problems are devolved, but most of the unions are happy that pay bargaining should continue to be at UK level. We agree with them. Others may take a different view on that, but that tends to be the view that most people take. Theoretically, the position could change, but at the moment there is no great demand for one. We are still within the UK pay framework, but there are many initiatives that we can take. Earlier today the nurse bursaries were mentioned. They are not irrelevant to the issue of recruitment. Various other suggestions have been made with reference to nurses and other parts of the work force. We have some flexibility on those matters.

Margaret Jamieson: I would like to pursue that point and to raise work force planning. We know that there is discussion with colleges about medical and nursing cover, but we are now experiencing difficulties in other areas, such as radiology. There does not seem to be a commitment to considering the long-term objective. If we are in a three-year financial process, we should at least be in a three-year work force planning process that allows us to anticipate the future needs of the service. Planning in the health service is very poor outside what we term the sexy services—nurses and doctors. We do not tell people that the NHS includes pharmacists, domestics, catering and radiology. This committee has touched on that issue in the past, but we have never seen the long-term work force planning that we believe would be beneficial.

Malcolm Chisholm: I assure Margaret Jamieson that we are considering work force planning, and not just within a three-year time scale. I referred to Professor Temple's group, which is considering the situation in a range of different positions, including radiographers, to whom you referred. Beyond that, there are the activities of the agenda for change—a UK agenda in which we are very much involved. It will include consideration of a range of work force issues, including pay. Work force planning is central to that. It is a major issue for us—the care development group gave a great deal of attention to planning in the social care work force.

Dr Simpson: I want to continue with the theme of pressures on the service. The deficits will be

dealt with for the most part by end-of-year spending. The minister mentioned demographic pressures. What point have we reached with the implementation of current working time directives and with the reductions in junior doctors' hours? I welcome the fact that there has been a 90 per cent achievement of contract levels in year one, but people work as junior doctors for six or seven years. I suppose that I should declare an interest—I have a son who has been a junior doctor for about five years.

Another pressure on the service is the introduction of new drugs and the problems associated with postcode prescribing. In my constituency there are waiting lists for drugs such as cognitive enhancers. People with limited incomes are being forced to pay money for drugs because the deterioration in their condition is such that they cannot wait for the health service to produce them.

We must also consider care home costs. The minister was right to say that there is an interim settlement, but that is being funded out of EYF. Next year we will be faced with the same pressures—multiplied, I suspect—which will have to be dealt with out of revenue funding.

If this committee is to understand the budget, it must understand the collective view from the centre on all those pressures. If it does not, we will compound a situation in which, although it looks as if substantial new money is going into the service and everyone expects improvement, in reality we are swimming hard against the current. Because we are faced by pressures that continue year on year and to which we can see no end, the new money will not produce any benefit.

Margaret Jamieson mentioned the work force. In 1999 there was an 11 per cent shortage of radiology consultants, but this year the shortage was 12.5 per cent. The situation is not getting better; it is getting worse. There are also problems with radiography. I do not know what the situation is elsewhere, but in my constituency waiting times for almost all procedures are increasing massively. That means that there is a perception that care is getting worse. How much of the new money for next year will be used to deal with the pressures that I have described and to get rid of some of the inequities in the current system?

Malcolm Chisholm: You have raised a number of issues. John Aldridge may be able to provide members with more detail, but I can indicate that we are at a fairly advanced stage with implementation of the working time directive, which has been a cost pressure. The same applies to the situation with junior doctors. The money to deal with that is now in the system, although there is still some work to be done.

Richard Simpson mentioned new drugs. A story broke in the news last night. We have been in discussions with the Department of Health about that this morning. Richard Simpson and other members will know that a great deal of activity is taking place on that front in the Health Technology Board for Scotland—which was also in the news recently—and in the Scottish drugs consortium, through which health boards are trying to deal with the uneven availability of drugs. I am sure that the issue of new drugs will be raised in the members' business debate on dementia this evening, to which I will reply.

We have put a significant sum into dealing with care home costs. It is difficult to say any more in detail about that until we receive the report of the group that is working on it, which is chaired by Owen Clarke. There will have to be discussions with the Convention of Scottish Local Authorities about that when we receive the report. That issue was flagged up by the care development group as something that must be addressed when we are dealing with long-term care.

10:30

You asked about staff. Additional funds are one part of that, but they are not the whole story. We will have to consider new ways of working as well. I am sure that Richard Simpson will welcome the moves to ensure that staff work more flexibly in primary care. That is one of the ways forward that we had in mind when we invested the new money for local health care co-operatives this year. I am sure that most people in primary care have taken that on board.

The need to arrive at better ways of organising services and to set clear priorities for service development does not take away from the fact that more money will be available for that area.

The Convener: I think that Richard Simpson might have wanted to declare an interest.

Dr Simpson: Yes. I should declare that I am the director of a care home group in England. However, it is not affected by any of these lovely increases.

Janis Hughes (Glasgow Rutherglen) (Lab): As we have come to expect from the budget process, we have a fairly large amount of data on finance and a smaller amount on activity. Over the couple of years in which we have been scrutinising the budget processes, we have not had a lot of data on patient outcomes.

In the health board in my constituency, huge amounts of money have been ploughed in to addressing waiting lists and waiting times, but it is difficult to quantify precisely what improvements have been made. Minister, if you were challenged

on the budget report, would you be able to quantify the improvements that have been made in relation to the amount of money that is being put in? Would it be possible to show what improvement has been brought about year on year by the money that is being put into the service?

Malcolm Chisholm: We are focused on that. Everything we want to do in health policy should result in better outcomes and a better patient experience. It would be reasonable to say that we should not expect the budget report to carry everything. There are many ways in which the information that you are talking about could be presented—that could be raised by the committee in any discussions with officials about improving the budget report. The Clinical Standards Board does work of great significance in terms of better clinical outcomes for patients. Two weeks ago, it published detailed information about every NHS board area in Scotland and the treatments that are available for heart disease. It will be able to do the same sort of work on other clinical areas, starting with the priority areas.

Patient experience goes beyond clinical outcomes and is an area that we want to focus on in the forthcoming paper on patient and public involvement. Feedback from patients is crucial in terms of improving people's experience of the health service. There are many ways in which we can capture that. I am quite open to more such work being done in the budget document, but I think that a lot of it is probably best done elsewhere.

Janis Hughes: I accept that. Perhaps the budget document is not the best place to go into great detail about certain subjects, but I am sure you accept that patients might want to know how long it will take to be treated for a certain disease, what kind of treatment they should expect and how that compares with what happens elsewhere. We have a good news story to tell but perhaps we are not telling it often enough. I accept what you said about the report of the Clinical Standards Board but I think that we should highlight such good news stories in another way. I would like an assurance that you believe that you will be able to quantify specifically what improvements are being made to patient outcomes from the money that is being put in.

Malcolm Chisholm: I do not disagree with you and I think that we should explore whether the issues that you are talking about can be covered in this document. Another way of doing that would be to conduct opinion surveys. It is worth repeating that the MORI survey that we conducted recently indicated that eight out of 10 people were satisfied with their experience of the health service. That in no way leads me to complacency but it is definitely worth remembering while we are attempting to address the problems that we hear about.

We need to capture patients' experiences of the health service in many ways. We will address that issue in our forthcoming paper. We are committed to that idea and are interested in finding out whether that experience can be captured by the budget document as well.

Janis Hughes: In the past couple of years, the committee has criticised some of the targets that are set out in the budget document and questioned whether they are achievable, tangible targets that people can identify with. I know that the targets are selected from the Scottish Executive's programme for government, but we are concerned about the vagueness of some of them, for example the minister's promise, in her letter, to put more money into the development of local health care co-operatives. Do you agree that some of the targets need to be firmed up and that much more detail is needed? We need to see how the targets can be achieved if we are to be convinced that they are doable.

Malcolm Chisholm: I am completely open to discussing targets. As you said, some of the targets are in our programme for government and I am sure that MSPs will expect us to keep our minds on those ones in particular while thinking of new ones. It is important to have targets and to monitor progress towards them. As I said, if members think that the targets should be more detailed, I am prepared to discuss that.

Janis Hughes: I accept what you are saying, but, with respect, we have heard that promise in previous years and the level of detail does not seem to have improved this year. What mechanisms will you put in place to ensure that it improves next year?

Malcolm Chisholm: The health plan contains more than 250 detailed actions. Most of those actions are being implemented and some have been achieved. That was a fairly specific set of commitments, so I suppose that, instead of simply welcoming your comments, I should ask whether you have an example of what you mean. That would allow me to respond in a more concrete way. I do not want to be too defensive. We have set out targets in the programme for government and there are many targets in the health plan, which received a healthy welcome.

Janis Hughes: I gave you an example already. The minister promised, in her letter, to put more money into the development of LHCCs. How will LHCCs be developed? What are you going to do to increase their involvement? That is the kind of thing I am talking about: targets are mentioned, but the way in which they will be achieved is not.

Malcolm Chisholm: As I said, we will want a

detailed statement about how the money that is being made available to LHCCs is being spent. We are not forgetting about the money that we are investing; we are monitoring the way in which it is spent and ensuring that it is spent on the objectives for which it was distributed in the first place. That is part of the general increased amount of performance assessment that is being done. There is a real step change in that this year. You should be assured that we are in tune with what you are suggesting.

The Convener: The committee has said many times that it is concerned about patient outcomes. There is a general feeling that, although we have data about people attending hospital and data about people dying, we do not have data about whether someone who has gone to the hospital with back pain still has back pain when they leave the hospital. We all want further development in the linking of the budget to the 250 targets in the health plan.

Malcolm Chisholm: With reference to the specific issue of primary care and the health plan targets, I should mention the commitment to ensuring that there is access to a primary care practitioner within 48 hours. That is perhaps more specific than my previous answer.

Mary Scanlon: This is the third year that we have asked for some sort of measurement of outcomes. We are constantly being told that more money is being put into the health service, but, as other members have said, it is difficult to measure outcomes.

The Executive's statistics tell us that, from 1997 to 2000, the number of clients who were seen by health visitors fell by 49,800, while the number of clients who were seen by district nurses fell by 12,200. You say that eight out of 10 people are satisfied with the health service, but I cannot see how they can be satisfied when health care is being reduced by such amounts. Those are phenomenal and frightening figures, given the emphasis on care in the community and the increase in the number of elderly people. Are you satisfied that your money is being spent wisely?

Malcolm Chisholm: I do not recognise the figure that you cite in relation to health visitors. That would have to be looked at in the round with regard to the number of people who were visiting people at home. Also, the figure might be accounted for by the fact that greater use was made of health clinic facilities rather than home visiting.

I do not have the table that you are looking at, but it is important to consider all the people who are involved in delivering care. There might be a decline in the number of clients who were seen by health visitors, but that might be accompanied by a corresponding increase in the number of clients who were seen by other health or social care workers.

Mary Scanlon: Our problem is that we cannot measure outcomes. The community care statistics tell us that, from 1997 to 2000, the number of clients who were seen by health visitors fell by 49,800. The statistics do not say that those 49,800 clients were seen by other people. How can we say that those clients are receiving better care?

That is our challenge. You sit there and say, "They might be going here, there or everywhere." We do not know that. All we know is that, according to the statistics, health visitors and district nurses see thousands fewer people than they saw in 1997. How do we measure care when people may have been treated elsewhere? We do not know where those people have gone.

Malcolm Chisholm: You flag up a danger. We cannot consider only one part of the statistics; we must consider them in the round. You flagged up figures on health visitors, but district nurses will have a different line in the budget. The figures are in front of you, so you have a slight advantage over me, but I suspect that the district nurse figures are different from those on health visitors.

10:45

Mary Scanlon: In one year—from 1999 to 2000—district nurses saw 7,300 fewer clients. Are those 7,300 people healthier people who do not need to see a district nurse, or have they lost out? We need to know that to have an informed input to the budget. We have scraped around for information for three years. We cannot make the informed judgments that we would like to make, because we cannot obtain the information from your department.

Malcolm Chisholm: That is information that you are using to good effect.

Mary Scanlon: Thank you.

Malcolm Chisholm: The information is publicly available. The only caveat that I give is that we must consider care in the round and the balance of people who are being visited at home, going to a health clinic and receiving other care at home. The general issue of home care hours has been flagged up recently, but the trend is being reversed because of the extra money for home care in the past couple of years. We must consider the spectrum of care for those people, rather than point out one line.

Mary Scanlon: I will respectfully ask the minister about home care. More than 9,000 fewer people now receive home care. All the statistics show that people receive less care at home. Will the minister say where I should go for the

information that he says is available? How do I measure health care in the community?

Malcolm Chisholm: We must be careful when we examine home care figures, because people often ask for local authority home care figures and forget that much home care is delivered privately. People may arrange such care themselves, or local authorities may commission it from private providers. We must consider the whole picture of home care.

There was a trend, but it did not start in 1997. That trend is being reversed. The most significant injection of money into home care services is being made with the increase from the £100 million that was announced one year ago in October 2000, which is coming on stream. More is to come with the second £100 million for personal care, which will cover the development of services in the community.

The trend is being reversed. We have a collection of statistics, which help to build up a picture, but we must try to capture people's experiences and their views of the services that they receive. We did much of that work in the care development group. We know that we must address many problems and difficulties, but the home care trend has been reversed and such provision is increasing.

Mary Scanlon: Not according to the figures.

Malcolm Chisholm: As you have the figures and I do not, all that I can do is undertake to write to you on district nurses and health visitors—

Mary Scanlon: And home care.

Malcolm Chisholm: I will write with a more detailed statement about the issues. My experience is that health visitor hours have decreased, but hours for others, such as district nurses, have increased.

Mary Scanlon: The figures have not increased in the recent statistics that I have.

Malcolm Chisholm: Okay. I will examine the most up-to-date figures.

Mary Scanlon: I have the statistics for 2000.

The minister returned to talking about his millions, but I am talking about people. Will the minister start talking about outcomes rather than millions?

The Convener: I ask Mary Scanlon to take on board the minister's undertaking to investigate the matter and send us a response.

Another point arises from Mary Scanlon's comments. In the wake of the Community Care (Scotland) Bill and the injection of investment, even more people will have different ways of accessing care, because of factors such as direct payments and the social work and health sectors working together with pooled budgets. The question is whether scrutiny and accountability will become even more difficult for us than they are at the moment. I would appreciate a written response to that question, rather than taking any more time at this point.

Nicola Sturgeon has a further point.

Nicola Sturgeon: No. It has been answered.

The Convener: We will clarify the points in this area that we want answers for and write to you for clarification.

Mr McAllion: For the past two years, the committee has been critical of the information in the budget about private finance initiative projects. In our most recent letter to the minister, we pointed out that that information was inadequate, because only capital costs were provided and there was no information about the annual revenue payments that health trusts are required to make under PFI contracts.

In her written reply to the committee, the minister addressed that criticism by saying that copies of the business cases for all PFI projects valued at more than £10 million have been placed in the Scottish Parliament information centre and that those business cases provide further information about the annual payments. First, when were those business cases placed in SPICe? Secondly, can you confirm that the business cases will show the Lothian and Lanarkshire health trusts' annual revenue payments for their PFI hospitals, the number of years for which they will have to make those payments and the capital costs, so that the net revenue costs to the NHS of PFI projects can be worked out?

Malcolm Chisholm: Yes. I give an undertaking on that. The business cases were not put into SPICe recently, but when they became publicly available. The main point of fiscal interest is the annual payments, which are set out clearly in those documents—as the minister's letter says—for any projects that are valued at more than £10 million. It is easy to find out that information. As you indicated, that information is about annual revenue payments, whereas the budget document indicates the overall capital value of the projects.

Mr McAllion: Do the business cases indicate the number of years for which the annual payments will have to be made?

Malcolm Chisholm: Yes.

Mr McAllion: How easy will it be to retrieve that information from those documents? Would you require to be a health economist to find exactly where that information is?

Malcolm Chisholm: No. You would not require to be that.

Mr McAllion: Why has that information been placed—some might say buried—in SPICe, rather than in the Scottish budget document? For each of the PFI projects that is listed, it would be fairly easy to include a footnote that said what a trust's annual payment was and for how many years it had to be paid. Why cannot that be done?

Malcolm Chisholm: John Aldridge will take that point.

John Aldridge: I dare say that that could be done.

Mr McAllion: If it can be done, why not do it?

John Aldridge: Our view was that putting the business cases for projects over £10 million in SPICe, rather than putting them in the budget document, would mean that the information would be readily available to MSPs at an earlier stage.

I suppose that there were two reasons for not putting that information in the budget document. One reason was that we thought that the information was already readily available in SPICe. The other reason was that it would take up a lot of extra space to provide all the information for each project. The committee previously raised the issue of the need to strike a balance in the budget document between putting more information in, which might be available elsewhere, and—

Mr McAllion: Only 10 projects are listed in the budget document. Of those, only six have budgets of more than £10 million; four have budgets of between £3 million and £10 million. That does not take up a lot of space. You could easily put footnotes at the bottom of the page, which would provide the information without taking up huge amounts of space. Why cannot I find out, for example, about the Carseview acute psychiatric unit at Ninewells hospital in Dundee, which has a budget of £10 million? You do not provide information about the annual payments that are made by Tayside University Hospitals NHS Trust for that facility.

Malcolm Chisholm: Nobody is trying to hide that information, Mr McAllion.

Mr McAllion: Well, it has been hard to get in the past. When I have asked about it, I have been told that it is commercially confidential.

The Convener: Why is that information not commercially confidential above £10 million?

Malcolm Chisholm: I am sorry, but are you talking about the above £10 million?

Mr McAllion: It has been difficult to find out the true costs of PFI projects, because the information has not been readily available. By the way, it is news to most members of the committee that those documents have been in SPICe for many months. When were they first put there?

John Aldridge: It varied from project to project. The requirement is that they should be lodged once the contract has been signed and the project is under way. That did not happen from the start. It is only more recently that we have introduced that requirement.

Mr McAllion: What does "more recently" mean?

John Aldridge: I think that the requirement was introduced about a year or so ago.

Mr McAllion: Have the documents been in SPICe for a year?

John Aldridge: They should have been available since then. Some may have taken a little while, but when we found any that were not lodged there we chased them up.

Nicola Sturgeon: My first question follows on from what John McAllion said. Will you put the business cases for all the PFI projects in SPICe? I do not understand why we can see the business case for a project in south Glasgow, whose capital value is £11 million, while the business cases for projects with capital values of £10 million or £9.6 million are to be kept hidden from us. Will you undertake today that the business cases for all PFI projects—there are not many of them—will be placed in SPICe?

My second question relates to the detail that we will find in the PFI business cases that have already been placed in SPICe. For example, will the business case for the new Edinburgh royal infirmary show any increases in the revenue cost from the point at which the business case was settled? It was reported at the weekend that the annual revenue payments for the Edinburgh royal infirmary will be some £1.9 million more than anticipated, which amounts to £60 million over the period of the contract. It has been reported that that will lead to a deficit in the trust. Will we find that information in the business case, or has it come to light only since the business case was written, in which case we would be unable to access it even from the documentation that you have put in SPICe?

Malcolm Chisholm: I shall let John Aldridge deal with some of the detail. Obviously, there have been quite a few figures flying about over the weekend in relation to the new Edinburgh royal infirmary. Some of those figures are quite misleading, particularly the figure of £38 million, which is quite mysterious and does not seem to bear any relation to—

Nicola Sturgeon: What about the £1.9 million a year?

Malcolm Chisholm: I was going to say that £1.9 million is the one figure that is correct. However, that is basically the uplift for inflation and it has not come as any surprise to anybody that, even in the brave new world of low inflation that we have had since the Labour Government of 1997, we still have some inflation. That is what the £1.9 million represents. John Aldridge may want to deal in more detail with that point, and also with the question about projects under £10 million.

John Aldridge: I shall start by dealing with the projects under £10 million. Table 5.20 in the budget document shows the capital value of those projects worth £3 million and above. The £10 million cut-off point for lodging business cases in SPICe was, I concede, fairly arbitrary. The figure was chosen simply to ensure that the largest and most important projects were there. We could reduce the limit, but I would be reluctant to undertake to require business cases for every PFI project to be placed in SPICe. A large number of very low-value projects are going ahead.

Nicola Sturgeon: Surely it is in the public interest that that information is available. With the greatest respect, I am not sure that it is for you to make an arbitrary decision on which PFI contracts are open to scrutiny by elected members and which are not.

John Aldridge: The fact that business cases are not in SPICe does not mean that they are not available. Business cases are available from trusts for any member of the public or anybody else who wants to get them. If members want every business case of every PFI project to be lodged in SPICe, that could no doubt be done. There would be a very large number of business cases for relatively small projects.

The Convener: Perhaps you could clarify for us the numbers that are involved. We could make a decision based on that information.

Margaret Jamieson: You said that the decision to lodge business cases only for projects that are worth more than £10 million was arbitrary. You also said that many projects were on a small scale, which may well be true. However, I use East Ayrshire community hospital in my health board area as an example of the fact that, irrespective of the cost, such projects are an important part of the NHS infrastructure. Nicola Sturgeon is right—we have a right to have those documents in SPICe if that is what we want. It is not correct to say that people can always get the business case from the trust. You would need a tin opener.

Malcolm Chisholm: We have undertaken to consider that matter. We will outline in correspondence how many business cases we are talking about and take it from there.

Shona Robison: I move on to the discussions that you are having with the health department about beta interferon. Will you clarify what the process will now be for a decision on beta interferon? Will you indicate whether you will support funding for national clinical trials, along the same lines as the Department of Health has announced?

11:00

Malcolm Chisholm: It should be pointed out that nothing has, as yet, been announced. There was what is generally called a leak, or a trail, to the BBC news last night. We contacted the Department of Health this morning and found that no official announcement has been made.

Two processes appear to be going on. One is the process that you all know about—the work of the National Institute for Clinical Excellence. NICE has published draft conclusions, which are being consulted upon, and will come to its final conclusions in due course. The Health Technology Board for Scotland will then kick in with comments.

From what we have gathered in the past 12 hours, it appears that the Department of Health might wish to do something over and above that. However, given that no official announcement has been made and that I only heard about it on the news last night, it is difficult for me at this stage to say what we will do. However, today we will certainly be in close discussions with the Department of Health. The development appears to be very interesting and we will keep in close touch and hope to say something about it soon.

Shona Robison: If the leak proves to be from a good source, and the Department of Health is taking that route, are you telling us that your department will actively consider the issue?

Malcolm Chisholm: Absolutely.

The Convener: I have a more general point on prescribing and the introduction of new drugs. Over a period of months and years, members of the committee have sought clarification on who is responsible and on the different bodies involved, such as the HTBS, the Scottish medicines consortium and various others. There has been some debate in the past week about the future of the HTBS. When will we get clarification on clinical governance and the decisions that are to be taken on which drugs can and cannot be prescribed in Scotland?

Malcolm Chisholm: There are two issues there. On the first, more general, issue, the chief medical officer has been reviewing the different clinical governance bodies. It is generally accepted that, although each of those bodies does good work, there might be an issue about how many bodies

there are and how they relate to one another. There will be conclusions from that review. It is always dangerous to predict when conclusions will be available, but it will be soon.

Your second point was more specific.

The Convener: It was about the future of the HTBS.

Malcolm Chisholm: The HTBS is one of the bodies that are being considered by the chief medical officer. We are considering the configuration of some of those bodies and there will be an announcement on that before too long.

The more fundamental matter is the work that the HTBS does. We are not saying that that work is not important; it has to go on, as does the related work of the Scottish medicines consortium. I am sure that everyone agrees that the work is important, but there will be developments on the precise configuration of those bodies before too long.

Margaret Jamieson: Will that have an impact on the drugs and therapeutics committees that are running amok in some health board areas?

Malcolm Chisholm: You describe the issue of the drugs and therapeutics committees in an interesting way. We have tried to introduce order and consistency to those committees through the development of the Scottish medicines consortium, which is an important step forward. The consortium tends to examine new drugs that come on to the market, whereas the Health Technology Board for Scotland tends to deal with drugs that have been around for a bit longer, such as beta interferon. There is confusion about the roles of, on one hand, the drugs and therapeutics committees and the consortium and, on the other hand, the Health Technology Board for Scotland. I do not know whether that answers your question. I was distracted by your colourful phrase.

Margaret Jamieson: The problem is that decisions about drugs from the centre can be overturned at health board level by the drugs and therapeutics committee if it does not recommend the use of the drug.

Malcolm Chisholm: That is what happened historically, but we expect it to happen less and less as the national groups kick in.

Margaret Jamieson: I do not want the problem to be merely reduced. If a drug is found centrally to be in the best interest of patients, it should be available irrespective of health board area. We are pointing out to you areas in which there is a difficulty in getting knowledge through to the point of contact with the patient and we want you to say that you will remove the problem.

Malcolm Chisholm: We are absolutely committed to dealing with the problem of postcode prescribing. I am sure that the matter will be raised in this evening's debate in Parliament and I will give a similar response then.

The Convener: You can take the committee's view into this evening's debate and into the discussions that you will have in future with the chief medical officer about the matter. Many members feel that in a country of 5 million people, which, I think, is the equivalent of the city of Birmingham, the situation flies in the face of common sense. One would not expect people in one part of Birmingham to have access to a drug and people in other parts not to have access. Frankly, it is ridiculous to continue with that situation in modern-day Scotland, which has bodies such as the HTBS that are able to consider whether drugs are medically and financially effective. There are strong feelings in the committee about postcode prescribing in Scotland.

Nicola Sturgeon: I want to move to the perennial issue of free personal care. Given that we are discussing the budget, an important matter is yet to be resolved. The money that has been set aside from 2002 for free personal care remains some £20 million short of what the group that the minister chaired said was required to fund that commitment and everything that went with it. Negotiations with his Westminster counterparts are continuing, but the indications are that Westminster will not agree either to continue to pay attendance allowance or to transfer the money that it saves to the Scottish Executive. The First Minister said that, notwithstanding that, the money will be available in full.

Putting aside Westminster's view for one minute, will the minister say, if the Scottish Executive must find that additional £20 million, where in the projected budget that money will come from?

Malcolm Chisholm: We have not reached the stage of giving up on our discussions with Westminster, if that is what you are suggesting. The care development group took a fairly robust line on the matter, which has been continued by the First Minister in his discussions with Westminster and in his public pronouncements about that. We are pursuing the matter vigorously and we still hope for a favourable outcome so it would be premature to say from where we will take money.

Nicola Sturgeon: I am not sure that it would be premature. I would be appalled if you had given up on the negotiations with Westminster, because I hope that those negotiations prove to be positive.

The First Minister has said, quite rightly, that there is a plan B: if the money is not forthcoming from Westminster, it will be found from within the Scottish Executive's budget. Given that the

committee is discussing that budget, we surely have a right to know where you think that that money will come from. Until we know that, a question mark remains over the funding of free personal care.

Malcolm Chisholm: There should be no question mark over the funding, because the commitment has been given. The question is hypothetical. If no money were to come from Westminster—and I do not need to remind the committee that the money is already spent in Scotland—a decision would have to be made about that. Since the decision on the source of any additional money has not been made, I obviously cannot talk about it to the committee this morning.

Nicola Sturgeon: Given that we are careering rapidly towards April 2002, can you indicate when the negotiations with Westminster are likely to reach a conclusion?

Malcolm Chisholm: I cannot give a precise date on that, because we do not see an end point except when we have been successful.

Nicola Sturgeon: This is an important point. Given that the commitment will take effect from April 2002, at what point will you decide that the negotiations are not looking hopeful and that the money will have to be found from elsewhere? When will you tell us where that money will come from?

Malcolm Chisholm: I cannot gaze into the future and give you an answer to that question. Obviously, a certain point will have to come, but there are quite a few weeks and months to go before the beginning of April. We hope that there will be progress.

The Convener: I presume that you will have contingency plans in place well before April 2002.

Malcolm Chisholm: Clearly, we will be looking at options for that.

The Convener: I thank the minister, John Aldridge and Trevor Jones for giving evidence.

We shall adjourn for a short time. I apologise to members of the public in the gallery, who must leave while the committee has a private discussion about the next item. Due to the fact that we received information at short notice last night, we had to spend more time discussing the matter in private earlier this morning than would normally be the case. The security people will bring the public back in when this private discussion is finished.

11:12

Meeting adjourned.

11:31

On resuming—

Community Care and Health (Scotland) Bill: Stage 1

The Convener: Good morning, gentlemen, and thank you for joining us. I apologise that we are running a bit late, but that is due in no small part to the fact that information on the budget, which we should have received in advance of taking evidence from the Executive this morning, was received only last night. The information had not been circulated to members, so we had to spend more time in preparation this morning. I apologise to our witnesses for keeping them waiting.

Before we ask questions, do the witnesses want to make a verbal statement? We have already received a written submission. Are you happy that we just go into questions?

Neil McConachie (Association of Health Boards' Chief Executives): I am quite happy to go to questions. Our submission speaks for itself. A verbal statement would just take up more time.

The Convener: Okay. Let me kick off. The committee's "Inquiry into the Delivery of Community Care in Scotland" highlighted our concern

"to ensure that principles of fairness and of equity underpin community care policy."

Does the bill uphold those principles?

Neil McConachie: My reading of the bill is that the answer to that is yes. Perhaps the pragmatic answer is that will we find out in more detail once we start to implement the bill and see where the warts are. At face value, however, we do not have any unease about the bill. The Executive seems to have tried to adhere to those principles.

Nicola Sturgeon: I am conscious of the fact that the bill was published less than two weeks after the publication of the care development group's report. On the face of it, that suggests that the Scottish Executive did not have much time to absorb the care development group's recommendations before the bill was published. In the light of that, have health boards been adequately consulted about the main provisions of the bill? Would you have appreciated more time for consultation?

Neil McConachie: I would always appreciate more time for consultation. If we are potentially uneasy about anything, it would be the target date of 2002. Let me qualify that by saying that I personally am a believer in the principle that one does not make progress without setting targets. There is perhaps some unease around that date.

Further discussion on the target date would have been good, but we need just to go for it and give it our best shot.

Is that the sort of thing that you were looking for?

Nicola Sturgeon: I was going to ask about your concerns about the April 2002 introduction date. I have read your written submission. Will you expand a little on the difficulties that the introduction date gives you; on the steps that you are taking to meet that date; and on whether, notwithstanding any concerns that you might have, you are confident that you will meet it?

Neil McConachie: I should first point out that today I am representing not just Argyll and Clyde Health Board but perhaps all health boards. Furthermore, Douglas Philips is attending the meeting because he chairs an ad hoc group on community care that work with health board groups. Coincidentally, he also works in Argyll and Clyde Health Board. That is by way of a preface to my point that if more than one local authority is included in a health board area, the problem is not the intent or desire to meet the date, but the sheer work load involved in working with each of those local authorities. Where only one local authority is included in a health board area, the chances are that if people do not meet the April 2002 deadline, they will get extremely close to doing so. However, in cases where five local authorities might be involved—in Greater Glasgow Health Board's case, six local authorities are involved—one of the principles is "One size does not fit all". That implies that, although we could put a framework in place, individual points of detail will still require us to spend time, set up meetings and so on.

Douglas Philips will explain some of the more specific steps that we are taking in our health board area to address such work load issues.

Douglas Philips (Association of Health Boards' Chief Executives): Much depends on where we start from. Everyone started from a different baseline, which means that in a health board such as Argyll and Clyde, where there are five partners, different people are at different stages of working on the Scottish Executive's joint resourcing and joint management circular and the local outcome agreements circular. As we say in our submission, it would be quite easy to prepare planning agreements—or, if you like, to tick a box—and we want to ensure that our arrangements will make a difference on the ground to patients or clients who receive community care. As a result, we will be at different stages with different council partners by next year.

There is also a practical issue about how the NHS family—the boards and trusts—and social work departments can identify from existing funding streams precisely what funding is committed for care for older people. The way in which authorities collect such information is different. We cannot really find out the costs of care for older people without also considering the costs of care of older people with dementia, which in some places is included in the mental health spend instead of the spend on older people's services. As a result, even such seemingly simple issues become quite complicated and require a huge amount of work.

Mr McAllion: The Minister for Local Government and Finance has announced new allocations—£100 million in 2002-03 and a further £100 million in 2003-04—to fund the care development group's recommendations on the implementation of free personal care. Is that provision sufficient to implement free personal care for all elderly people?

Neil McConachie: As I have not worked out the calculations, I am not sure that I could give you anything other than a subjective opinion.

Mr McAllion: So no real work has been carried out on the likely costs of implementing free personal care in your area.

Neil McConachie: I am not aware that we have submitted any figures.

Mr McAllion: In paragraphs 2.6 and 2.7 of your submission, you mention work force issues, particularly the "intensive support and training" that staff will require, and indicate that there is no identifiable funding for such support and training. How much it will cost to provide them?

Neil McConachie: I feel uncomfortable having to say no to two questions in a row.

Any programme of change must involve staff at all levels as much as possible in the design so that they feel a sense of ownership and can input their ideas. When you do that, there will be a feeling of threat. Some people will think, "Is this going to affect my job? What does it mean to me? Could my job move 30 miles?" All those questions will be asked. Involvement is the basic principle, but beyond that, we have to think seriously about training. New skills will be required and identified, but other people potentially—and I stress potentially—will find themselves displaced. We do not want to lose people, so we have to think about whether we can retrain somebody to do a job, which will allow someone else to be trained to do another job that meets their needs as well as the needs of the situation and the people we are trying to look after.

We have to examine how we work with the work force to support people through a change programme that potentially will involve cultural changes from the organisations in which they

work, and changes in the duties that they are asked to perform, and the way in which we approach the care that we provide. It is about being supportive to the work force, because if we are not, and we do not put enough thought and effort into that, that will be an obstacle, as opposed to a force for good. Those are the principles at which we are aiming.

Mr McAllion: Do existing training budgets cover the costs that are involved? Will there have to be an additional specific allocation?

Neil McConachie: On a base management principle, going into a programme like this we should identify a ring-fenced sum of money, because traditionally, as we all know, training budgets usually are among the first to get the push. The answer to your question is yes.

Dr Simpson: One of the elements in the costing package is how many more long-stay beds will be closed, because one of the recommendations is 100 per cent resource transfer. Do we have any idea, at national level, how many more beds will be closed, what the programme is for closure, and what funds will be released by that? The average cost of an NHS bed is £800, but with a package in the community it is £400-odd, even given the current negotiations, which is a substantial saving.

I have two points. First, how quickly can we move towards what you outline in paragraph 2.2 of your submission, which is about disinvestment and flexible reinvestment? Secondly, how much do health boards need to retain in order to ensure the adequate provision of medical and specialist nursing services, and health promotion and health prevention services, in the community care sector?

Neil McConachie: I do not have an added-up number. We have a number of beds that we should be aiming for. On the closure of beds, the principle that we are most comfortable with is that when money is released, and care is reprovided, what is left should be part of a pool. The partners should then discuss how to use the money to provide what is most needed and address the gaps.

In paragraph 2.3 we outline the principle of 100 per cent resource transfer. We are slightly concerned that as care is reprovided, people who require continuing NHS care are likely to be those who require the most intensive care, therefore the proportion of investment in them will go up, but as money leaves the system, we will lose flexibility in the pool to put intensive resources into those who are the most vulnerable. There must be discussion with partners on the ground about the appropriate balance and where resource transfer is used. Resource transfer is not an automatic balanced equation, because you have to examine those who are going to remain and require care, as well as those who are moving into alternative models of care.

Dr Simpson: Do you think—

The Convener: Richard, I will have to cut you off there.

Mary Scanlon: I wish to address joint working between the NHS and social work. You say in your paper that you are "up for it", but you also say:

> "there is a question about the extent to which proper implementation can be achieved … by April 2002."

You raise concerns about planning and commissioning issues, as well as operational service matters. You also raise the question of delayed discharge. I am concerned about your references to culture and attitudes. You say that there are cultural differences between partner organisations and different attitudes and opinions. That does not inspire me with confidence, given that joint working is to be up and running in six months.

Neil McConachie: I would like to separate what you said into two parts. One can be up for it, but better prepared if obstacles that must be tackled to make changes are identified. I do not think that identifying challenges that we face indicates in any way that we do not want to get on with the job in the most aggressive fashion. I would be more worried if we said that we are up for it and that everything in the garden is wonderful and rosy. We would be accused of not paying sufficient attention to detail. I am happy to stick by that—we are up for it, but we know that there is work to do and we must get on with it.

11:45

Mary Scanlon: What will you do to overcome cultural attitudes and differences?

Neil McConachie: I return to the issue of working together with staff and bringing staff together in the same room who come from different organisations and backgrounds, with different practices. There must be joint training and an approach whereby people have the opportunity to speak to each other so that they can begin to understand each other and where others are coming from. One cannot click a finger and say that everyone must think or behave in the same way because legislation says so. It is a matter of how training and working with staff is approached—it must be done on a mixed basis.

Mary Scanlon: You have only six months. What have you done?

Neil McConachie: At a strategic level, for two or three years, there have been roughly quarterly meetings in Argyll and Clyde between the leaders

and chief executives of the local authorities and the chairmen and chief executives of various NHS bodies. Those meetings have been facilitated by the Scottish local authorities management centre at the University of Strathclyde and have tried to eradicate the finger-pointing culture that says, "No, that belongs to the local authority," or "No, that belongs to the health board." I think that we have been successful.

Trying to work together and change cultures from the top is extremely important. That cannot happen without working with staff at all levels, and what I have described is an example of what we are doing. The provision of local councillors on unified boards will undoubtedly drive the process of working together to change culture and attitudes. Joint training of staff who provide services is a critical and positive element.

Shona Robison: You talked at some length about joint working. Will you say more about what role there is for joint assessment?

Douglas Philips: We share the view of joint assessment set out by the care development group—single shared assessment is the only way forward. People at the operational level must adapt existing processes and move to the single shared assessment process as quickly as possible. By that means, the real, integrated care needs of individuals can best be planned and delivered.

Shona Robison: That will not be without difficulties. What action is required to ensure that there is not simply a paper exercise of intention and that the process actually happens?

Douglas Philips: I am optimistic about that. People in that field to whom I speak are keen to ensure that the single shared assessment process works. Reluctance has been shown in one or two places where people have had their own local assessment processes—there has been some reluctance to give up something that they feel has worked well. However, people are getting used to the concept and can see how the new procedure will work. They can see the value and benefits to patients.

Shona Robison: What mechanisms to improve joint monitoring and accountability might be put in place?

Douglas Philips: NHS health boards are keen to be able to measure the health outcomes and to ensure that the changes that the bill proposes will deliver something meaningful and tangible for individuals. Clearly, the performance management arrangements are crucial. In our paper, we set out some possible options for measuring performance. It is our view that we need both to manage the performance of the whole system and to have health outcome criteria by which we can judge whether the changes for individuals, as well as for the system, have been beneficial and can be shown to have been for the better.

Shona Robison: Do you think that there are ways of involving the public in the process of planning joint service delivery and monitoring the progress that has been made?

Douglas Philips: In the paper, we say that service users and their families are fundamental. They must not only perceive a real difference, but be given evidence that a real difference has been made to the care that is being delivered to them.

Shona Robison: Many documents say that the views and involvement of service users and carers are important. However, finding ways of involving those people in planning and monitoring is more difficult. What ideas do you have for ensuring that that happens?

Douglas Philips: In our health board area, we have over the past 15 months done an enormous amount of work to develop a strategy that we describe as new for old, which is a strategy for older people in our health board area. Older people were crucial participants in the process of developing that strategy. We ran a series of theatre company events, which enabled us to access in a more innovative way the views and opinions of older people on the level of service that they perceive is currently available from NHS and social care agencies and how they expect that to change to meet their needs better in the future.

Margaret Jamieson: In responding to Shona Robison's question, you seemed to confuse the accountability process with the performance management process. In your paper, you flag up different mechanisms that could be used for performance management, such as the clinical effectiveness strategy group. By its nature, that group would be totally alien to colleagues working in local authorities. Another issue that you discuss is self-regulation. Would that self-regulation be by local authorities, by health authorities or by an amalgam of the two? Could you expand on your ideas in that area?

Neil McConachie: I admit to finding it easier to envisage how accountability will run down the health line, because that is the line with which I am familiar. Under the performance assessment framework that has just been published, we will be held to account on an annual basis through the Scottish Executive. When we talk about joint management, we are talking about a new way of providing services. I accept that there is still a lack of clarity about whether people will be held to account for their contribution to joint management or for their performance inside their owner organisation. That is bound to be the case unless one sets up a completely new organisation that is

held to account independently, instead of having a joint management arrangement in which people remain part of their original organisation. I can see how those working on the health side can easily be held to account through inclusion in the performance assessment framework for health. However, more thought needs to be given to how what we might call the joint management group will be held to account and by whom.

Margaret Jamieson: Did you discuss that issue with the colleagues whom you are representing here today? Was there a consensus among them about the road that we should go down?

Neil McConachie: I have not received a round-table response from colleagues on that issue.

The Convener: I must now draw this question-and-answer session to a close. There are two or three issues on which we would like further clarification from our witnesses, such as health board lists, the points that Margaret Jamieson touched on and definitions. Unfortunately, we are running out of time rapidly, so I suggest that we follow up by asking those questions in writing. At that point, you can add any further comments that you want to make to the committee.

Neil McConachie: Could I make one quick comment?

The Convener: Yes.

Neil McConachie: I am not sure whether this is a question or a comment; it is not easy to read bills. Our opening comments have been very much about the fact that this is not just about services but about how we provide all sorts of services before somebody gets to the point where they might require services for care of the elderly. One of the points that intrigued me was that, in regard to deferred payments and the potential for selling somebody's house after—I assume—death to pay for care, the bill does not make any reference to what that might mean to a partner who is also moving towards that situation. The stress might accelerate the need for care. Will the committee consider that point?

The Convener: That is a good point. Thank you for raising it with us and thank you for your contribution this morning.

We will now question Unison. Good morning, gentlemen and welcome to the Health and Community Care Committee. First, I apologise for the time that we have kept you waiting. We have had to deal with information not being given to us in time to allow us to examine it yesterday, so we had to discuss it in private before this morning's meeting. That has had a knock-on effect on our timing.

We have received your written submission and we have a series of questions to ask you. I will kick off by saying that the committee was concerned that any policies on community care should be underpinned by the principles of fairness and equity. Do you believe that the provisions of the bill uphold those principles? Are you generally happy with the bill?

Jim Devine (Unison): Thank you for the opportunity to address the issue. Joe Di Paola and I are members of the human resources group that has been set up to look at the HR issues that relate directly to the bill. In our submission, we have highlighted the three models that will become operational under the bill. Each of them causes us concern, because they are short-term models and there has not been medium-term and long-term thinking.

We are not convinced that the principle of fairness will be upheld. We made the point in the introduction to our submission that we need a protocol for discussions so that the trade unions are involved early on in partnership working, to ensure that the principles of fairness and equity that are highlighted in our document are upheld.

The other point that we highlighted in our submission is that this is a massive exercise. We think that it will involve almost 100,000 health and local government workers. Much enthusiasm exists in the service for delivering the type of care that the committee wants to see, but that enthusiasm will dissipate quickly when individuals are working on secondment beside colleagues from health and local government who might be on very different terms and conditions; there might be a difference of £4,000 or £5,000 in their pay. When somebody who is seconded leaves the service, they might be replaced by an individual who is on vastly inferior terms and conditions. Many HR issues are associated with the bill.

The Convener: With respect, the point that I was trying to get at in my opening questions was about fairness and equity in the community care services that are delivered to the client, or the patient. We will return to staffing issues, which are obviously your main concern. We want to see an improvement in the delivery of community care services that is effective and is also fair and equitable. What you are saying is that although you might see that there is fairness and equity in the provision of better community care services, you have a problem with the fairness and equity of the way in which that will affect your members as the bill stands.

Jim Devine: Absolutely.

The Convener: I do not want to lead you, but would it be fair to say that you do not feel that there was adequate opportunity for consultation between the publication of the care development group report and the publication of the bill?

Jim Devine: There is a problem with the initial care in the community group that was set up. Human resources was seen very much as a side issue. As a union, we are here to talk about HR issues. Equally, we have 150,000 members in Scotland. Some members of their families are carers who receive those services directly. We had no involvement whatsoever in that side of things in the working group that was set up.

12:00

Janis Hughes: I declare, as an interest, that I am a member of Unison.

Notwithstanding your comments and understandable interest in HR issues, will you comment on the powers that ministers have under the proposed bill for the regulation of social care, for the purpose of separating out the personal care element from the housing and living costs of residential care packages?

Do you think that a definition of personal care is required in the bill? That has been discussed, but there is not unanimous agreement across the board.

Jim Devine: Personal care was defined south of the border along with nursing care. The bill is about getting away from asking what a social work bath is and what a health service bath is. It is about defining clearly what the arrangements and responsibilities are.

You might have to follow the lead that has been set south of the border and have a definition.

Janis Hughes: Would you like to see that in the bill as primary legislation?

Jim Devine: Yes.

Janis Hughes: Leading on from that, we asked the previous group of witnesses about the timing of the introduction of free personal care. I note from your submission that you welcome that introduction. Do you think that the commitment that the Executive has given to introduce it by April 2003 is an appropriate and achievable time scale?

Jim Devine: The six action points that we identified in our submission will be difficult to implement. There is enthusiasm, but there is a series of practical and cultural issues, which were discussed in the previous witnesses' contributions. I see real difficulties, but it is important to have that target because we want to ensure that it is on the agenda. As a union, we are ensuring that it is on every agenda—for our health committees, local government committees, management committees and branch committees. We are saying that it is a priority. The Executive needs to stick to that deadline. I have my doubts about whether it is achievable, but in the short term, it would provide a culture of togetherness. It would say that health and local government get together and would show that they do not all have horns.

Dr Simpson: You do not mention direct payments much in your submission. The bill will make it a duty for those to be provided and wants to encourage them. What are the staff implications of that because direct payments will allow the individual to purchase care services?

Jim Devine: Direct payments will cause us difficulties, which is why we have gone on to talk about options of management. There is a lot of enthusiasm and commitment and many projects are taking place. However, there will be difficulties as bad practice and bad examples start to come through the system.

We were given a variety of promises and guarantees about the private finance initiative and what that would mean within the national health service. Privatised staff were working in Hairmyres hospital for £4.18 per hour, with no weekend money, overtime rates or pension. Our concern is that if the resources are dissipated—and I see the logic in that—we will have difficulties with the provision of service. We want to provide a quality care service.

You want accountability. When the minister was here earlier this morning, you said that if you are putting money into the service, you want to see the outcomes of that. We are not coming down in favour of any of the three management structures that we brought before the committee, but if you want to go down the road of direct payments, you will have to use one of those models.

Dr Simpson: COSLA's submission mentions considerable concerns in relation to local authorities being dragged in to authorise the services of staff over whom they have no control. What sort of mechanisms should we have beyond the registration under the Regulation of Care (Scotland) Act 2001? Will there need to be local agreements?

Jim Devine: Each of the options that we have talked about in our submission involves the need for professional as well as managerial accountability. We all know the horror stories about the individuals who were recruited without appropriate checks or training and who were not the kind of people we would want to see providing care.

The Parliament should lay down minimum standards. Then we can debate how to provide those minimum standards; we have identified three options relating to training, recruitment policies and ensuring that the appropriate checks are made. I realise that going down that road conflicts with some of the proposals in the bill.

Margaret Jamieson: I want to move on to joint working. I should declare an interest in that I am a member of Unison. I was interested in some of Jim Devine's responses.

You emphasised trade union concerns about terms and conditions and the professionalism of staff. However, the Community Care and Health (Scotland) Bill is about delivering a service to the most vulnerable in our society. Your submission talks about professional accountability. Given that we have just passed the Regulation of Care (Scotland) Act 2001, which requires those professionals to meet certain criteria, similar to those expected of nurses and other professions, how does that square with what you have said about the individual's accountability to their professional accountability?

Jim Devine: I do not really understand your question. We welcome the Regulation of Care (Scotland) Act 2001 as a positive step forward. As members know, we have argued that anyone who goes into any health care setting, whether in the private or public sector, should have some form of training and that there should be minimum standards. We welcome the developments in that area.

The element of accountability is crucial. However, as I said, I accept that that runs contrary to the idea that individuals should determine some of their own care. It is about how we square that circle.

Margaret Jamieson: Are you saying that individuals who are assessed as being in need should have a service imposed on them, by whatever authority, without a choice of what that service should be? They might wish to compensate a member of their family financially or they might wish to buy the services of Joe Bloggs down the road.

Jim Devine: I accept that. That is the difficulty with the structure and the strategy that we are presenting. The benefit of the Scottish Parliament is that we can come and present our way forward, but say that we accept that it runs contrary to some proposals. We welcome individual choice, but if individuals have a choice in the exact way that Margaret Jamieson has outlined, there are potential difficulties.

Margaret Jamieson: Since the time when I was involved in Unison, there have been significant changes, particularly in the way in which services are delivered. Perhaps I should direct my question to Joe Di Paola. For years we had home helps, but very few individuals have that title any more. We talk about home care and a work force that has more skills and, in some instances, long-awaited increases in pay. Is this a further development of something that has been happening already, to fit in with the modern-day needs of the service?

Joe Di Paola (Unison): You are absolutely right. This is probably one of the most radical and crucial developments that will take place in service delivery. Unison represents huge numbers of employees, both on Jim Devine's side in health and on my side in local government. We are committed to seamless delivery for people—that is what our members are employed to deliver. We must ensure that staff are properly trained, organised, managed and resourced to deliver care. We fear that the huge and rapid changes that the bill will occasion in the delivery of a whole range of personal care services have not been properly thought through and have not been properly consulted and agreed upon. I think that I heard the minister say earlier that 70 per cent of the budget will be on staffing. That applies to local authority staffing as well.

We are not here to defend entrenched positions in the health or local government sectors, or even to defend a Unison position. We are more than happy to give members whatever information we can to aid your deliberations, but members must be aware that the implications of the bill for the staff who will deliver the radically changed services are such that we will have to get things right and do so quickly. As Jim Devine has said, we are not pushing any particular model. We are happy to discuss with you and with health and local authority management ways of making progress; however, as trade union officials who represent Unison members, after the delivery of the services, our prime regard has to be the way in which the people who deliver those services are properly looked after, resourced, managed and paid.

Margaret Jamieson: I totally agree. However, we must accept that the bill is a move forward. There are many things in the past that none of us wants to remember—things that perhaps put us where we are today.

Joint working initiatives have been springing up; the Unison submission cites examples in Perth and Kinross and in Dumfries and Galloway—I am sure that you did not have enough paper to list all the examples. However, in a submission that was sent to the Local Government Committee by South Ayrshire Council, the council proposes

"that a single body is charged with monitoring effectiveness of joint working and providing an arbitration service where joint working is failing. It would be necessary for this body to be independent."

What is your view of that statement?

Joe Di Paola: I think that that is almost an admission of failure. If you have to set up an arbitration body for the component parts of a joint working arrangement—in health, local

government, the voluntary sector and wherever else—it is as if you are saying, right from the start, "This is not going to work. There will be real problems and we'll require a referee who is outwith the participant bodies." We are arguing for a clear protocol that will set out how all the agencies and their employees can get together to deal with any issues that arise.

Joint working is the way forward. It is the only way in which we can deliver proper services in the 21st century. Everyone must be committed to it and everyone must be inside the circle. Proposals for an arbitration service seem to me to be an admission of failure.

Eddie Egan (Unison): Fear is a big issue. Everyone is committed to citizenship issues and joint futures, and groups are setting up joint assessment schemes. However, if such initiatives are not pulled together by unified boards, what kind of message does that send to the health sector? Let us consider the situation in the Lothians, which has four different local authority providers and one unified board: is a physician at Edinburgh royal infirmary to learn four different assessment schemes?

We can get people together, although at the moment partnership working across the health sector is not happening. The drivers in our national health service are partnership and staff involvement. Elements of joint future working are now at the top, although sometimes it does not happen at all.

I am convinced that local authority and health authority professionals are concerned about charging for a nurse who assesses a client—a citizen—who requires that level of care. The funding can come from A rather than B. If the citizen does not get the funding, staff are compromised. Standards are set for them by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. It is likely that social services staff will have the same problem with their professional organisations. If we can pull them together using single assessment across almost all of Scotland, the time scale will be more manageable and achievable. That will allay a lot of fear. People, especially at senior management level, need to stop being precious about their budgets. Joe Di Paola and Jim Devine articulated that.

The Scottish Parliament is introducing a bill. We owe the older people of Scotland a better, seamless service. Our members do not fear the bill. I listened to the previous witnesses who said that they were up for it. So are we, although it will not be easy. We can implement single assessment across Scotland with scrutiny from the Scottish Parliament and other places. We must identify what the professional issues are. How do we ensure that nurses' registration is not compromised with the UKCC? I do not see that as a problem, but as a way of enhancing the service.

12:15

Margaret Jamieson: You are right. Citizens should be at the centre. They should not have to fit into health or local authority frameworks. If citizens require social care, that is what they require. Does the bill go far enough? Should we set up something similar to the situation in Northern Ireland where there is one united employer?

Eddie Egan: Given that I am the chair of Unison's Scottish health committee, and that my counterpart is unfortunately stuck in the outer islands—

Margaret Jamieson: I will take that as a no.

Eddie Egan: I would not survive a week if I said that.

Margaret Jamieson: We need to take things beyond saying "I work in health," or "I work in local government." Many issues that relate to human resources are thrown up when we examine those two areas.

In your submission, you do not expand on other areas of your membership. That may be an oversight on your part, which you might wish to correct today, as you have a significant number of Unison members in the voluntary sector who deliver social care.

Jim Devine: In the paper, we are saying that we want to start a debate. The short-termism of joint funding will not stand up. That is for the reasons that we outline in the section about HR, in which we address issues including terms and conditions. We want to start a debate about where we will be in the medium and long long term—as does the Health and Community Care Committee.

We give three solutions. In one of the proposals that we are working on for health and local government, we are going to Northern Ireland. I do not know enough about the situation there and we receive mixed messages—

Margaret Jamieson: As we did when we took evidence.

Jim Devine: You are right. The voluntary sector is a crucial issue. We want to move the game onward in exactly the way that Margaret Jamieson has described. We want to flag up the problems that exist with the present proposals and suggest solutions. Northern Ireland presents another model and there will be others.

Margaret Jamieson: In your paper, you mention the differences in the terms and conditions of local authority workers and health workers. I know the system; the conditions that

apply are national sets of conditions. You then cover the provisions that exist for the voluntary sector. They involve thousands of sets of terms and conditions, yet you make no reference to that.

Jim Devine: We are having discussions with Scottish Care, because of the bill and the way that—

Margaret Jamieson: That is the private sector. I am talking about the voluntary sector.

Jim Devine: I accept what you are saying. We have membership in the voluntary sector, but our experience of some parts of the voluntary sector is that it is not what one might call a model employer. We have had some difficulties—difficulties that you will be aware of from your previous job. We are here to talk about what we would consider model employers and good practice. The convener mentioned fairness. The ethos of the Unison health committee is quality care, dignity and accountability for the staff, clients and patients.

The Convener: I have to wrap things up at this point. We have many more questions, so will you indulge us by allowing us to put them in writing? We can then expand on any queries that we have about your written submission.

As you have stressed, we are talking about the long-term direction of care services in Scotland. I take Eddie Egan's point that as long as we are all positive about what is going on and realise that we are about improving services, and as long as people are in dialogue with one another, many of the issues that you have brought before us today can be addressed. However, we have to do that in partnership with the component parts, including the voluntary sector, the private care facilities, the statutory bodies, the Parliament and the Executive. Thank you for your contribution so far. We will be in touch.

Good morning to our next witnesses. I apologise for keeping you waiting. We have had a bit of an odd morning. You have given us a written submission on the bill, and we have a number of questions that we hope to get through today. The committee is concerned that the community care policies and services that we deliver in Scotland should be underpinned by principles of fairness and equity. Do you believe that the bill upholds those principles?

Councillor Ronnie McColl (Convention of Scottish Local Authorities): I think that it does. I do have a short opening statement.

The Convener: I am sorry, but we have only about 20 or 25 minutes—I know that you have to be away by 12.45. If you read out your opening statement, we will have less time for questions, but if you provide us with a copy of the statement, we can pick things up in writing after the meeting. The most productive use of our time today is probably to ask the questions we want to ask, based on what you have given us so far.

Councillor McColl: That is fair enough. There are five members of the delegation—the various members will deal with different questions as they arise. This is only my third day as spokesperson, so please be gentle.

The Convener: I wish you all the best in your new post.

Janis Hughes: You state in your submission that you would be unhappy if the Executive issued statutory guidance on charging, as you think that that would result in ill-defined and unresourced commitments being passed down to local government and that you would have to find money out of your already stretched social work budgets. Can you outline the progress of the work that COSLA has undertaken on charging guidance for local authorities and the proposed time scale for completion of that work?

Jim Dickie (Convention of Scottish Local Authorities): A great deal of work has been done and COSLA has reached an interim position. The final details must be linked to the detailed proposals, guidance and regulations that will follow and to the completion of the progress of the bill. The starting point was difficult because, as members are aware, there are 32 different charging systems in Scotland. That reflects the position that central Government took until relatively recently. Now we recognise that a balance needs to be struck between having a completely open situation, in which every authority has its own system—people in neighbouring authorities would perceive inequities in such a system—and having a centrally prescribed position that ensures that everywhere the situation is the same. Local government should retain some flexibility to determine how it uses its resources to carry out its responsibilities.

Janis Hughes: In your submission you state that

"the issue of mandatory guidance on charging does not arise until an assessment of COSLA 's guidance has been undertaken".

Is that the current stay of play?

Jim Dickie: Yes.

Janis Hughes: You may have heard my next question being put to the previous witnesses. COSLA is one of the only organisations from which we have received evidence that it would be more appropriate for the definition of personal care to be included in regulations rather than for it to appear on the face of the bill. Can you explain how you reached that view?

Jim Dickie: This is a complex area, as the time that it has taken to produce a definition of personal care and the difficulty that the care development group has experienced in resolving the issue reflect. In our view, the definition of personal care that is agreed while the Parliament is considering the bill may not be the definition for all time. There must be some recognition that experience of implementing the bill, of providing care and of managing finances will lead to a changed understanding of personal care. If the definition is included in regulations, all the parties concerned will have more flexibility to review, adapt and fine-tune it over time. We regard the care development group's proposals as manageable, pragmatic and realistic. They provide us with a basis that will allow us to move forward.

Shona Robison: I have a supplementary question on that issue. Is there not a danger that, if the definition does not appear in the bill, it could be watered down? If it were included in the bill, changes to it could be made in the future, but they would need to be considered by the Parliament and would be subject to scrutiny. The definition would not be set in tablets of stone, but any major changes to it would be made through the democratic process. Service users, carers and interested organisations have good reason for wanting the definition of personal care to be enshrined in the bill. It could not then be changed by a future Administration by the stroke of a pen

Jim Dickie: I doubt whether the definition could ever realistically be changed by an arbitrary decision by any of the parties. The nature of community care services is now such that decisions are taken largely by consensus. Services evolve and priorities are set by consensus. That is the reality on the ground. Increasingly, users and carers have a central position in the evolution, development and prioritisation of services. That is an important safeguard.

Given the capacity that parliamentary committees have for scrutinising the performance of the Executive and of care providers—the health service, local authorities and so on—there would be ample scope for them to review fairly closely the performance of the bill and of care providers on the ground. I do not envisage any great difficulty with that approach.

This is a complex field and it has been difficult to get to where we are. I am a wee bit anxious about setting everything in concrete at this stage, in case we have to revisit the whole process soon. There is scope for evolution and, given my experience on the ground with users and carers, my view is that they would recognise that degree of pragmatism.

Mary Scanlon: Last week, we received a submission and oral evidence from representatives of the Royal College of Nursing, who suggested that nurses were reluctant to be employed by local authorities or other organisations that have not employed nurses before. Given that local authorities are to become major employers of nurses, I was shocked to hear that the RCN had not talked to COSLA and that, consequently, COSLA had not talked to the RCN. There is serious concern about the huge human relations issues that must be overcome, given the fact that the systems must be in place in six months.

12:30

Jim Dickie: I am not entirely sure that I agree that local authorities will become major employers of nurses. The provisions of the bill on joint working are enabling, to a large extent. They leave open the arrangements for managing and resourcing community care services, which are to be agreed at the local level between the health authorities and local authorities. I recognise that nurses are concerned that their professional status is being threatened and that they feel that they might have to move out of nursing into some other care sphere. I am sure that we can deal with the practical issues that exist within the constructive setting of the developing joint working relationships. I am not unduly concerned about that, although I take your point about the importance of the nursing profession talking to local authorities soon.

Margaret Jamieson: I do not share Mary Scanlon's view that nurses will have to change their employer base just because joint working is going to be introduced. For example, an individual might remain in one establishment, even if their needs change over the piece. They may need one type of nurse for a few years, after which they would move on to another type of nurse. If the local authority houses that individual, it would be wrong to specify that that local authority should have to provide that service. Am I correct to say that, if joint working is introduced, the local authority will buy in such services from health colleagues in the area?

Jim Dickie: Perhaps I can provide an illustration that is based on local experience and that I am sure is typical of the arrangements that exist in a number of areas. In the authority in which I work, we have what we call an intensive home care service, which co-locates home care staff, home care managers and community nurses, who are seconded in from the local primary care trust. The local nurse manager has access to other community nursing services, which can be accessed as and when required for the group of people with whom we work on the basis of an assessment. I do not suggest that that service is unique, but it is a model of how we might be able

to move forward, as it allows the flexibility that Margaret Jamieson referred to. It is important that we recognise that people change over time and that we should not get stuck with a rigid prescription. We should be able to respond flexibly to people's needs.

Mary Scanlon: It sounds as though many of the perceived threats could be overcome if people were simply to talk to one another.

The submission from COSLA says that

"no case has been made for the creation of a further power of ministerial direction which could have a perverse effect on joint working arrangements".

Could you explain what that means?

Jim Dickie: The stage that we have reached on joint working has been achieved through a lot of hard work. I take the point that previous witnesses have made about the different levels of joint working and its effectiveness throughout the country. That has been arrived at through commitment and effort. I firmly believe that the way forward is to construct the opportunities that I have just outlined to bring together people who deliver services and their line managers. The greater the confidence that they have in each other's judgment, performance and targeting of resources, the more feasible it is to think of joint working and integrated working as really meaningful.

It would be wrong to start by creating a superstructure—a new organisation—to take over responsibility for that. Such an organisation would pluck key elements out of the existing organisation, and that is a recipe for turbulence and disruption. We have had experience of that both in the health service and in local authorities over the past few years. That would not be the starting point for me. We may reach that stage at some point in the future, but it is far too early to say what will happen. The danger of providing for such a superstructure in the bill is that it would be seen as a threat. People instinctively react badly to threats. We are talking about building a culture and climate of confidence and collaboration. The suggestion seems unhelpful and unnecessary at this stage. The Executive and others have levers for monitoring and holding people to account so that we can be encouraged, pushed and cajoled without that specific step being necessary.

Mr McAllion: In your submission you are fairly forthright in your opposition to the ring fencing of resources. Indeed, you complain about the increase in ring fencing in recent years. However, the care development group pointed to a £43 million gap between grant-aided expenditure for community care services for the elderly and actual budgeted local authority expenditure on those services. Given that gap, how can we ensure that additional funding, such as the £100 million in each of the next two years for free personal care, will actually be spent on that unless it is ring-fenced?

Jim Dickie: That is a difficult issue. I am sure that you will be aware that local authorities have responsibility for the full range of social work services. Although there appears, according to one calculation, to be a deficit in the spend on community care services in relation to GAE, local authorities have overspent in other areas. Local authorities take those decisions at local level to deal with their responsibilities, and the process can be difficult and painful.

Mr McAllion: If the Parliament votes, as it will on the budget, for £100 million to be allocated to implement free personal care, why should local authorities be able to overturn that decision?

Jim Dickie: I am coming to that point. If that proposal is made explicit in the bill, it would be surprising if local authorities sought to thwart it.

Mr McAllion: If money for free personal care was ring-fenced, would not it be easier to pool budgets between local authorities and health boards?

Jim Dickie: I do not think that it would be any easier or any more difficult. The field that we are talking about requires a lot more pooling and joint management of resources than is constituted in the care development group's proposals. I expect that we will go beyond that in terms of the resources that we commit to joint activity.

Mr McAllion: The care development group has recommended that all the funding for older people's services should be the subject of clear outcome agreements that are closely monitored. Would COSLA support that?

Jim Dickie: Yes.

Mary Scanlon: We are concerned about outcomes, as you have heard, but we are also concerned about inputs. The Scottish community care statistics for 2000 show that net expenditure by social work departments on all community care clients fell by £45 million between 1997 and 2000. What is the point of putting more money into the budget if we cannot measure the outcome and if spending over those three years fell by £45 million according to Government statistics?

Jim Dickie: Local outcome agreements are an important way of dealing with that issue. That approach deals with the outcomes of the activity that we are engaged in. It is a useful safeguard for how we approach the issue in future.

Mary Scanlon: You are receiving more money from the Executive, but you are cutting community care funding by £45 million.

Jim Dickie: We also spend on other services

substantially more than we receive from the Executive. Local authorities face a difficulty in balancing their resources with their responsibilities. On the care development group proposals in the bill, we are committed to working through a mechanism of local outcome agreements that will safeguard the investment that people want to make.

The Convener: Richard Simpson will speak next. I ask him to talk about deferred payments and top-up costs.

Dr Simpson: I will ask about both. Delayed discharges are a big problem, but we cannot discuss that today. They relate to joint working. If the budget has been underspent by some £43 million and delayed discharge numbers have increased by 20 per cent or 25 per cent in the three years to which Mary Scanlon referred, the health service must pick up the tab, so joint working must start to show signs of success.

COSLA has clear concerns about deferred payments. Your submission says that there is no budget for dealing with them in the three-year local government settlements. Should deferred payments be covered by the bill? Should local government receive extra money for them?

This morning, we heard about how long an individual is likely to have before a local authority claims the capital involved, but partners are another matter. If there is a lien on a house, a local authority would not want to evict anyone from that house. The purpose of the arrangement is to prevent people from being evicted.

Jim Dickie: That is a clear misunderstanding of the arrangements. There is no question of eviction being an option. We were slightly surprised that that question was asked today. We understand people's concerns about that, but the reality is different. That is a public information issue. I am trying to remember your earlier question.

Dr Simpson: It was about your funding concerns.

Jim Dickie: A new responsibility is being placed on local authorities and they must construct a system to manage that new activity. I would be concerned to find ways to fund that that avoid impoverishment of people who require care, but we must also ensure that that is not a back door to discounted access to services. If people postpone payment and no provision for interest is made, local authorities will have to pick up the tab. That technical issue must be dealt with through the process, eligibility requirements and the financial arrangements. We will have to be careful about that. The responsibility is new and we must explore it.

We have set out our concerns about top-up costs. We must ensure that people's personal allowances are safeguarded from predatory demands, because it is important that people have a basic amount of money to use for personal purposes.

Dr Simpson: Do you think that that safeguard should be in the bill?

Jim Dickie: Yes.

Dorothy-Grace Elder: Do you have any other suggestions on what it would be useful to include in the bill and do you think that anything has been omitted?

The Convener: I thought that you were going to ask about carers.

Dorothy-Grace Elder: Yes—the protection of carers. I had also planned to ask a question about the housing situation when someone dies, but that has been covered. How can we make progress on aid to carers generally?

The Convener: The bill says that carers should have a right to an independent assessment from a local authority. What impact would assessments and any additional funding that they require have on local authority budgets?

Jim Dickie: We welcome the bill's provisions on carers. We were slightly disappointed that carers were not the subject of a separate bill, but we express some satisfaction about the fact that the bill will enhance their position.

It ought to be possible to address carers' proposed separate right to assessment with the additional resources that will be made available to us over the next few years. There is some speculation—nobody has a great deal of certainty—about the additional demand that might be made on authorities for that. At this point, it would be unrealistic to claim that we will be grossly under-resourced. We will have to suck it and see.

Crucially, the developing relationships with carers—their greater capacity for sticking up for themselves through local organisations—means that the position will become clearer quite quickly. We are fairly sanguine about the situation.

12:45

Dorothy-Grace Elder: Do you include advocacy in that?

Jim Dickie: No, we regard that to be separate, additional and important. We certainly invest in that.

The Convener: Margaret Jamieson has a small, final question on implementation.

Margaret Jamieson: In your submission, you indicated that implementation will have cost and

staffing implications and that the time scale that has been set in the bill is not realistic. You also discussed the task of implementing such a complex scheme. However, you seem to be saying today that things are already in place on the ground. How do you back up your statement about complexity?

You mentioned in your submission that staff need to be trained in risk assessment. I sincerely hope that staff who deliver services assess the risk on a daily—perhaps even an hour-by-hour or minute-by-minute—basis. Brokerage and contract management requirements were also referred to. To me, that implied that you really did not like the bill and were throwing a spanner in the works so that you did not need to go down that road. That is not what you have said in your oral evidence today.

Jim Dickie: I certainly want to disabuse the committee of any notion that we have got the situation sorted. I heard some of the earlier witnesses talking about being up for it and I share that view. I suggested in my introductory comments that good work is going on, but that that work is not perfect and has not reached an end point. We are in a process of continuous improvement. I believe firmly that relationships on the ground and at senior level are getting better—people now understand each other's language much better.

However, it is impossible to legislate for changes to take place suddenly—on a particular day—six months from now. Hard work is necessary. Within the framework of the bill, the conditions are being created for moving further down that road. That is the message that I tried to give.

The bill contains some innovative elements about contracts and training. For example, the expansion of direct payments is an important area to which we are committed. Despite a lack of experience in that area, there is a common view that direct payments are a good thing and should be implemented. However, the system of operation will be complicated. Who will be hired to provide the care and where will they come from? In large part, those people do not exist at the moment. Businesses must be grown in the independent sector so that they can be engaged to provide those services. That takes time and requires the local authority—as the overseeing agency, so to speak—to be confident that the people working or managing those services are of an acceptable standard. Systems have to be set up to safeguard the interests of the people who are being empowered.

In my opinion, appetites for accessing direct payments vary across different care groups. Although there is considerably less enthusiasm among older people—which I understand—there is a massive demand for direct payments among younger people with physical disabilities. There will have to be a differentiated response. Different approaches are used to deal with the interests and welfare of those two groups. Direct payments are a good thing, but we must work at improving the system.

Margaret Jamieson: Given that you have clarified your position and maintain that the time scale is unrealistic, what in COSLA's view would be realistic?

Jim Dickie: It would be reasonable for the bill—complete with its provisions on direct payment—to be enacted on 1 April, but people should not expect that the whole show will be on the road immediately. It will take time to achieve wide-ranging implementation, which will involve local outcome agreements, performance targets and so on. We should be reasonable about that.

On joint working, the bill incorporates a lot of the joint future group recommendations. It is important to state what we want to happen, but we recognise that the implementation of that should be a process of continuous, gradual improvement. We do not want that to take for ever, but we need to negotiate and agree with each other on the milestones for progress. Not everything will happen on 1 April.

Personal care and nursing care issues seem to be a priority for everyone and it is important that we recognise that that aspect of the bill must be up and running quickly. The other bits will take a while.

Margaret Jamieson: Are you suggesting a rolling implementation?

Jim Dickie: Yes, that is right. We need to hold each other to account on that, which I think we can do.

The Convener: Thank you very much for giving us evidence. I apologise again for keeping you—we have kept you five minutes longer than you requested. I hope that that is not too much of an inconvenience.

We would be grateful if you would accept other questions, which we might come up with as a result of examining your statement and your earlier submission. We will be happy to accept your comments about the bill—or about anything else.

I remind colleagues that we have a meeting about the draft report on organ donation this evening at 6.30 in room 5.14. I have requested sandwiches because it is a teatime meeting. I thank members.

Meeting closed at 12:52.

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