HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 17 April 2002
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
10th Meeting 2002, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS

*Bill Butler (Glasgow Anniesland) (Lab)
*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)
*Nicola Sturgeon (Glasgow) (SNP)

*attended

WITNESSES

John Aldridge (Scottish Executive Health Department)
Alistair Brown (Scottish Executive Health Department)
Alasdair Munro (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

ASSISTANT CLERK

Michelle McLean

LOCATION

Committee Room 3

Scottish Parliament

Health and Community Care Committee

Wednesday 17 April 2002

(*Morning*)

[THE CONVENER *opened the meeting at 09:46*]

Item in Private

The Convener (Mrs Margaret Smith): Good morning, everybody. Welcome to this morning's meeting of the Health and Community Care Committee. I hope that everyone had a good recess. We have received apologies from Janis Hughes.

I suggest that the committee consider in private item 4 on our agenda, on cancer services. We will consider possible witnesses for our visit to the Beatson oncology centre and on the new West of Scotland cancer centre to discuss cancer services in Scotland. Is that agreed?

Members *indicated agreement*.

Subordinate Legislation

The Convener: Agenda item 2 is consideration of subordinate legislation. This morning we will consider eight instruments that are subject to negative procedure.

Road Traffic (NHS Charges) Amendment (Scotland) Regulations 2002 (SSI 2002/56)

The Convener: The first instrument for consideration is the Road Traffic (NHS Charges) Amendment (Scotland) Regulations 2002 (SSI 2002/56). No members' comments have been received, and the Subordinate Legislation Committee has no comments to make on the instrument. No motion to annul has been lodged, so the recommendation is that the committee does not wish to make any recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement*.

Scottish Commission for the Regulation of Care (Appointments and Procedure) Regulations 2002 (SSI 2002/106)

The Convener: The next instrument for consideration is the Scottish Commission for the Regulation of Care (Appointments and Procedure) Regulations 2002 (SSI 2002/106). Again, no comments have been received from members and the Subordinate Legislation Committee has made no comments on the instrument. No motion to annul has been lodged, so the recommendation is that the committee does not wish to make any recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement*.

Scottish Commission for the Regulation of Care (Staff Transfer Scheme) Order 2002 (SSI 2002/108)

The Convener: The next instrument for consideration is the Scottish Commission for the Regulation of Care (Staff Transfer Scheme) Order 2002 (SSI 2002/108). No comments have been received from members. The Subordinate Legislation Committee has made some comments on the instrument. It states:

"in the Committee's view, the drafting of the scheme, in naming individuals, represents a somewhat unusual or unexpected use of the powers conferred by the parent Act that may also raise issues of respect for private life under Article 8 of the ECHR. To that extent, it may raise a devolution issue. The Committee therefore draws the instrument to the attention of the lead committee and the Parliament on these grounds."

Do we have any further information on why the Subordinate Legislation Committee has done that?

Jennifer Smart (Clerk): That is the committee's recommendation in its report. However, no motion to annul has been lodged.

The Convener: We have no time to investigate the issues that the Subordinate Legislation Committee raises, but the committee has brought it to the Executive's attention for future reference. The recommendation is that the committee does not wish to make any recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement*.

Regulation of Care (Fees) (Scotland) Order 2002 (SSI 2002/112)

The Convener: The next instrument for consideration is the Regulation of Care (Fees) (Scotland) Order 2002 (SSI 2002/112). No comments have been received from members and the Subordinate Legislation Committee has made no comments on the instrument. No motion to annul has been lodged, so the recommendation is that the committee does not wish to make any recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement*.

Regulation of Care (Applications and Provision of Advice) (Scotland) Order 2002 (SSI 2002/113)

The Convener: The next instrument for consideration is the Regulation of Care (Applications and Provision of Advice) (Scotland) Order 2002 (SSI 2002/113). No comments have been received from members and the Subordinate Legislation Committee has made no comments on the instrument. No motion to annul has been lodged, so the recommendation is that the committee does not wish to make any recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement*.

Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002 (SSI 2002/114)

The Convener: The next instrument for consideration is the Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002 (SSI 2002/114). No comments have been received from members and the Subordinate Legislation Committee has made no comments on the instrument. No motion to annul has been lodged, so the recommendation is that the committee does not wish to make any recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement*.

Regulation of Care (Registration and Registers) (Scotland) Regulations 2002 (SSI 2002/115)

The Convener: The next instrument for consideration is the Regulation of Care (Registration and Registers) (Scotland) Regulations 2002 (SSI 2002/115). No comments have been received from members and the Subordinate Legislation Committee has made no comments on the instrument. No motion to annul has been lodged, so the recommendation is that the committee does not wish to make any recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement*.

Regulation of Care (Excepted Services) (Scotland) Regulations 2002 (SSI 2002/120)

The Convener: The final instrument for consideration is the Regulation of Care (Excepted Services) (Scotland) Regulations 2002 (SSI 2002/120). No comments have been received from members and the Subordinate Legislation Committee has made no comments on the instrument. No motion to annul has been lodged, so the recommendation is that the committee does not wish to make any recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement*.

Budget Process 2003-04

The Convener: Item 3 on our agenda is the beginning of the budget process 2003-04. Our new budget adviser, John Cairns, is present. Colleagues from the Scottish Executive are also with us again. Could you identify yourselves and indicate your areas of expertise, so that we know to whom to address questions? If you would like to start by making a general statement, that would be helpful. I will then open the floor to questions. This morning you can expect a general probing from the committee, rather than specific questions. We have only just managed to get our adviser in place, so we might return to you later in the process with more specific queries. Today we will take a general approach, perhaps picking up on issues that we have touched on in the past.

John Aldridge (Scottish Executive Health Department): I am John Aldridge, the director of performance management and finance in the health department.

Alistair Brown (Scottish Executive Health Department): My name is Alistair Brown and I am the head of the performance management division of the directorate of performance management and finance.

Alasdair Munro (Scottish Executive Health Department): My name is Alasdair Munro and I am the head of the analytical services division of the directorate of performance management and finance.

John Aldridge: I do not want to say very much by way of introduction. In the latest Scottish budget document we have attempted to take on board some of the comments that the committee has made in previous years. We found it difficult to meet all the requests that the committee has made, but we have done what we can to improve and expand the information that we provide in the document. I hope that that is of some help to the committee. We are very happy to take on board other suggestions in future, where possible.

The Convener: Will you identify what you consider to be the improvements in this budget document as compared with previous years?

John Aldridge: In particular, we have tried to add more information about the activity that budget spending has achieved and to provide information about what drives spending decisions—issues such as staff numbers and activity in the health service. That is the main change that we have tried to make in the document. We have also tried to improve to some extent the objectives and targets that we have included in the document.

The Convener: Would it be fair to say that, generally speaking, the health department and the Executive as a whole are moving away from merely considering how much money is poured in at one end toward considering outputs at the other end: that is, what is to be done with money and why it is being used in one area and not in another? Is that what you mean by activity?

John Aldridge: Absolutely. Across the Executive there is a move towards trying to identify more clearly what money achieves, instead of merely identify how much money is spent. Every department in the Executive has had difficulty doing that, in part because much of the activity that is funded by the Executive is carried out through agencies that are at arm's length from the Executive. The Executive does not do much at its own hand—in the case of the health budget, it works through health boards. In the case of many other departments, it works though local authorities.

The Convener: We will pick up on that, because that theme has come up repeatedly in the past two or three years.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): It will be of no surprise to John Aldridge that my interest is in the accountability of health boards—or NHS boards as we call them now—to the health department. In particular, I am interested in how the national priorities for coronary heart disease, mental health, cancer and so on go down to the local level and match up with funding. We have been unable to find that out, because we cannot trace the pounds through the system. How are you trying to achieve transparency for us—we are not accountants—so that we can trace those resources in the budget? Also, how does the department ensure that NHS boards are operating within the national health plan?

John Aldridge: As I have explained on previous occasions, resources are distributed to NHS boards in Scotland through a general allocation—a large sum of money that is distributed primarily on the basis of the Arbuthnott formula. It is then for NHS boards to identify how best to use the resources to meet national and local priorities. Alongside that, ministers set priorities. For some years, the clinical priorities have been cancer, coronary heart disease and mental health. There are also priorities for children, young people and older people. The department sets general priorities, but it also sets some specific priorities, for example on reduction of waiting times. It is, thereafter, for health boards to deliver that agenda. We examine that through the performance management system.

I must make it clear that it is not possible to say that a particular element of the Arbuthnott formula

share that a health board receives is specifically for cancer or coronary heart disease. However, from within NHS boards' own budgets, they may distribute resources in that way to meet their priorities. I invite Alistair Brown to explain how the performance assessment framework will address the second question, which asked how we hold NHS boards to account for the way in which they use resources.

Alistair Brown: The white paper of December 2000, "Our National Health: A plan for action, a plan for change", with which the committee will be familiar, pledged the Executive to introducing a comprehensive performance management framework for NHS Scotland, which would assess health improvement, clinical outcomes and standards of service alongside good financial management. The performance assessment framework was drawn up in 2001. We got it into a state such that it could be sent to NHS boards last October. In drawing up the framework, we consulted widely, including organisations such as Audit Scotland, the NHS, local authorities and anybody else who wanted to respond to the consultation on the web.

We have ended up with a framework containing 60 quantitative measures and about 35 qualitative assessments. When we remember that the framework attempts to cover the full range of NHS activities in Scotland, those 60 indicators and 35 assessments represent quite a high level of aggregation. The summary framework attempts to set out a small and carefully selected number of targets, indicators and outcomes.

The department is gathering information under those headings about the performance of each of the 15 NHS boards' systems. I can elaborate on the framework's features, if committee members want me to do so. The department will discuss the information about the health systems with each board at the annual accountability reviews. The outcomes of those review meetings will be summarised in letters from the department to the chief executives of the NHS boards. Those letters will be published in the NHS boards' annual reports.

We have also indicated to NHS boards that, in their annual reports, they should publish selected information from the performance assessment framework. That will allow boards to fulfil accountability requirements.

Margaret Jamieson: I want to pick up on that. It will not satisfy me if the performance assessments are published in the annual reports, because that would mean that the performance assessments would be over a year old. In addition to that, selective publishing by NHS boards is unacceptable. The committee has consistently asked for publication to be part and parcel of the performance assessment and for the department's letter to be published when it is issued to the boards.

I ask the department again to consider doing what every committee member since the Health and Community Care Committee's inception has consistently suggested the department should do. You are not meeting our aspirations, which are driven by the aspirations of our constituencies. Could committee members see the form to which you referred? The form might be helpful to us, if we need to call you back at a later date.

On accountability, will those reviews continue to be done in a closed room? If not, will they be open to the public? Will they be held in the NHS boards' areas, so that the public can attend? We have not moved forward on that issue.

Alistair Brown: I will respond to those points, but perhaps not in the order in which they were raised. We will send a copy of the performance assessment framework document to the convener for distribution to members. However, the document has been on the worldwide web since last October.

Margaret Jamieson: I assume that the document has been refined since then.

Alistair Brown: The document has not been changed since last October. It is the same version that we sent to boards on 4 October.

The Convener: Were no changes made to the document after it had been put out for consultation?

Alistair Brown: No. We put the document out for consultation in June and took account of comments in the version that was sent to the NHS boards in October. That version will form the basis of the performance analysis that will underpin this summer's accountability reviews. We will send hard copies of the document, if that would be helpful.

The Convener: Yes.

Alistair Brown: On the issue of the department's letter to each NHS board, our current position is that the letter is for action by the boards. It is fair and reasonable to expect the boards to take responsibility for publishing the letter. In many cases—

Margaret Jamieson: You are totally missing the point.

Alistair Brown: Last summer, most NHS boards made the letter public by tabling it as a board paper.

Margaret Jamieson: You have to be in the loop to get the board paper. That is the whole point.

The Convener: Do you want to continue? I am sure members will return to that point.

Alistair Brown: On the question of selective publication of performance assessment framework—PAF—data, my choice of words has probably given a wrong impression. We are about to provide guidance to NHS boards about the publication of PAF information in their annual reports, which will say that that information should be balanced and transparent. The information should reflect the full range of performance across the range of services, so that it includes areas in which there might be weaknesses that need to be addressed and areas that the NHS boards are proud of. There must be a balance of information. At this stage, we have not said that everything in the performance assessment framework should be published, because to do so would mean that each NHS board would need to publish a book that would be almost the size of the AER document.

10:00

The Convener: Let me compare such a document to something similar. From time to time, all members receive copies of the report that Her Majesty's Inspectorate of Education publishes when it inspects one of their local schools. Such reports are for action by the school and by the local authority, but they are still published and made available both to local members and to parents. Such reports receive input from local members, the wider community, parents and school boards. That level of transparency seems to me to be perfectly reasonable. If that is available at the level of a school, why cannot we expect a similar level of transparency for the massive amounts of public money that are given to health boards?

Alistair Brown: Let me make two points. First, the performance assessment framework is one of a variety of ways in which the work of the NHS is scrutinised and reported on. Members will be familiar with the work of the Clinical Standards Board for Scotland. As I left the office, I picked up the Clinical Standards Board's report on the performance of Argyll and Clyde NHS Board on the secondary prevention of heart attack. It is one of six such reports on every one of the 15 health systems. The Clinical Standards Board is about to publish another set of reports on schizophrenia. This spring and summer, more reports will be published. We are talking about the publication of up to a dozen such reports on each NHS system.

In addition, the Scottish Health Advisory Service publishes reports. A large amount of pretty consistent and systematic information is published about the performance of NHS bodies. I do not say that in answer to the point that was made, but it is part of the context.

Secondly, we are still part way through the first year of the cycle of collecting and analysing PAF information, which we discuss with NHS boards and publish. There is perhaps scope for us to consider where the best balance lies between publishing comprehensive reports and producing doorstop or telephone directory amounts of information.

Margaret Jamieson: I think that you fail to understand the point that we have consistently made. We receive copies of the SHAS reports to which you referred, but we do not get copies of the performance assessment framework information that relates to the NHS board areas that we are involved in. We have asked why we do not get that information, but we have not received a suitable answer. It is not for officials but for us to determine whether the information is valid and appropriate.

The Convener: I clarify that Margaret Jamieson makes that point on behalf of all elected members, not simply members of the committee.

Margaret Jamieson: The committee has consistently asked for that information.

John Aldridge: We will take that message back. Alistair Brown has tried to explain the reasoning behind the line that we have taken until now. We have attempted to strike a balance between being as open and transparent as possible and not overloading the system with enormous documents that might be unwieldy to use. We are certainly happy to take that back and reconsider the issue.

Margaret Jamieson: To be frank, it is for us to make that decision.

Nicola Sturgeon (Glasgow) (SNP): We have heard "We'll take it back and look at it" before now. We now want an answer. If we cannot get the information, we want to hear a better reason for keeping it from us than the one that you have given us today.

Mr John McAllion (Dundee East) (Lab): John Aldridge mentioned the general allocation to boards on the Arbuthnott principles. That means a shift of resources away from relatively affluent areas to more deprived areas. For example, Tayside will lose over time compared with Glasgow. However, there are very deprived areas—some of the most deprived—in Tayside. What checks does the Executive make to ensure that boards are operating the Arbuthnott principle in the allocation of funds in their board areas? Is that process part of the performance assessment framework?

John Aldridge: It is up to individual health boards to decide where they need to invest the resources that they get to achieve the best health

outcomes. They are not necessarily obliged to invest more money in deprived areas than in other areas.

Mr McAllion: Does not the Executive even check whether they are doing so?

Alistair Brown: Within the performance assessment framework, there is a measure of the proportion of expenditure that goes into the most deprived areas. A bit of technical work is being done on how one measures deprivation and expenditure on it. I will find the measure in two seconds and read out what it says. Alasdair Munro's people are doing work on measurement of deprivation and the appropriateness of indicators of deprivation.

Mr McAllion: If you gather the information, do you do anything about it? If you discover that Tayside NHS Board is not directing money to the most deprived areas, do you just say, "That is up to them; it is their decision"?

John Aldridge: No. As with any other item in the performance assessment framework, if we identified any issue at the time of the accountability review and through the performance management system throughout the year—deprivation is one of the factors, as Alastair Brown said—we would raise that with the health board and ask it to explain the situation. The board might come up with a satisfactory reason, but if it does not, we would ask it to develop plans to address the problem.

Mr McAllion: What is this "ask it"? The health boards are appointed by and accountable to the minister. If he does not like what they are doing, he should tell them to do something about it.

John Aldridge: We could tell a board to do something about it. When I said "ask", I was referring to asking a board to produce plans. We would not tell a board precisely what to do. We would tell it to put the matter right, but we would expect the board to identify what needed to be done to put it right. It is a question not only of saying that money should go into deprived areas, but of focusing that money where it will do most good.

Mr McAllion: I will ask a totally unrelated question. On page 100 of the annual expenditure report, you mention that one of the priorities is to

"develop policies which reflect the Executive's commitment to equality".

In the objectives that are set out on page 139 to page 141, there is nothing to say how you will promote equality. Why is that?

John Aldridge: The simple answer is that that is because the objectives and targets in the AER still need to be developed further. I am sorry that I have not said that in previous years. The objectives and targets do not cover the full range of what the Scottish Executive health department does, but I accept fully that they should do. It does not mean that equality is not important; equality underlies a number of things that happen in the health service. For example, the Arbuthnott formula is designed to improve equality in the distribution of resources.

Mr McAllion: Nothing in the 65 pages of the AER that deal with health services says, for example, how gender differences in access to health services will be addressed. There are no objectives, no targets and no indication of how you will monitor that. You seem to have done no work on that at all.

John Aldridge: Work is going on in that area, but I accept fully that it is not yet well developed.

Mr McAllion: It is not only not well developed; it is invisible in the AER.

Alasdair Munro: We have been doing work over the past few months on how best to monitor trends and inequalities within each health board area. We have drawn up a list of indicators that we could use for that. The list includes items such as inequalities in mortality rates from coronary heart disease or in mortality rates from cancer. Those indicators will become part of the performance assessment framework.

We will do more work in the next few months in which we will begin to consider inequalities in respect of access to services and how best we can measure those inequalities within each NHS board's area. We will also consider other aspects of inequality that might be important, including inequalities between urban and rural areas, which concern many people. We may also consider gender inequalities in the next few months.

Mr McAllion: That is fine, but if you do all that work, why should not it be included in the reports? The minister is accountable to the Parliament through committees such as the Health and Community Care Committee, which deals with the budget. If such things are not put in the budget, how can there be accountability?

10:15

Alasdair Munro: We have only just completed work to identify the best set of indicators for monitoring inequalities to use at NHS board level. A year from now, when we come to produce a report, I hope that we can begin to draw on that information and show what is happening in respect of inequality, not just nationally, but within individual health boards.

Shona Robison (North-East Scotland) (SNP): Can you provide the committee with examples

from the past three years of when you have had to issue instructions to health boards relating to lack of compliance or when you have been unhappy with performance?

John Aldridge: That would depend on definitions. We are in regular contact with most NHS boards in Scotland on a number of issues. That contact occurs almost daily; it is certainly weekly. The issues range from minor issues to more serious issues.

Shona Robison: You have just discussed some concerns with the committee. You said that you have the power to issue instructions to health boards, if that is required. Have you done so in the past three years? If so, can we see evidence of it?

John Aldridge: There have certainly been occasions when we have indicated to NHS boards that we are unhappy—in some cases, very unhappy—with how they have tackled issues. One example that has been made public concerns the Beatson oncology centre in Glasgow. The minister and the department took clear action to ensure that problems in the centre that had not been addressed were addressed.

Shona Robison: That is an extreme example. We are looking for evidence that the health department has some daily control over, and awareness of, what happens at health board level and that it monitors that. There is general concern that control, awareness and monitoring are not as robust as they could or should be. It would be helpful if you could provide us with reassurance that they are.

John Aldridge: I hope that I can reassure members by—

Shona Robison: It would be good to have evidence.

John Aldridge: As you said, the Beatson oncology centre is an extreme example, but there are other examples. They include financial performance, about which I have previously spoken to the committee. If budget forecasts arrive that show that there is a variation from balance at the end of the year, we will speak to the NHS board and tell it to sort out the problem. If it says that that would be too difficult, we hold meetings with it and hold it strictly to account. We demand plans that show how a balance will be achieved. That happens weekly or monthly.

Among the main functions of Alistair Brown's division in the Executive are maintaining liaison with the NHS boards throughout Scotland and ensuring that it knows what is going on in each area. It identifies where things appear to be going wrong and takes action or requires boards to take action if things are going wrong. If action that is taken by Alistair Brown's staff does not work, we have the scope to escalate activity and call in more senior officials. We can call in people from the boards to the department to explain themselves.

Nicola Sturgeon: Could you talk us through the steps that would be involved in that, from the moment when it is discovered that a board is not complying with your wishes to the point at which you force compliance?

John Aldridge: I will take a relatively easy example to illustrate that. A clear protocol is set out for financial controls and for the steps that need to be taken to implement them. There is a statutory duty on health organisations to break even in a given year. If their financial forecasts suggest that that they will not break even at the end of the year, we contact them.

The first stage involves asking health board representatives why that is the case and obtaining an explanation from them, more or less immediately. If the explanation is that it will be all right on the night as they are expecting income during the next half of the year that is not reflected in the initial figures, and if we are satisfied with that, that is the end of the matter. If we are not satisfied that a health board is aware of the reasons why it is diverging from what ought to be the case, we hold a meeting with its representatives and ask them to explain more clearly exactly why they have got into that position and what steps they intend to take to recover it.

If the extent of the divergence is more than a marginal amount, the board must produce a written recovery plan. That plan is then monitored on a regular weekly or monthly basis until it is delivered. It must include milestones and must show how the board will deliver balance. If, despite adopting such a plan, a board does not deliver on it, a meeting will be held at which the senior officials, including the chief executive and, probably, the chairman, of the health board and trust concerned, will be summoned to account for themselves to the accountable officer of the health department, who is Trevor Jones. If the board still does not deliver, the ultimate sanction is to change the board.

Nicola Sturgeon: Arguably, that is not the best example, because it involves a statutory duty and is therefore the most black-and-white example that could be used. What if Malcolm Chisholm announced that £40 million extra were to be allocated to improve performance in a particular area, for example to cut waiting times from cancer diagnosis to treatment? How does the process work in such situations, which are less black and white and which do not involve a statutory duty on a health board to ensure that money is spent on the health minister's priorities?

John Aldridge: The arrangement for such cases is similar to that which I have just described, but it depends on the issue exactly how it would work. Waiting times are an interesting example. If extra resources are announced to reduce waiting times for cancer or coronary heart disease treatment, for example, the health department waiting times unit will play its specific role of following up the progress of each board on a regular basis.

The unit first ensures that the boards have targets that are appropriate to what they will achieve locally towards the national target. Secondly, it monitors that progress over the years. Thirdly, it identifies with the board why progress towards the local target is not being achieved—if that is the case—and whether the situation is recoverable and, if it is not, it starts an escalating procedure similar to that which I described earlier, with senior staff being called and held to account for what they are doing and why. If a board deliberately refused to carry out national policy, the ultimate sanction would, again, be to change the board.

Mary Scanlon (Highlands and Islands) (Con): I seek clarification. We are trying to ascertain the extent of the discretion that local health boards have. Page 108 of the annual expenditure report says:

"In general, NHS Boards have discretion over how they spend the funds allocated to them as long as it is in accordance with the agreed Local Health Plans, which in turn must reflect national priorities."

Are you saying that health boards have absolute and total discretion, provided that they do exactly what you tell them to do?

John Aldridge: I would not go as far as that. Health boards have discretion, but they must deliver on the national priorities. However, those priorities do not account for all the boards' resources and do not limit their discretion completely. Health boards produce a local health plan, which should have a balance of national and local priorities. The plan should show how the board will deliver on national priorities and what local priorities will be addressed. When a board has set out its proposals in the plan, we expect it to stick to that. The board can be held to account over the plan.

Mary Scanlon: So they are your priorities.

John Aldridge: The local priorities are not necessarily—

Mary Scanlon: They must reflect national priorities.

John Aldridge: Indeed.

Alistair Brown: Local health plans should include national priorities.

The Convener: Health boards can add different local priorities on top of the national ones.

John Aldridge: Absolutely.

Mary Scanlon: Only if they have spare cash.

I want to come back to one of John McAllion's points. Last year, the minister said:

"The main areas that will be covered"—

in the performance assessment framework—were

"first, health improvement and the reduction of inequalities; secondly, fair access to health care services."—[*Official Report*, *Health and Community Care Committee*, 31 October 2001; c 2110.]

John McAllion mentioned Tayside NHS Board, which had a budget deficit of £12.9 million or £19 million—whatever it was. If health boards pass their performance assessment but do not balance the books, will the board be sacked? Which is the priority: the performance assessment or balancing the books?

John Aldridge: My colleagues might wish to comment on that. One element that has status in the performance assessment is financial balance. If a board fails to deliver on any of the aspects that the performance assessment framework covers, it will be held to account. It will always be difficult to determine when the situation is so serious that the board should go because it has failed on so many issues. Boards do better on some issues and worse on others.

Mary Scanlon: In the case of Tayside, we heard only about the finances. Did the board achieve the aims of the performance assessment framework that the minister set out? Might financial deficits point to a shortage in funding? Is it the case that health boards genuinely try to achieve the aims but cannot do so within the existing budget?

Alistair Brown: I have two points in response. First, Tayside's financial difficulties predated the existence of the performance assessment framework.

Mary Scanlon: I was speaking generally.

Alistair Brown: We cannot answer the question of how Tayside—which was your example—performed against the indicators in comparison with other NHS boards. Indeed, we still cannot answer the question because we are in the first year of the cycle of gathering and analysing information for the performance assessment framework.

My second point is not about Tayside, but I hope that it is relevant. We check that NHS boards fulfil sustainably the objectives and targets that they are set. There is not much point in a board going all out to meet targets one year if the deficit that that creates is so large that the board cannot hope

to meet the targets again. We would be pretty upset with boards that took that approach.

Mary Scanlon: Last year, in a response to a question from Margaret Jamieson, the Minister for Health and Community Care said that he would not allow NHS boards to pull the wool over his eyes. At the same meeting, Trevor Jones said that the Executive would collect data, rather than using

"data that are submitted by the NHS boards."

That sounds as if the Executive does not trust the data that the boards send. Trevor Jones continued:

"An action plan will be agreed … and … sent out in a public letter to the NHS board."

Our concern is about the public letter being tucked away in annual reports. I would like to come back to the figures. The minister also said:

"We are strongly committed to patient and public involvement."—[*Official Report*, *Health and Community Care Committee*, 31 October 2001; c 2110-2111.]

Will the witnesses say what has been done to ensure that NHS boards do not pull the wool over their eyes, how many action plans have been sent out and what has been done in terms of public involvement?

10:30

Alistair Brown: I will try to respond to two of the three points that you have raised. I am not an expert on public involvement, although I am aware that a good deal of work is going on in the department.

I am not familiar with the context in which the minister made the remark about wool pulling, but I am fairly sure that part of the answer to any danger of wool pulling is the collection, analysis and presentation of information in the performance assessment framework. You asked whether we perhaps did not trust information submitted by NHS boards. Within the Common Services Agency there is the information and statistics division, or ISD. It has a large professional staff whose job it is to gather, analyse and purify statistics from the NHS. The information is published and at least some of it has the National Statistics stamp on it, meaning that it accords with certain standards of data analysis and validation. It is with a high degree of confidence that we use information that is pulled together by ISD from the NHS.

The performance assessment framework contains a number of other sources of information—for example, summaries of SHAS reports and summaries of the Clinical Standards Board for Scotland reports. There is also some work in progress; a section of the performance assessment framework is on staff governance and an important source of information for that section is consistent and systematic surveys, starting this year, of staff attitudes in the NHS. Those surveys should provide an independent source of information.

That was about wool pulling. I said that I would also respond on—

Mary Scanlon: Public involvement.

Alistair Brown: Well, you also asked how many action plans we had sent out. I imagine from your quote from Trevor Jones that you were referring to the kind of communication that would go from the department to an NHS board after the annual accountability review meeting, outlining the things that had been agreed. We send such letters after every annual accountability review meeting. We have done so over the past two years. We have already discussed the committee's view on making such letters public, and our position at the moment is that they will be made public—at least at the time of the publication of the board's annual reports. The committee has said that it would like them to be made public more quickly. I do not think that we can give you a commitment on that today, but you have certainly made your view known.

The Convener: We will make that view known to the Minister for Health and Community Care when he is here. It would obviously be a policy decision.

Dorothy-Grace Elder (Glasgow) (SNP): I take it that, when a board fails to deliver on some aspect of health care, the information that you get on that failure comes from the board and from higher management.

John Aldridge: It varies. A failure to deliver on an aspect of the service might emerge from a Clinical Standards Board report or a SHAS report or whatever. There are a number of sources of information on how a board is performing.

Dorothy-Grace Elder: Do you encourage the unions to report directly to you?

John Aldridge: We would expect the unions to raise any issues that they may have primarily through the local partnership forums in their areas.

Dorothy-Grace Elder: But that does not mean that you encourage them to report directly to you.

John Aldridge: We would not encourage them to report directly to us any more than we would encourage other people to do so. However, it is always open to any individual to contact the department directly on a particular issue.

The Convener: Does the department monitor partnership forums around the country to pick up on any trends or to discover whether major issues are being left unresolved?

Alistair Brown: I cannot give an answer on whether someone in the department reads the minutes of all partnership forum meetings.

The Convener: That was behind my question.

Alistair Brown: We can find the answer to that question.

I will give an example of the fact that people from a trade union background are in touch. The committee will know that there has been a lot of concern about hospital cleaning services. Trade unions in the health service have been in touch with the minister and with officials in the health department on that. That is not the only example.

Dorothy-Grace Elder: From which source did you first hear about the crisis at the Beatson oncology centre? Did you first hear about the matter when it became public—when the consultants walked out?

John Aldridge: It depends what you mean by—

The Convener: I am sorry but, with respect to Dorothy-Grace Elder, that question is perhaps unfair. I will reword it. It was mentioned that you have a continuing monitoring process that enables you to identify problems as they occur. We want to know whether you have to wait until an issue such as the situation at the Beatson centre blows up publicly before you become aware of it. The Beatson example is important, but it is just one example. We must ensure that you have early warning systems in place that make you aware of such situations when they are on the horizon, so that you do not have to wait until you read about them in the *Daily Mail*.

John Aldridge: In general, we pick up issues and get advance notice of them. I would like to think that in most cases we manage to resolve matters before they become a problem and hit the papers, but that does not always happen. In some cases, we might underestimate the seriousness of an issue; in other cases, we might overestimate the seriousness.

Dorothy-Grace Elder: Did the board report serious concerns about the Beatson centre to you? Did anyone report those concerns to you in the months leading up to when the crisis became public?

Alistair Brown: To the best of my recollection, senior colleagues at the health department were in touch with the North Glasgow University Hospitals NHS Trust and with senior clinicians at the Beatson centre about concerns that became public, such as those relating to medical secretary staffing and physical accommodation. As far as I am aware, we did not receive advance notice of the planned resignation of the clinicians.

Dorothy-Grace Elder: You must appreciate that the clinicians felt free to speak only once they had resigned. The situation had been rumbling for a long time. I return to the point about a fail-safe—there must be other strands of information. For example, people must feel free to come to you to blow the whistle on what is happening.

John Aldridge: That happens on occasion. There is nothing to stop people whistle-blowing.

Dorothy-Grace Elder: Nor is there anything to encourage them.

Shona Robison: I return you to the reports by the Clinical Standards Board that you mentioned. I gather that one of those reports, which is on severe and enduring mental illness, contains concerns about the quality and consistency of services throughout Scotland. What measures will the health department take to ensure that the resources that are allocated to mental health from the centre find their way to local mental health services, without being diverted into other services?

John Aldridge: The point of Clinical Standards Board reports is to identify standards that are challenging. The Clinical Standards Board would almost be failing if every part of the system in Scotland were already meeting the standards that it sets. The standards should be challenging—they are about continuous improvement in performance. It should not be regarded as a failure that not every part of the system meets the relevant standard.

It is fair to say that Clinical Standards Board reports are precisely the kind of thing that will feed in through the performance assessment framework.

Alistair Brown: Yes, I agree. The primary responsibility for assessing the Clinical Standards Board reports and working out how to ensure that standards are met, as far as possible, in the local health systems lies with the NHS board. The NHS board will have arrangements for clinical governance within the board structure. The CSBS reports raise predominantly clinical matters. The boards therefore have the responsibility, through their clinical governance procedures, to follow the recommendations.

The second point to make is that the CSBS has a follow-up timetable. It does not just issue reports and then have no one review the action. The timetable is a matter for the board but, if it has serious concerns, it will check on progress no later than one year after the original review.

Shona Robison: What action will the health department take if a health board—for good reason, because boards have other important priorities—is directing money that has been allocated centrally to mental health services away

to other services and is therefore not able to respond acceptably with an improvement in standards as per the CSBS's report?

John Aldridge: Alistair Brown made the point that it would become a clinical governance issue. I mentioned that there is a statutory duty to break even, taking one year over another. There is also now a statutory duty on chief executives of NHS bodies to provide clinical quality. In effect, clinical governance is also a statutory responsibility resting on their shoulders. They will therefore be taking that very seriously.

If we received evidence that, despite the CSBS report showing that a change needed to be made, a health board was diverting money away from mental health services to some other purpose, we would follow that up through the procedures that I mentioned—performance management arrangements and escalating intervention.

The Convener: I have a question about facts. I understand that the annual expenditure review reports a growth in the total Scottish budget of approximately 5.6 per cent in cash terms. In real terms, the growth is 3.1 per cent but expenditure on health will rise by 3.9 per cent in real terms. What level of health inflation are you working on having to deal with?

John Aldridge: I might ask Alistair Brown to comment further. As I mentioned, different elements of the health budget have different historical patterns of growth. Government generally uses the gross domestic product deflator as the measure of inflation to allow one programme to be compared with another. That is currently running at about 2.5 per cent a year.

As we mentioned in the report, there are other aspects. For example, prescribed drugs spending has been increasing at about 10 per cent per year and we have no reason to doubt that that pattern will continue. Also, in recent years, the NHS pay bill has risen by approximately 4 per cent per year. Again, there is no particular reason to doubt that that will continue. We take into account such factors in determining how much resource is needed.

The Convener: Drugs and pay are therefore both significant components of the budget that are running at increases of more than 3.9 per cent. What is balancing that?

John Aldridge: The figure that you have to compare the 4 per cent and 10 per cent increases with is the cash increase not the real-terms increase, because the 4 per cent and the 10 per cent are also cash figures.

Pay accounts for about 60 to 65 per cent of the health budget. Prescribed drugs account for a relatively small proportion. That still leaves a balance to meet the other pressures.

The Convener: We hear from our local health boards that, by the time they have dealt with the increases for pay or the consequences of things such as junior doctors' hours or diktats from the health department, they have little left with which to manoeuvre. On the face of it, it might appear that boards have been given a substantial increase, but after the money that they must spend on certain things is taken away, they have only a small proportion left to work with.

10:45

John Aldridge: I do not disagree with the basic premise that pay increases in particular use up a large element of the extra resources that the health service gets each year. However, I do not think that that should necessarily be viewed as a bad thing. I have always taken the view—I think that ministers do so as well—that paying staff a fair amount for what they do is an important element of ensuring quality in the NHS. We will not get good-quality service without that.

The Convener: I do not think that you will find anyone around this table disagreeing with that.

John Aldridge: I agree with your point that only a relatively small proportion of the extra resources will be available for absolutely new developments.

Mr McAllion: The graphs and tables on pages 109 and 110 of the budget document show that spending on acute services accounts for more than half of all spending on all care programmes and that that is set to increase. At the same time, the Executive's policy is to get more people out of the acute sector and have them treated in the community. That seems to suggest that, although we are putting more patients into the community, less of the health service budget is being spent on community services. What action is the Executive taking to ensure that health boards switch spending away from acute services to meet the needs of patients who are going back into the community to receive services there?

John Aldridge: I will start answering that question, but Alasdair Munro might want to comment on the figures as well. The figures show the increasing trend towards spending on acute services, but that is in cash terms. It does not necessarily mean that the proportion of money that is being spent on acute services is rising. That is just a point of information.

Developing services in the community and in primary care is an important element of the Executive's policy on health services. We would expect to see, as part of the local health plan process, how the health system was planning to use the total resource available to expand primary

care and community services and the effect that that would have on acute services. The nature of acute services means that they include most of the high-cost elements of the service. A large element of expenditure on health care will always have to be devoted to acute health services.

Mr McAllion: General practitioners and local health care co-operatives are key components of delivering health care services, but they do not work for the NHS. The Executive does not have any control over them, because they are contractors. You can sack boards, but not GPs. What steps can you take to ensure that LHCCs have the management set-up to deliver the care services that the Executive is identifying? I do not see anything about that. How do we know whether an LHCC has only one officer manager and an assistant and is incapable of delivering services?

John Aldridge: LHCCs work within the context of the primary care trust, as you are aware. The specific resources have been issued for LHCCs. We have ensured that those have been imparted to LHCCs by the NHS boards specifically to ensure that their management capability is advanced and that they are able to play a full part in the local activities of the health system.

One reason for the new unified board system is to allow us to move away from the idea that there are two sides to the health service and to consider the whole-system approach. That will ensure that what matters is that the patient gets care throughout their journey, rather than being passed from one organisation to another.

Mr McAllion: What leverage do you have over GPs?

John Aldridge: We have leverage over GPs through their contracts, but it is fair to say that we do not have as much leverage as we would like to have. The LHCC arrangements are designed to ensure that GPs not only have the capacity to play a fuller part, but are tied in more closely to the primary care trust.

Mr McAllion: Who is monitoring the situation to ensure that that is happening?

John Aldridge: The primary care trusts.

Mr McAllion: And you monitor the primary care trusts.

John Aldridge: Yes, through the NHS boards.

Mr McAllion: Is that part of the performance assessment framework?

Alistair Brown: There are a number of performance measures for GPs, including the number of GPs per 1,000 population compared to the number of practice nurses.

Mr McAllion: You are not monitoring how GPs perform, however. Instead, you are hoping that the trusts do that.

Alistair Brown: We are monitoring that. In December 2000, we set a target in the white paper that anyone who needs access to a member of a primary care team should have it within 48 hours. We believe that that was a pretty good performance measure.

Mr McAllion: It is hardly comprehensive.

Alistair Brown: No. Obviously there are many other aspects of primary care performance to take into account. The performance assessment framework contains a measure on drug prescribing in the primary care sector and on how effective GPs are, for example, at prescribing statins.

Mr McAllion: Effectively, you are dealing with private businesses. They might be cutting costs, which might in turn be harming the delivery of health care. Someone should be responsible for checking whether that is happening.

Alasdair Munro: A range of information is monitored that is relevant to the behaviour of GPs. For example, we can monitor admissions to hospital and pick up concerns about GPs not referring people appropriately to hospitals.

Mr McAllion: Does anyone know the management systems of all the LHCCs? Does anyone record what kind of management systems they have?

John Aldridge: We would expect the primary care trusts to know that.

Mr McAllion: Do you know whether they have that information?

John Aldridge: I cannot tell you today that I know that.

The Convener: Where witnesses have not been able to give us a hard-and-fast answer to questions in oral evidence, we have traditionally asked them to send us a written response.

Margaret Jamieson: On the performance of GPs in LHCCs, there was supposed to have been a push away from private contracting GPs towards personal medical services. However, despite all the pilot schemes, which have ironed out particular problems, we have not seen much movement in that direction. If we are serious about having a whole-system approach to health care, which includes the general practitioner, the GP should be required to look at the whole patient.

At the moment, we have no systems that financially disadvantage GPs when they decide that they are not going to treat a patient and are determined not to tell anyone why, or when—as regularly happens in many health board areas—

they decide to have nothing more to do with patients with drug addictions, because they say that their complaints are attributable to their addictions. If we allow that situation to continue without checking how GPs are contributing to the overall health system, they could begin to introduce conditions for people who abuse alcohol or tobacco and who persistently turn up suffering from migraines, for example. They are beginning to cherry pick, but the budget makes no provision for other services to pick that up. We are paying twice—sometimes three times—as much for the same service.

John Aldridge: Your points are valid. I would like to think that such cases are not too widespread, but I know that there have been some. However, they are a source of concern throughout the UK. Negotiations are taking place about a new GP contract, which is why I mentioned that we have a lever over GPs as independent contractors just now. To be fair, the GPs' representatives, the health service and the Government all take the view that the contract needs to be changed to concentrate more on issues of quality and on tying GPs more closely into the health service agenda. There is no disagreement on that. The discussion is about exactly how to achieve it. The points that you raise have been recognised, but an answer to them has not yet been found. I hope that the issue will be addressed.

Mary Scanlon: As we have just come back from recess and I have spent time working in the region that I represent, I came to this matter quite late, but I have tried to compare last year's draft budget to this year's. I have also looked for outcomes, because for the past three years members of the committee have said, "Okay, more money is being put in, but we want to see the outcomes." We want to see that the outcomes are better, especially as it has been revealed that 20 per cent more money per capita is spent on health in Scotland.

When we compare table 5.4 of this year's budget document with table 5.4 of last year's budget document, we see that planned spending for 2002-03 and for 2003-04 has been reduced. Members have mentioned that 10 per cent of the NHS budget is spent on drugs and that the annual inflation rate in that sector is 10 per cent. We hear about more money coming into the NHS, but if drugs and other factors take more of the budget, that must lead to cuts elsewhere.

I took John Aldridge's advice about statistics from the ISD. When I looked for outcomes, I found that the median wait, which is the subject of one of the targets, has gone up from 47 days to 57 days; the number of patients seen within 12 weeks has gone down from 62 per cent to 53 per cent; the number of out-patients is down by 63,000; and 10,000 more people are on the waiting lists. The outcomes are not great.

As I might not get in again, I will ask my final question. The Executive is about to produce a diabetes framework. Have you had discussions with the minister about the cost of implementing it? Did you cost the cancer plan and the health plan? Do you cost all the management executive letters—now health department letters or HDLs—that are given out to health boards but are not always accompanied by funding? Have you costed the good practice guidance on audiology? Do you work with the ministers every time that there is an announcement to ensure that there is money to back the announcement? Given that you are giving health boards less money rather than more money, do you tell them where to take the money from in order to finance your new plans? That is all.

The Convener: Is that all?

Mary Scanlon: Yes. That is it. I thought that, as I might not get in again, I should have a good go at it.

John Aldridge: I will try to deal with a number of those issues. Forgive me if I do not manage to deal with them all.

Mary Scanlon: I will remind you if you do not do so.

John Aldridge: Yes, do. Your first point was about the reductions in the provisional budgets. There have been small reductions because unallocated resources—either for revenue or for capital purposes—have been transferred to the local government budget to contribute to the cost of free personal care, as local government is delivering that service. That explains the reductions in the overall figures for the health budget.

Mary Scanlon: So that money has gone from the unified health boards to the local government budget.

John Aldridge: No. It should not have come from unified health boards.

Mary Scanlon: They have experienced the biggest reduction.

John Aldridge: Unified health boards?

Mary Scanlon: Yes, health boards' unified budgets.

John Aldridge: The money should not have come from them.

Mary Scanlon: Tables 5.4 in the draft budget documents for this year and last year show that planned spending on the health boards' unified budgets has dropped from £5,138.1 million to

£4,991.1 million in 2002-03 and from £5,505.8 million to £5,338.2 million in 2003-04.

John Aldridge: There may be a difference in what is included in the figures. We will come back to you on that matter.

You asked whether we cost policies such as the cancer plan. A great deal of work was put into identifying what it would cost to deliver the kind of services that are required by the cancer plan. As a result of that, ministers decided—as members will recall—explicitly to announce some extra resources. However, it would be a mistake to suggest that those are the only resources that are being spent on implementing the cancer plan. An awful lot of the resources that health boards already receive go to cancer services. Some of the cancer plan recommendations will be achieved by adjusting the existing spend so that it is used in different ways, but the minister also announced a supplementary £60 million over three years to deal with specific matters that relate to the cancer plan.

Mary Scanlon: Did you estimate the finance that would be required to implement the cancer plan? Do you have a price tag for the diabetes framework? Is there a price tag on the HDLs?

11:00

John Aldridge: We do not always have a precise cost on every HDL that is issued. That is partly because many HDLs have a marginal impact on spending, which can go either way. Many HDLs can be achieved by readjusting spending within the local area. As the convener mentioned, the resources that health boards receive contain a margin—however large or small that may be—that is available for new developments. HDLs do not therefore always need extra specific funding.

Although we do not always succeed, we try to ensure that every new policy development is costed before it goes to ministers. Ministers will not take a decision unless there is information on the financial consequences of that decision. That is a standard requirement throughout the Scottish Executive.

Mary Scanlon: So, basically, you do not know what the diabetes framework will cost or what the total cost of the cancer plan will be. You send out health department letters to health boards, which ask them to meet your performance assessment, but you do not give them additional funding or advice. I know that many health boards have difficulty with the good practice guidelines on audiology because the boards would need to take money from elsewhere to implement them.

John Aldridge: I hope that I am not giving away something that has not yet been announced, but—

Mary Scanlon: Spare the minister a soundbite.

John Aldridge: Extra money will be provided for the purpose of audiology.

The Convener: I think that we should wrap things up at that point—

Mr McAllion: I want to ask a question on an entirely different subject.

The Convener: You can ask the question orally and we will ask for a written response.

Mr McAllion: The estimated payments for private finance initiative contracts are given on page 13. There is £77 million in payments for the health and community care service this year but, next year, the payments go up to £99 million, which is an increase of £22 million. Does that simply reflect the fact that new PFI hospitals are coming on stream or have there been changes in the expected payments for PFI contracts? I am thinking in particular of the PFI contract for the Edinburgh royal infirmary, for which I understand that Lothian University Hospitals NHS Trust has had to make substantial additional payments because of cost overruns.

John Aldridge: The figures simply reflect the fact that new PFI hospitals are coming on stream. If you wish, we can provide more written information on the Lothian position. The cost to the health board of the new Edinburgh royal infirmary, which is a PFI hospital, is the same as was contracted for. The fact that Lothian needs to make some financial savings to balance its books is not due to anything in the PFI contract.

Mr McAllion: It would be helpful to get a letter to clarify that position.

The Convener: I will recap on two or three other things on which it would be helpful to get written clarification. Colleagues may add in any other points of clarification at this time.

On Mary Scanlon's question, we need clarification on the reduction in spend. On John McAllion's question, which was about the shift from acute to primary care, you said that some of the figures were in cash terms, not real terms. We need a written response on where the budget shows the real-terms figures for the shift into community services and primary care services.

On Nicola Sturgeon's point, which other members have also made, we need more information on how the data that are used in the performance assessment system are collected and evaluated. You gave us an example of what would happen if a board's books did not balance. You gave us an example in terms of waiting times. We did not question you on that, but it would be helpful if we had a couple of other examples from the performance assessment system of matters

that are not statutory duties and that do not have ring-fenced money attached to them.

For the sake of argument, let us say that that we are talking about diabetes services, multiple sclerosis nurses or something else that we have discussed in the past. How would you go about evaluating whether the information that you are being given by a health board is correct? What would follow on from that? That will give us a spread of information on how the performance assessment system will work with three components: statutory duties, ring-fenced money and an issue that is not one of the clinical priorities, although you may want to include a clinical priority as well.

Mary Scanlon: I ask Mr Aldridge to address the outcomes that I mentioned in relation to the ISD statistics on waiting times, the number of out-patients who are seen within nine weeks, the waiting times for appointments and the waiting lists. That may identify whether there is a need to reallocate resources. We have to see what is happening.

Mr McAllion: The target for cancer on page 141 of the annual expenditure report is:

"Ensure that by 2005, the maximum wait for urgent referral for all cancers will be 2 months".

That is incredibly wrong for urgent referrals. We need the Executive to explain why it chose that target.

Mary Scanlon: Why is the wait one month for breast cancer but two months for other cancers?

The Convener: That is a policy issue that we will have to take up with the minister.

One other point that we touched on and on which we did not receive the full picture was how the performance assessment of GPs and others in the primary care framework will be done with primary care trusts. We would like a fuller picture of that. That should occupy us until the next time we inflict ourselves on you, or vice versa. Thank you, gentlemen.

That brings the public part of this morning's committee meeting to a close. We will take a comfort break.

11:07

Meeting suspended until 11:15 and thereafter continued in private until 11:28.

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