HEALTH AND COMMUNITY CARE COMMITTEE

Monday 29 April 2002
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
12th Meeting 2001, 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

Richard Carey (Highland Acute Hospitals NHS Trust)
Brian Devlin (Highland NHS Board)
Roger Gibbins (Highland NHS Board)
Malcolm Iredale (Highland NHS Board)
Derek Leslie (Highland NHS Board)
Ken Proctor (Highland Primary Care NHS Trust)
Caroline Thomson (Highland NHS Board)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

ASSISTANT CLERK

Michelle McLean

LOCATION

Highland Council Headquarters, Inverness

Scottish Parliament

Health and Community Care Committee

Monday 29 April 2002

(*Morning*)

[THE CONVENER *opened the meeting at 11:09*]

Budget Process 2003-04

The Convener (Mrs Margaret Smith): Good morning and welcome to this meeting of the Health and Community Care Committee. We are in sunny Inverness—we are delighted to be in the Highlands this morning.

The purpose of the meeting is continued examination of the Scottish Executive's budget, which we have to consider a couple of times every year. This year, the members of the Health and Community Care Committee decided that we wanted to question a couple of health boards about how they decide to spend the money that they get in their block grants from the Scottish Executive. We have found over the past two and a half years that the Executive's budget document is becoming more clear about what happens to the money until it reaches health board level. Thereafter, it becomes difficult for us to track the money through all the health boards in Scotland to find out how they make decisions and spend their money, and whether they are able to track what they do with that money. We then set that information against some of the clinical priorities that have been endorsed by the Scottish Executive and the Scottish Parliament, such as cancer, coronary heart disease, children's health and mental health.

Last week, we took evidence from Lothian NHS Board, which has particular issues as an urban health board and as a tertiary teaching hospital centre. We decided to come to Highland NHS Board to find out a bit more about how the issues that affect rural and remote areas impinge on budget setting. I do not intend to examine the budget line by line financially; this is the Health and Community Care Committee, not the Finance Committee. We are interested in the wider issues that Highland NHS Board must consider when it sets its budget against the backdrop of its being a rural health board.

As some of the people who are present know, trying to be accessible to all Scotland is part of the ethos of the Scottish Parliament, so I repeat that we are delighted to be in Inverness this morning. I welcome the witnesses—I could call you our victims, but that would be wrong—with whom we will discuss the issues I have just outlined. Please begin by introducing yourselves. Thereafter, Caroline Thomson and Roger Gibbins will make a few remarks and my colleagues will ask questions.

Caroline Thomson (Highland NHS Board): Thank you, convener. I, too, was going to mention the weather. We have had blue skies and sunshine for six weeks—the warmth of our welcome will have to compensate for the grey skies. I welcome the committee to the millennium city—I suspect that Mary Scanlon had something to do with bringing the committee to Inverness. Your visit signals that the Parliament is interested in and committed to the challenges that we face in the provision of services in the periphery of Scotland.

Highland NHS board has the largest landmass of any health authority in Britain—the board area is the same size as Wales. As such, we face challenges to do with remoteness, transportation and access to services, and there are big issues about recruitment and retention of staff. We face a daily struggle to provide an equitable service in our area, to ensure fair and consistent distribution of resources and to ensure that people who are most disadvantaged by isolation, ill health and lack of opportunity are properly looked after. We welcome the opportunity to discuss those and other issues with the committee. We want members to leave the meeting confident that we are an open, progressive and ambitious NHS organisation. Our long-term vision is for the Highlands of Scotland to become as well known for the health of its population as for the beauty of its scenery. We look forward to explaining more about how we do things here.

After I introduce our team, I will hand over to Roger Gibbins. Brian Devlin is our communications manager and the lead executive on public and patient participation. Malcolm Iredale is the NHS board's director of finance, Dr Roger Gibbins is the board's chief executive and Derek Leslie is the board's director of strategic planning and performance. Dr Ken Proctor is the medical director of the Highland Primary Care NHS Trust and, last but not least, Richard Carey is the chief executive of the Highland Acute Hospitals NHS Trust.

Roger Gibbins (Highland NHS Board): We have prepared a brief desktop presentation that we hope will cover some of the broad issues in which the committee is interested. I will take this opportunity quickly to run through the presentation. I presume that all members have a copy of the presentation. If not, we have some spares. We appreciate that the information that is contained in the presentation is of a high level.

The presentation is designed to give members a broad overview and to allow you to come back to us with the detailed questions that the meeting is about.

On the first page, we set out Highland NHS Board's philosophy. We see ourselves as an organisation that works with the public, patients, partners and the Parliament to make the Highlands a healthy place to be. We have a series of ambitions. We want our community to be well informed, motivated and interested in its health. We want good, accessible and flexible health services and we want a well trained and supportive staff group. That is what we set out our stall to achieve.

11:15

On the second page of our submission, we set out the governing principles that we try to adhere to as we go about our business. We understand today's meeting to be about how the planning process works and, in particular, how finance fits into the context of policy planning locally and nationally and into an accountability framework. That framework has local and national aspects. We work to a five-year planning framework and have a series of processes of accountability to the Scottish Parliament, the Scottish Executive and the Highland public. I want briefly to talk members through the policy, finance and accountability framework. I will then allude to a few local issues that members might wish to discuss.

On page 4 we have tried to show the policy pathway that we follow, which is very much steered by national priorities. Those priorities, of course, have been widely discussed and consulted on; they are now drawn together into the national plan—"Our National Health: A plan for action, a plan for change". Together with local priorities, they form the Highland health plan, which is produced after a local planning and consultation process. That plan is agreed in draft form with central Government and is implemented throughout the year.

A financial plan must underpin the policy plan and, on page 5, we set out the financial pathway. The current budget for the national health service in Scotland is about £4.7 billion. That money is shared out to NHS board areas according to the Arbuthnott formula. Some 4.4 per cent—£209 million—comes to Highland. We then follow a process of developing and building up trust budgets and provider budgets, taking account of inflation and unavoidable costs. As well as implementing priorities in the local health plan, the money forms the renewed budgets for the two local trusts and other providers. Our budget management and control through the year is designed to achieve our financial targets, which obviously contribute to the position in Scotland generally.

I will give members some illustrative figures. The uplift in Highland from last year to this year was some £17 million, of which £13 million plus is shown in the left-hand box that is labelled

"Roll forward Trust Budgets + Inflation + Agreed costs".

That leaves about £3.5 million for the right-hand box—

"Prioritised developments from Local Plan"—

which are developments that have come through the local planning process.

The third pathway is the accountability pathway, which is shown on page 6. The Highland health plan is a key accountability document and we include in it a very detailed financial plan. We sent a copy to the clerk, so I hope that members will have been able to examine it before the meeting. Among other things, it sets out key deliverables that we negotiate and agree with the Scottish Executive health department, which holds us accountable for delivery. In Highland, we also make promises to our public on the delivery of key targets. We also sent the committee our "Healthy Promises" document, which we publish every year. It sets out the promises that we make to our public this year and how we achieved our promises last year, thus completing the accountability loop. The rest of page 6 shows how that works.

This year has seen the introduction of the performance assessment framework, which is set alongside quality targets for Clinical Standards Board for Scotland inspections. We have routine monitoring through the year, particularly in the operational units of trust management teams and through reports to the NHS board, its governance committees and the Scottish Executive. The end-of-year position on the key deliverables is reported back to the Scottish Executive health department and we are held to account through the accountability review. As I have said, we also report on our performance against our promises to the public. We are explicit about the targets that we have achieved and those that we have not.

That is a very broad overview of the procedure that we follow. I am sure that members will want to ask about it in more detail.

One issue that we want to flag up for members is the impact of the Arbuthnott report, "Fair Shares for All", on Highland. Although Highland gained overall under the revised distribution formula, we have been disadvantaged by the calculation of deprivation in Highland. Some of the indicators that were used to calculate deprivation under the Arbuthnott formula—such as car ownership and multiple occupation of housing—are not sensitive

to rural deprivation. However, Highland has gained because of the cost of running services in remote and rural areas. For the first time, the considerable increased costs that we incur from providing services in an area that is the size that Caroline Thomson mentioned have been recognised. We can describe our approach to that issue in more detail, if members would like.

Page 8 of the paper lists some particular challenges for Highland. Given the geography and spread of population in the region, access to services is a key issue. An increasingly critical issue for us is how we maintain services in remote areas, as the standard of services and expectations increase and retention and recruitment of staff become more difficult. Although Raigmore hospital is classified as a district general hospital, we run some regional services from it, because of the geography of the area and the great distances that people must travel to come here. We can provide members with more detail on the particular challenges that NHS Highland faces.

We are optimistic and positive. We have great aspirations for Highland and for the health of its population. We would not want to finish without mentioning the opportunities that exist. There is the future funding that has been made available to the health service through the chancellor's budget. We believe that Highland is well placed to make the most of that funding by considering all aspects of health—not just health care. That will be assisted by the work that we do with our Highland wellbeing alliance partners, which are the other public and private sector agencies with which we work. Our other advantages are local coterminosity and cohesion, the existence of a Highland identity, and the closeness of public interest and participation in the work that we do.

I have given the committee a brief high-level overview that I hope will enable members to explore some of the detailed issues in which they are interested.

The Convener: I am sure that we will.

Dorothy-Grace Elder (Glasgow) (SNP): Thank you for your presentation. I also thank the public, who have travelled long distances to attend today's meeting.

My question concerns your priorities in setting budgets. I know that you are trying to follow the national priorities and that you also have local priorities. Some of the new money that is available at national level must be used to tackle problems such as delayed discharge. What are your priorities and how do you work them out? Do you do that with full public consultation?

Roger Gibbins: I will respond briefly to that question, before handing over to my colleague Derek Leslie, who will talk about the planning process and how we engage people in that.

The national priorities are local priorities. Cancer, mental health and coronary heart disease are all issues in Highland. We welcome the national priorities and try to deliver on them locally, just as we try to deliver on them nationally. Inevitably, we have specific local priorities alongside the national priorities. For example, at the moment Highland is not alone in having an increased number of patients who require renal dialysis, which is not identified as a national priority. However, we want to meet those needs and to do so in a way that is appropriate to where people live and how they access services. We have invested in renal dialysis services locally and need to do more. We attempt to strike a balance between local and national priorities.

Derek Leslie (Highland NHS Board): It is really good to see you all up in the Highlands. We started to have some realistic ambitions two years ago when the Arbuthnott allocation was announced. Many boards were treading water, but for once, we had an opportunity to make some progress.

The planning process of two years ago, which set the scene for this year, started with two or three days on which people talked about the issues and the priorities that they wanted Highland to have. As has been said, we do not have a choice about some matters. We must budget for statutory must-dos, such as the European working time directive deal for new doctors' hours. We receive an allocation for such things and must provide for them.

Roger Gibbins talked about gateway or service pressure issues, which occur when a service that we deliver must respond to greater demand, and he mentioned end-stage renal disease. We expect, in the next year or so, to have invested an additional £1 million in two and a half years on securing that service for our population and rolling it out to rural communities.

We have a network of local health care co-operatives, which engage—as part of their natural processes—with users and carers in their communities. They are responsible for the bottom-up approach to planning and service responses, which finds its way into the planning process and is taken through the health board and the trust management structure. Both trusts have prioritisation processes that try to balance the need to respond to demand against services and aspirations to develop services, which come up through the planning process, eventually to the board and into the health plan.

Dorothy-Grace Elder: I know that there is controversy over whether renal services should be

provided in Wick or elsewhere. I will not go into that, because I am sure that Mary Scanlon, your Highland area member, will want to question you about that, if there is time.

Lothian NHS Board estimated that it had a pot of money after the new money came in, a sort of reserve pot—not reserves with a capital R—on which it had freedom to think up what innovation the money could be spent on. Has Highland NHS Board reserved a pot of the new money? If so, how much is it and what might it be spent on?

Derek Leslie: We in Highland have called this year the year of consolidation. That might be bureaucratic speak for consolidating what we started last year. We have a pot of money that amounts to £670,000 this year, but we move on to development funding next year of about £4.9 million, and about a further £3 million the year after that. That allows us with our partners, such as the local authority and the Highland wellbeing alliance, and in chats with our MSPs, who have their own pet projects, to pull together for next year's health plan how we will spend and invest that resource. During the year, initiatives will be produced that fall into the category of must-dos. We must assign some of that development pot to underwriting the must-dos.

When the unified board was formed, we recognised that our planning process had to be streamlined and modernised. Part of our development work on the health plan this year is intended to do that and to make the plan more inclusive, more open and more honest.

Bill Butler (Glasgow Anniesland) (Lab): I will press Mr Leslie a little more on increasing public involvement and taking a more inclusive approach. Highland NHS Board covers a large area and public demands will conflict. What role do consumers, patients, family members and taxpayers, or their preferences, play in the decision-making process? How is that acted on and how you will make the process more inclusive and more democratic?

11:30

Derek Leslie: Because of the rural characteristics of our patch, the impact of, or the drive that comes from, local health care co-operatives and their involvement with communities is essential. We adopt and respond to the national priorities, engage with our health council, engage with the Highland Community Care Forum on community care issues and undertake many other initiatives, but it is important that we acknowledge that general practitioners and those who work in rural communities also have priorities that do not sit comfortably with priorities such as coronary heart disease or mental health. Their priorities make their way into the health plan through whatever LHCC debate goes on.

We have a bottom-up approach. An awful lot of our priorities have been underwritten by what we call redesign initiatives. That phrase is a bit jargony. Redesign initiatives are about engaging people in stakeholder conferences and exploring what the issues are for them. We can give you a number of examples. Maternity services are one. Stroke services are another. A strong network of Highland users in our mental health services has been running and has been supported by the board since "A Framework for Mental Health Services in Scotland" was published in 1997. We now have what we call local implementation groups, which have champions—forgive the language—from the local authority and from the health service, who sit down with users, carers and practitioners in the community setting to set the agenda for their development plans for the next two to three years. They all feed into the process, which needs to be balanced through the planning that comes up from the trusts to the board.

Bill Butler: You mentioned mental health services and Highland users. Will you throw some more light on that?

Derek Leslie: An organisation called the Highland Community Care Forum was established a number of years ago. Members might have heard of it. The forum comprises a number of Highland user groups that work in the various communities and have what they call "round tables". They tend to be the key focus for any dialogue or debate on mental health services and are engaged at LHCC local implementation group level and through their contact with the board and the local authority.

Bill Butler: Do those who are involved feel that that level of participation is acceptable or would they like to be able to participate more? Do you find that level of participation and communication to be acceptable?

Derek Leslie: There is always room for improvement. When users are involved, there is often frustration that we do not have the level of resources to make the investment to meet their aspirations.

Caroline Thomson: The Highland users group has existed for about 10 years. It influenced fundamentally the siting of our new mental health facility. My understanding is that no major decision is made without that group's full involvement. Users of mental health services have also provided training for some of us and for local authority members, particularly those on the joint community care committee. We have found that to be extremely valuable.

Our voluntary organisations are an essential partner in providing services. We give more money to the voluntary sector per head of population than any other NHS board in Scotland, although that is still not as much as we would like to give. However, when we received our Arbuthnott uplift, we passed it all on to the voluntary sector.

I will bring in Brian Devlin, because he is in charge of patient involvement and participation. He could give you some broader examples of how we involve the public.

Before I finish, I will mention our youth parliament, Highland Youth Voice, which I would not like to forget. It is a democratically elected youth parliament. Tomorrow, I will go down with the convener of our local authority to meet the Deputy Minister for Justice, Dr Richard Simpson, who has responsibility for drugs policy. We have a very vibrant youth parliament, which is heavily involved in aspects of health, such as "walk the talk" initiatives. We are proud of the involvement that we give the youth parliament in our joint children and young people's committee.

The Convener: Before we hear from Brian Devlin, I will bring in Mary Scanlon who has a supplementary question on participation.

Mary Scanlon (Highlands and Islands) (Con): I would like to come back to the uplift of £17 million and the £3.5 million that Roger Gibbins mentioned. I hope that we get an opportunity to do that later, because I noticed in last month's team brief from Raigmore that that hospital has been working to make £1.6 million of efficiency savings.

On consultation, Caroline Thomson mentions "full involvement" and we have heard about involvement in setting the agenda and the planning process. I note the comments in the Highland NHS Board submission about the community being "well-informed" and "motivated" and about the need for

"real involvement of all stakeholders"

and accountability to the Highland public and the importance of public interest and participation.

Caroline Thomson sent me a letter last year, when I asked about Arbuthnott funds and how they were allocated. It stated that the priorities would include

"Out of Hours Services and the development of Intermediate Services".

The letter also stated that primary care and local health care co-operatives were priorities.

In the past year, the Health and Community Care Committee has heard from Dunbeath, Lybster and Helmsdale about the loss of their doctors. I know that Highland NHS Board is talking to official bodies, such as Highland Community Care Forum, but how have you engaged with the people of Helmsdale on their concerns about the loss of their doctor and the services that are provided there? Have you engaged with them in setting the priorities for Arbuthnott funding, which is all about equality of access to health care? Those people do not feel that they have equal access to NHS services.

The Convener: Could you come back on that point? Brian Devlin can then comment.

Caroline Thomson: At some point I would like to give Brian Devlin the opportunity to give the committee the broader perspective on patient and public involvement. We are not complacent about patient and public involvement. We strive constantly to make it better and more appropriate to the area that we serve.

Mary Scanlon: What have you done to include the Helmsdale action group? People from that group are here today. It is one of many groups that are concerned about the loss of their GP and the fact that nothing has been put in place.

The Convener: The answer that I want from Caroline Thomson is on the generalities of engaging with the public. I am sure that the Helmsdale situation is very interesting, but we would like to hear about engaging with the public in general, whichever communities you talk with. Single-handed GPs are an issue and we will move on at some point to recruitment and retention. If Caroline Thomson answers Mary Scanlon's question, we would then like to hear from Brian Devlin about the general points.

Caroline Thomson: I know that I do not have to tell the committee that Highland NHS Board came into being on 1 October 2001. The issue of recruitment of a replacement GP to serve Helmsdale was dealt with by the primary care trust, because the health board had no locus in that at that time. I will bring in Dr Ken Proctor, because he will give you a better explanation of how we did that.

Ken Proctor (Highland Primary Care NHS Trust): I have great sympathy with the Helmsdale action group. What it has been trying to do is exactly what the primary care trust has been trying to do, that is, to provide safe and sustainable health care services in remote and rural areas. The management of significant change in order to do that has not been easy. I fully appreciate and accept that.

The days of having single-handed practitioners—be they doctors, nurses, community psychiatric nurses or other health care professionals—are rapidly passing. Our ability to recruit staff to work in those situations is significantly hampered by the way that modern

doctors and other health care professionals are trained. They are trained to work in shifts and in teams. We then ask them to work single-handedly, around the clock and with little peer support.

The challenges faced in Helmsdale are a microcosm of those seen throughout the remote and rural health care communities. They are significant challenges in relation to providing safe services. It is worth pointing out that what we currently see in Highland is a sensitive barometer of what is going to happen within the medical profession in the rest of the country over the next few years. Our ability to attract practitioners is predicated, to some extent, on our ability to provide them with the sort of support that they want to see.

One of the main support planks is out-of-hours support. In areas where there have been enough practitioners—nurses, doctors and others—we have seen the rapid growth of out-of-hours co-operatives, which allow all the professionals to work in a different way within a system. That is exceedingly difficult to do in an area where we do not have many practitioners on the ground to start with.

We have been trying to work with communities to provide a different form of service out of hours, but which also allows their practitioners to be available within hours. That work is continuing in a lot of areas of Highland as we speak. Partly due to the Helmsdale issue, communities are becoming more and more aware of the fact that the old order changeth, and that while they may have had a single-handed practitioner for many generations, it will no longer be acceptable or possible to deliver that in the future. We need to start examining new models of care.

Mary Scanlon: The point is, Dr Proctor, that communities are losing their doctors. Yes, we realise that the days of Dr Findlay and Janet being on call 24 hours a day, seven days a week, are gone, but the point is that you have been aware of that, not for one year but for many years. Communities are concerned. You face challenges, but communities cannot see anything replacing their doctors.

People in those communities are not unreasonable. They realise that there are problems with recruitment and retention, but they are looking to you for a substitute—something to give them the level of care that they require, given the horrendous weather problems in winter and the remoteness that they face, which increases the cost of journeys to see a doctor. We all know the challenges, but how much do you engage with those communities? How much do you listen to them in setting your priorities, and how long will you wait, while they lose their doctors, before putting something else in place?

The Convener: Before you answer, Dr Proctor, I will abuse the privilege of the chair and ask you a supplementary question. Can you explain the options that you have in your armoury to deal with the issues that have been raised? We have all seen those issues at first hand. One thing I think that all members of the Health and Community Care Committee do at various points is escape out of Edinburgh. I spent time in Argyll last summer and saw the recruitment problems there. What do you have in your armoury to try to attract people? What, if anything, could you get from the Scottish Executive and the Scottish Parliament that might make that job easier? It seems to me that flexibility is required: not just flexibility in what you pay people, but flexibility of out-of-hours services. How can you achieve flexibility?

Other issues that have been raised are housing and the fact that even if a practitioner is attracted to an area, their spouse or partner may not get employment in the area. The issues are complex. I am interested to know what you are able to do about those issues, and whether there is anything that we can do to improve flexibility. Obviously, we have salaried GPs and dentists now. I would like your opinion on that and on whether we can do anything else.

Do you have a supplementary question, Nicola?

Nicola Sturgeon (Glasgow) (SNP): The points that the convener and Mary Scanlon have raised are important. I want to take us back a step to where Mary Scanlon started. It is important that we do not gloss over the issue of public consultation. The models of public participation that we have heard about sound fantastic in theory, but on the way in today I was handed a piece of paper that said that the people of Helmsdale

"have been subjected to a change in service without any consultation that"

they can discover. Before we go on to discuss the points of detail that have been raised, could you talk us through the consultation that took place with the people of Helmsdale prior to the decision being taken to merge the GP practices of Helmsdale and Brora?

Ken Proctor: I am happy to do that first, but I may have to be reminded of some of the other questions, because I suspect that there could be a whole day's debate on this issue alone.

The Helmsdale appointment was advertised in the normal way. No individual practitioners came forward for the post, but the neighbouring practice of Brora did. A meeting took place with the local MSP and MP in Helmsdale a year past February to discuss the matter. Thereafter, there was an open meeting to discuss the issue with the community. At that stage, we were in a difficult

situation, because not a single practitioner had come forward to apply for the post. However, the Brora practice was willing to amalgamate with the Helmsdale practice and that amalgamation went ahead. There was considerable disquiet in the community and, as we are aware, that has continued until now.

We were pushed into doing what we did because we have to provide medical services to all communities; we have no option but to do that. We had a locum in Helmsdale for a considerable time while we worked through the intricacies of the paperwork and the red tape through which we have to work. We had to get the Scottish Medical Practices Committee's permission to amalgamate the practices. The trust did not take it upon itself to do that to the Helmsdale population. The Scottish medical profession had to agree to the amalgamation. The important point is that the service was deemed safe and sustainable. Does that answer your question?

11:45

Nicola Sturgeon: It explains how the decisions were made, but it does not quite explain local people's involvement in the process. The community's views seem to have been alienated completely from the decisions that were made—perhaps those could not be reconciled. To what extent were local people kept informed and to what extent were the changes discussed with them? I visited the community and it seemed that people felt that they had been kept completely in the dark throughout the process and had no way of making their voices heard.

Ken Proctor: The community council's representative was on the appointments committee. We believed that that allowed communication between the community and the trust to be a two-way process. At some stage in the process such communication did not happen.

The Convener: I want to move on to more general issues. I appreciate the fact that the amalgamation of the Helmsdale and Brora practices is important to people in that area, but we are here to cover the whole strategic gamut. What can you do about the general issues? I am sure that amalgamations of practices are happening elsewhere in the country. How can you tackle such problems? If you do not have the weapons in your armoury to tackle them, can the Scottish Parliament and Executive give you something to help you to do so?

Ken Proctor: We work in a number of guises. The General Medical Services red book regulations are fairly restrictive. We run the inducement practitioner scheme, but it is becoming outmoded and outdated. Within it we have the associate GP scheme. In Highland we have 24 associate places, but only nine associates are in post. We cannot recruit for the rest of the places. Just over 30 inducement practices—about half of all the Scottish inducement practices—are on our patch. Three or four places in those practices are vacant at any given time.

Within the existing regulations it is exceedingly difficult to produce an attractive package to bring GPs to work in areas such as those in the Highlands. It is becoming ever more difficult to amalgamate the GMS regulations, the inducement practitioner scheme and the associate GP scheme. On Friday, we considered what to do in Bonar Bridge and Lairg if, when the inducement practitioner retires, the other practice does not want to take on their list. If the practice does want to take it on, it will lose the associate that the inducement practitioner had. We will then be half a doctor down in our equations. I do not want to go into more detail than that.

The Scottish Medical Practices Committee has been fairly helpful over the years, but it has also been fairly restrictive about the number of practices into which we are allowed to bring practitioners in addition to the essential practitioner. It is early days for the new GP contract that has just been announced, but we hope that it might provide flexibility and variation in how we provide services.

We are also considering the personal medical services contract in Skye and Lochalsh. It might allow us to bring in practitioners—not just GPs—to work in a more systematic way, rather than have single isolated practitioners. Our doctors in Wick have decided to step back from the PMS route until they see what the GP contract produces, so I think that we will have a mixed economy for a considerable time.

The Convener: If you want to raise anything further with us on that issue, we will be happy to accept a written submission from you on the specific difficulties that you face in recruitment and retention of staff. You might suggest a way forward for us. That issue goes wider than the budget process and is something that the committee takes very seriously. We understand that, although recruitment and retention is a problem throughout the service, there are specific issues that you have to deal with.

Ken Proctor: Over the past few years, we have undertaken an inquiry into why doctors came to the Highlands and, more important, why they may have left. Those who do not settle move on very quickly. There are three reasons for that, which have nothing to do with health care. You mentioned two of them. First, there is the problem of finding houses. People think that the Highland region is a wide area and that if someone can find

a piece of land, they can build a house. It is not like that. A lot of doctors cannot find property. Secondly, there is the difficulty of the education of their offspring. There are limitations to that, and many doctors from elsewhere are used to choice. Thirdly, there is the involvement of the spouse or partner. Unless the spouse or partner gets a job that they are happy with—and that involves our working with the education authority, the social services and others—the doctor will not be happy and will move on very quickly.

The Convener: I do not want to labour this point, but I think that it is pertinent. You made a point in passing about the way in which we train our doctors. We are not training them to be self-reliant as independent practitioners. However, there are various schemes elsewhere that do that. For example, Australia has such a scheme for outback doctors. You might want to write to us with your thoughts on what changes in training might help to make a rural practice more attractive to a doctor who has completed their training.

We will now hear about the generalities of public participation from Brian Devlin, and then Margaret Jamieson will discuss accountability issues.

Brian Devlin (Highland NHS Board): I shall take a strategic view of the way in which we are managing the public and patient engagement agenda. As you are aware, the new NHS boards are boards of governance. One of the main ways in which we have tried to address the governance responsibilities of our board is by setting up a series of governance bodies. They are examining issues of health improvement, the improvement of health services, staff governance, resources and auditing. We have also decided to create a public and patient engagement governance group, which we believe is unique in Scotland. We are keen to get the message across—to you today, but to the population in general—that engagement is a means to an end, which is better health services for people.

We believe in engaging people at all sorts of levels. At a macro-level, that means engagement in resource allocation. At a service level—my colleague Derek Leslie has already mentioned this—we conducted a maternity services review, which took us into every community in the Highland region. I led the review for part of the time. It was genuinely one of the most participative exercises in which we have ever engaged. We also recently completed a stroke redesign project on the same model, by asking people who have had strokes what sort of service they require and what they want for their parents and spouses. A number of years ago, we started the healthy promises initiative that Roger Gibbins mentioned. That was important because, for the first time, we were able to ask ourselves what the man or woman at the bus stop in the Highland region expected and received from the health service. There is a lack of understanding about what the different strata provide.

We have tried to boil down what we are doing over the next 12 months. Importantly, we have reported back on the things that we have completed, the things that we have not quite completed and the things that we have not completed at all. That degree of openness and transparency has meant that, as well as celebrating our success, we have had to be open with the public about what we have not done. That has got us some way towards convincing people that we are trying to be a transparent health service.

The Convener: What kind of public response has your document received? It seems a fairly clear, interesting and accessible document.

Brian Devlin: Although we provide the document in many different places such as GPs' surgeries and chemists, surprisingly, we have not received much feedback about the ways in which people want things to be done differently. We have received many positive responses from people through the media and other sources that recognise that we are going that extra mile in being very upbeat about our achievements. That said, our letterbox has not been swamped by correspondence from people asking us to change this promise or to consider that issue.

Caroline Thomson: We have just completed a lifestyle survey of 2 per cent of our population that we have been conducting for a number of years. Although the results of the survey have not yet been published, I can tell the committee that the percentage response rate was in the high 60s. We use multiple tools because no one tool will appeal to everyone in the population.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Following on from the point that was made about transparency, I want to consider the issue from the other side and find out just how transparent the public pound is. I welcome the fact that your accountability pathway goes right through to performance assessment, but it seems that at no point along that pathway do you report to the public.

Unfortunately, we do not have a copy of your accounts so that we can see that a funding announcement was made in Edinburgh, the money went to Highland NHS Board and eventually trickled down to a particular LHCC, which delivered a particular service. In the budget process, we are trying to find out whether we can chart that. How do you report back on your accounts and indicate the standard of your performance to the public in Highland?

Roger Gibbins: Although we hold annual general meetings, I would not hold them up as a particularly glowing example of accountability to the public. They do not catch the imagination of the people in Highland enough to make them attend.

In answer to your question, I do not think that we do that sort of thing. We are transparent and explicit about where the money goes in Highland and publish that information in the accounts. However, the documents are fairly dense and inaccessible and, over the past two years, we have become very explicit in our health plan about our investment strategies. For example, this year, the plan shows in a lot of detail how the £17 million uplift is accounted for. Those documents are publicly accessible, but we could perhaps make them more accessible and provide more of an explanation about what they do. We have provided the committee with a copy of the plan, and I can draw the committee's attention to the relevant pages if members are interested.

Caroline Thomson: This might be an appropriate point to ask Malcolm Iredale to take the committee through the cost cube work. I am also aware that Richard Carey has not yet spoken—

The Convener: Richard looks quite happy about that, actually.

Caroline Thomson: He could talk about staff governance issues, partnership forums and so on. It is just as important that we explain to our clinical staff where the money goes. Quite often, there are misunderstandings about that. We want to give them more information. Margaret Jamieson is absolutely right. People hear and read about extra money for health, but it is not always obvious to everyone where the money goes.

Margaret Jamieson: I want to stop you there. You have just mentioned clinical staff. I am concerned that they are not included in the partnership to develop services. If they are involved from day one in working up either a redesigned project or a new facility, surely they will understand how much those projects will cost.

Caroline Thomson: It is clear that I have been misunderstood. The staff are involved in all service developments. I was addressing the broader issue of people reading in newspapers about the allocation of extra money to the NHS. When I speak to groups of staff, they are sometimes not absolutely clear about where all the money goes. I was making a broader point. Staff are fundamentally involved in the redesign of services, such as the stroke service and the maternity services review. They have to be.

12:00

Malcolm Iredale (Highland NHS Board): May I say something as director of finance at the NHS board? As we indicated in our health plan, the investment that we make is fundamental. There is a separate section that itemises clearly the money that comes in and where it goes out; that is supported by regular monitoring. In Highland, for the past two and a half years, we have always put a summarised report to the open board—that covers not only the then health board, which is now the NHS board, but the two trusts in the area. The summary that we produce is accessible and is usually supported by overhead projections of graphs that show where the money has gone. That increases accountability during the year and we report on it in our annual report.

We have touched on our "Healthy Promises", which explains to the public how we are delivering the services. I have also engaged with the business community to recognise that the NHS is a major business in Highland. We need to talk to lawyers, solicitors and groups of business people to explain how the health service works and how the money flows round the system. It is interesting to talk to people, such as bankers, about their commercial perspective on certain things—I can explain how the NHS and the public system works and we can all learn something from that.

We recognise that sometimes costing—the questions that politicians like to ask about how much an initiative costs, for example—needs to be presented in round figures. I like to put a chart on the wall to show what amount of the pie is spent on certain things; that is the easiest way to explain things.

Over the past 12 months, Highland has developed the cost cube, which brings together finance and activities and will allow us to say how much we are spending in a geographic area or on a programme of care. That work, which has involved finance people and clinical staff, will be released this week. The initiative is unique to Highland and we hope that it will be useful to allow clinicians to appreciate not only their part of the finance, but the wider picture of where the money is going.

Margaret Jamieson: How does the cost cube fit with the clinical priorities, or is it entirely separate?

Malcolm Iredale: It is not in total isolation. It tries to explain where the money is going and it will allow us to make judgments about whether a particular area of care needs investment. The cost cube shows the differences between the treatment costs in secondary and primary care. When we move between the two sectors, we must understand the finance as well as the clinical service, otherwise we end up with financial

instability and a potential risk of not achieving our statutory break-even.

The cost cube is a tool that can be used at several levels. We have tried to ensure that it is accessible to as many people as possible, including clinicians.

Margaret Jamieson: I am happy about that, but I want to go back to the fundamental question of the transparency of the public pound. You mentioned your annual report and all the rest of it, but given that you have such a huge geographic area, how can you be sure that you are reaching everyone and giving them the opportunity to participate? Do you publicise your accounts widely?

Malcolm Iredale: The accounts are well publicised and are available in a summarised version. The annual accounts are a large computer printout, which can be obscure. The important thing is the way in which we summarise that information and get it out to the public. We could perhaps use the LHCCs to reach out and provide a context in which people like me could give a presentation and talk to the communities. We are conveying the broad picture and trying to address specifics in the localities as well.

Nicola Sturgeon: I have two questions. First, I want to follow up on what has been said. Do you publish, as a matter of routine, your performance assessment framework returns to the Scottish Executive? Do you publish any letters that you receive back from the Scottish Executive that highlight areas for action?

Caroline Thomson: Historically, we have always published in full at an open board meeting the letter on the accountability review. We look for ways to be clear about whether we have fallen short of what our public deserve. The performance assessment framework has only just come into being with the new board and our accountability review is not until August. However, we have dealt with many of the PAF indicators in our open board meetings and we have begun to address them systematically. We have been explicit about which areas we need to do further work on.

Perhaps Roger Gibbins can pick up on that.

Roger Gibbins: I can confirm that. We are not yet at the stage where we have the performance assessment framework information, never mind being able to publish it. However, as soon as we have gone through the process and have the information, we will make it available.

Nicola Sturgeon: I have a copy of the acute trust's team brief for March this year. I notice that the team brief refers to £1.6 million of cash savings. Where were those savings made? Also, if I may follow on from the previous discussion, what consultation was there before decisions were taken?

The Convener: This is an opportunity for Richard Carey to stun us all.

Richard Carey (Highland Acute Hospitals NHS Trust): Good morning, everyone. I wondered how long I would get away with sitting here quietly. Obviously, good things do not last forever.

The first thing to be said is that the trust's efficiency savings programme represents 2 per cent of the total budget. Notwithstanding the fact that additional investment is now coming into the health service, the public and the taxpayer expect us to ensure that the money that we have is spent as efficiently and as effectively as possible. Regardless of how much money is in the system, I believe that we need to ensure that we have an efficient organisation that can deliver savings.

The savings come from a variety of things. Most of the money has come from increased income. To that extent, the phrase "efficiency savings" has been used in a very broad sense. Our definition of "efficiency savings" includes increases in the trust's income from additional work. It should be borne in mind that many of the services that we provide are provided to other health board areas. For example, some of the income has come from recovering finances that were due from bodies such as Grampian NHS Board and Western Isles NHS Board.

We have looked at the cost of the provision of services and at our charges. We have uprated things such as accommodation and catering charges in line with inflation. A lot of the money has come from such things, but most of the schemes are on a small scale. The £1.6 million does not include anything major that has made a significant impact on front-line patient services.

Nicola Sturgeon: Can you give me a couple of examples?

Richard Carey: We have reduced our administrative costs by not filling certain posts. That is the kind of thing that we have done.

Nicola Sturgeon: Is the public involved in the decision-making process for the programme of efficiency savings?

Richard Carey: To be frank with you, we do not involve the public in efficiency savings, which we see very much as a matter for internal good management. However, it is fundamental that we involve the clinicians. The clinicians understand the need to generate savings so that we can invest the money in other priorities. The clinicians participate in the process but, to answer your question, we do not involve the public in decisions about efficiency savings programmes.

Nicola Sturgeon: You make it sound as though the efficiency savings are made so that you can redirect money into other projects. However, my reading of the team brief is that the savings are made to reduce the trust's financial shortfall and to meet financial targets, not to free up extra cash for more worthy projects.

Richard Carey: That was the case until recently, because the financial situation was difficult, as it has been throughout the NHS in Scotland.

The Convener: Shona Robison has a question.

Shona Robison (North-East Scotland) (SNP): My intended question is the same as the previous one.

The Convener: All right. It is good to see unanimity among party colleagues.

Mary Scanlon: My question refers again to the point about consultation, participation and accountability. You mentioned that you work with your LHCC colleagues. Members of the Health and Community Care Committee have a copy of a letter from the lead clinician of Inverness local health care co-operative, Dr Scott, about epilepsy. The issue was raised last week in evidence to the committee.

Dr Scott was asked whether, after experiencing a first seizure, anyone gets

"an appointment … within four weeks."

His answer was "not a hope." His response to queries on "Getting a diagnosis" and "Access to NHS support" was "cannot comment"

Are you willing to accept such dismissal of people in the Highlands who have problems as a result of epilepsy? If you are not, do you occasionally say to your LHCC colleagues that epilepsy is a greater priority than they make it? How much do you take into account the guidelines of the Scottish intercollegiate guidelines network—SIGN? Epilepsy Action Scotland told the committee last week that a guideline has been out for five years, but has mostly been ignored in Scotland.

Margaret Jamieson: Could I ask whether Dr Scott's colleagues from Highland NHS Board have seen his letter?

The Convener: I will explain about the letter. At the end of last week's committee meeting, I asked our Highland colleague, Mary Scanlon, to inform us of local issues that might crop up and to provide background on them. We discussed epilepsy at last week's meeting, in relation to a petition. Epilepsy services in the Highlands were mentioned as an issue that we might pick up on when we were here in Inverness. Mary Scanlon gave us a copy of a letter that she had received that was signed off on behalf of Dr Scott, who is the lead clinician of Inverness LHCC. The letter was in response to questions from Mary Scanlon about epilepsy services in the Highlands. I do not know whether you have seen the letter.

Brian Devlin: We have seen the letter.

The Convener: Okay. I think that Margaret Jamieson has a follow-up question on that matter.

Margaret Jamieson: I am concerned about the tone of the letter. If that demonstrates the partnership approach, it has blown out of the water everything that you have said this morning.

Caroline Thomson: I hope that that is not the case. A reply is sometimes couched in terms with which we would not necessarily all be happy, but I am sure that the letter was an attempt to give an honest reply about the issues.

The letter must stand with other correspondence, including a letter about the service from Richard Carey. Given that the letter is a reply from an LHCC lead clinician, I could ask Ken Proctor to take us through that. Richard Carey might want to add something about the visiting service.

The Convener: I think that I would not be speaking out of turn if I said, on behalf of my colleagues, that we would not necessarily expect the response "not a hope" when an MSP requests information about someone's chances of help after experiencing their first epilepsy seizure. However, we expect honesty from clinicians who work in the service because we must work together to improve the service.

As well as picking up on that issue, can you answer Mary Scanlon's other questions about practices and facilities for epilepsy patients? Richard Carey, too, might want to speak on those matters.

Ken Proctor: First, I apologise if the committee feels that Dr Scott's approach and tone are not appropriate. I accept that, and will take that back to him. I point out that Dr Scott's letter was in reply to a letter from Mary Scanlon, to which was attached a health services shopping list for people with epilepsy that lists 27 issues. I suspect that Dr Scott was trying to give bullet point responses to bullet point questions.

From a national perspective, epilepsy has not had the support from the Executive that one might expect. We have many priorities in the health service around all the other things that we know and love. Epilepsy does not feature in those priorities. From the local perspective, the Inverness LHCC had its annual away day a couple of months ago, at which there was significant representation not just from the services, but from the patients and the public. The groups were

asked what their priorities were for the health service in Inverness for the next year, but epilepsy did not appear on any of their lists. We have to start against that background. We need a driver—perhaps from above and supported from below—to get the issue on to the agenda in the appropriate place.

12:15

The Convener: So a political driver from the Executive and a clinical driver from perhaps the Clinical Standards Board for Scotland are needed. The wider issues of recruitment and retention are behind that, as they affect not only epilepsy, but other neurological diseases such as multiple sclerosis and Parkinson's disease. I am talking about neurological services in general and access to neurologists. Do you want to say something about those issues?

Richard Carey: Recently, a number of developments in the acute sector have begun to address the wider issue of neurological disorders. We have appointed a specialist nurse in neurological disorders and have received support from health-related organisations such as the Multiple Sclerosis Society in delivering improvements. Another important improvement in the acute sector, which will benefit many patients who have neurological conditions, is magnetic resonance imaging scanning. That is due to come on stream at Raigmore hospital in July. Those are examples of improvements in the service that will benefit patients.

We must take into account the fact that we need support from colleagues in Grampian to provide such a specialised service. We are considering the development of a clinical network with colleagues in Grampian, as we do not want to replicate unsustainable systems. We do not want to employ single-handed, unsupported people and face difficulties when people are on holiday or if the service cannot be sustained in a person's absence. Developing such services in conjunction with colleagues in Grampian is a priority that we are considering.

Mary Scanlon: I think that we all agree on the three clinical priorities of cancer, mental health and heart disease, but I hoped that those priorities would not lead to the exclusion of epilepsy services. Everything cannot be a priority or nothing will be a priority—I understand that—but, in the setting of priorities, I would be gravely concerned if epilepsy were allowed to fall off the agenda. Dr Proctor confirmed, as did Dr Scott in his letter, that:

"This process has not as yet raised Epilepsy as a priority issue."

Epilepsy may not be a top priority, but I hope that it is not ignored and excluded. I have the impression today that epilepsy is excluded; Epilepsy Action Scotland also has that impression.

A Scottish Parliament information centre paper mentioned that Raigmore hospital received a D for its epilepsy services. The only other trust in Scotland to receive a D was Renfrewshire Healthcare NHS Trust. That rating means that epilepsy services in Highland are "Very basic/limited services", which is a matter of concern. You set priorities, but in setting those priorities, you allow conditions such as epilepsy to be excluded. If you are saying to people that they cannot see a clinician or get a diagnosis within four weeks after their first seizure, and telling them that they do not have a hope, that is a serious concern. I am concerned by not just the tone, but the approach.

Dorothy-Grace Elder: On rereading Dr Scott's letter, I wondered whether he made his remarks despairingly. Perhaps he knew that he would not receive any help from those above him.

I want to move to another subject that has been mentioned many times by a number of bodies and members of the public. Highland seems to be accused of being a blank area for pain services in Scotland. The area has up to 67,000 people in the community who suffer from long-term chronic pain, such as arthritis and back pain. Highland is the only area that is consistently mentioned as having no proper pain services, although I think that some help has been given by one or two enthusiasts in Wick and Lochaber.

However, Inverness has no proper pain services. I declare an interest as the convener of the cross-party group on chronic pain. One of the 130,000 hits on the Parliament's website following the recent members' business debate on chronic pain was by a young lady called Kerry McEuan from Nairn—she does not mind my using her name. Kerry is only 20 years old; she is not a terminal case, but she has had to be sent to hospice surroundings for regular treatment for pain, because there are no specialist pain doctors outside the hospices. In a cri de coeur, this young woman says:

"The Highlands and Islands are a disgrace to the NHS"

in not having proper pain services.

I understand that you continually turn down even small requests for money. The Pain Association Scotland says that Highland is the only area in which a request that it made for just £5,000 was turned down, both by the social work department and by the health board. Those who are trying to relieve the pain of pretty desperate people in Lochaber by creating a hydrotherapy pool were refused even a letter of approval, let alone money. What is happening in Highland? Why is this attitude being taken?

Richard Carey: I accept that the provision of pain services in Highland is not as good as we would like it to be.

Dorothy-Grace Elder: It is non-existent.

Richard Carey: That is true. The main reason for the current situation is that pain services are normally provided by anaesthetists. However, none of the anaesthetists whom we employ at Raigmore hospital is a specialist in pain control. They are specialists in many other areas, but acute pain control is a sub-specialty in the training of anaesthetists. Unfortunately, none of the anaesthetists whom we employ has an interest in that sub-specialty.

One of the anaesthetists who previously worked in Wick was able to offer pain services. When he moved to Fort William, he was able to offer the same services there. That explains why pain services are available in some parts of the Highlands and not in others.

When we advertise vacancies for anaesthetists, we seek to encourage applications from people with an interest in the sub-specialty of acute pain control. In the next two or three weeks, we will interview anaesthetists. If we receive an application from someone who has an interest in developing an acute pain service, we will be keen to encourage that.

Dorothy-Grace Elder raised the issue of the proposed hydrotherapy pool at Fort William. There is a debate among clinical staff about the efficacy of hydrotherapy. Regrettably, we must make decisions about priorities. If we provide hydrotherapy pools in some parts of the Highlands, how many other parts of the region will want and expect to have such facilities? The decisions that have been made relate to prioritisation.

Dorothy-Grace Elder: Yes, but at the moment you are providing nothing. A hydrotherapy pool would be a start.

The Convener: I would like to move on to discuss the issue of Arbuthnott.

Dorothy-Grace Elder: Perhaps we can return later to the issue that I have raised.

Shona Robison: You said that Highland had gained from the Arbuthnott report in respect of the costs of rurality, but had lost in respect of deprivation. That was quite clear. How would you like the way in which rural deprivation is measured to determine resource allocation to be refined or altered? From a Highland perspective, how do you think rural deprivation should be measured to reflect more fairly the issues that Highland faces as a rural area?

Roger Gibbins: As I said, the problem with the Arbuthnott formula is that it is based on information—primarily from the census, but also from other sources—that relates to essentially urban definitions of deprivation. In rural areas, car ownership is a necessity, rather than a luxury. Multiple occupation of housing is not a feature of some sparsely populated rural communities, but there are other housing problems that indicate deprivation. The whole analysis is skewed towards an urban concept of deprivation.

We might want to provide you with our thoughts on that issue in writing, if you are interested in taking the issue further and considering the sort of indicators that could be used. Obviously, indicators need to be drawn from a published census or similar general household survey information. You would need to see what was published and available. Indicators that recognised the low-pay and distance issues that we face—for example, issues of family support and the distances that people live away from supportive communities and their relatives—would be more reflective of rural deprivation.

Shona Robison: It would be useful to have your thoughts on that in writing.

Janis Hughes (Glasgow Rutherglen) (Lab): In your opening remarks, you mentioned that one of your priorities was to establish a fair and consistent delivery of health care. I represent a largely urban area, so I am especially interested in the way in which the inequalities in health in Highland compare with those in an urban health board area. We have heard about inequalities in certain medical areas—for example, epilepsy and pain control. Could you say a bit more about that? How are inequalities different in Highland?

Roger Gibbins: Some areas of the Highlands have higher levels of ill health and deprivation. Those can be analysed and drawn out from the activity data that we have, as well as from measures of the population. Pockets of deprivation include areas around Lochaber and Fort William, the north-east above Inverness, and Wick. Is that what you were asking for?

Janis Hughes: Inequalities in health obviously exist everywhere, but do you think that the inequalities in health in the Highland area are different from those in more urban areas?

Roger Gibbins: They are no different, in the sense that the characteristics that determine people's health chances are the same. Income levels, family circumstances and the lifestyles that people adopt are the same core determinants that we are trying to tackle in the Highlands, through our health improvement strategies. The issues are similar to those in other places. However, in the Highlands, they are compounded by the issue of accessibility and the fact that people live such a

long way from facilities. There is also the difficulty that the local facilities that we provide for communities are becoming increasingly difficult to sustain because of cost, the recruitment and retention problems that we talked about and the requirement to meet the CSBS guidelines and those of SIGN, which Mrs Scanlon mentioned. It is a challenge to meet CSBS standards in some of our peripheral services. Those are the kinds of issues that make the provision of services, hence access to services, more difficult in the Highlands.

Caroline Thomson: I am not sure whether you have a copy of the director of public health and health policy's report, "Working Together for a Healthier Highland". On page 52, the document shows that, in terms of the number of deaths from cancers, heart disease, strokes and cerebrovascular disease, the Highlands are on a par with the rest of Scotland. However, the numbers of accidental falls, road traffic accidents, suicides and self-inflicted injuries and other injuries are substantially higher in the Highlands. We analyse the figures and we can give you more information in writing. However, the general reason for those numbers being higher is the huge distances that people have to travel all the time to do everything—to shop, to access health services, and so on.

We have been aware of the suicide rates for a number of years. Often, they can be connected to having a rural population where farming communities have access to means. We also have spectacular mountain ranges on which, sadly, there can be falls and death. We constantly analyse the similarities and differences in the cases and we try to target our plans accordingly; we can supply the committee with a more detailed written submission.

12:30

Janis Hughes: Because of the geography of the Highlands, people have to travel much further for renal dialysis services. Arbuthnott meant that you gained because of rurality; but why does the inequality persist with people here having to travel further than people in urban areas?

Roger Gibbins: We are trying to address that specific point and Richard Carey will explain further.

Richard Carey: The development of satellite units for renal services is a good example of how services that were once centralised can be provided locally. Because of clinical standards considerations, the movement is often in the opposite direction, towards centralisation. There may have to be a rebalancing of what is provided locally and what has to be provided in centres.

The development of the satellite renal dialysis service in Wick is a good example of the NHS in Highland responding to the needs of the local community and responding to a local priority as opposed to a national one. We have made a commitment to the public in Wick that the service will be up and running in January next year. The service is expensive, but when we consider the problems that people have in making long journeys to Inverness two or three times a week, we believe that the service is cost-effective and that it is the right thing to do. In time, we hope to develop a similar service in Fort William.

Caroline Thomson: At any one time, eight hospital consultants are in their cars travelling round the Highlands. Before the Arbuthnott allocation, we tried to provide a service that took into account our rural geography and that is why we were having financial problems. We simply have to deal with that from day to day.

Margaret Jamieson: The committee considered Arbuthnott in great detail and made recommendations prior to its first shot. I understand that it has recently been re-evaluated.

You indicate that certain areas have levels of deprivation that have not been taken account of properly. However, you also say that, because of other parts of Arbuthnott, you have the facility to expand. If you can do that, are you not guilty of not applying locally the principles of Arbuthnott?

Roger Gibbins: No, I do not think that we are guilty of that. Arbuthnott acknowledged, for the first time, the costs of rurality and remoteness. I will consider remoteness first. We are a long way from other hospitals and tertiary centres. Raigmore hospital serves a population of some 200,000 but has to provide that population with many more services than other similar district general hospitals have to, because it does not have easy access to Glasgow, Edinburgh, Aberdeen or wherever. We are remote and we therefore incur a higher cost in providing services to rural areas. Our local community hospitals cost 20 to 30 per cent more than similar hospitals elsewhere in Scotland.

The acute services that we provide in Fort William and Wick cost between a third and two thirds more per patient than it costs us to provide those services in Raigmore. Those costs have never been acknowledged before. That is why we have been running at a deficit in Highland and why we have been unable to provide other basic services for the whole population, not just for people in remote and rural areas. We have discussed those problems and are now going to deal with them.

There is a pattern of services in Highland that reflects the remote and rural nature of our area. We now have the money to fund those services to

an extent, although one never has enough to fund all the needs, as we have said. There is more that we can do for services in remote areas, just as there is more that we can do for the general population. That is the work that we have now embarked on through the cost-cube analysis that Malcolm Iredale described. We can therefore see where resources are consumed by people across Highland in different ways. The other point is that we have not yet got the Arbuthnott money that we are due to get. Some money came through in last year's budgetary allocation and more is due, but we have had only 50 per cent of what is available to us. We can plan for that to ensure that we use it most effectively to meet the broad needs of the population in the Highlands. We are confident that we are using that money wisely and appropriately for the intended purpose.

Margaret Jamieson: I would like to pick up on the point that Caroline Thomson made about eight consultants travelling at any given time. What use do you make of telemedicine?

Richard Carey: We provide telemedicine in quite innovative ways. For instance, our dermatologists provide a telemedicine service not only to parts of the Highlands but to the Western Isles. That is an example of a specialty that is amenable to that sort of technology. Other specialisms do not appear to be so amenable to that kind of technology and there is still a need for patient contact with the specialist.

Another good example of telemedicine is the way in which we have developed teleradiology in the Highlands. If someone has an accident in Wick, there are no consultant orthopaedic surgeons there, but we have the facility to take X-rays, send them down a digital line and get a consultant orthopaedic opinion from Raigmore or from further afield. That patient can therefore be properly managed and decisions can be made about whether they can be treated locally in Wick or whether they will have to make the journey for specialist treatment in a bigger centre. There are some good applications of teleradiology and telemedicine in the Highlands.

Mary Scanlon: On the Arbuthnott considerations, your submission refers to hidden rural deprivation. That is quite important. Caroline Thomson mentioned the levels of suicide, particularly among young men, but there are also serious alcohol problems here. Given that the Arbuthnott money is to address poverty, deprivation and inequality of access to health care, and given that much deprivation is hidden, how will you measure in years to come when the money comes through whether we have gained better access to health care in the Highlands? How will you measure whether that money has been used to reduce inequalities in health care, given that those inequalities are hidden?

Roger Gibbins: The word "hidden" refers to the fact that such inequality is not recognised in the formulae that are used. It is hidden from the Arbuthnott formula itself and from the allocation of resources. It is difficult to describe and to pull out in population terms, as I indicated. We will measure the impact of our services through the sorts of areas that Caroline Thomson was describing earlier. We undertake lifestyle surveys to see how access to and use of services benefit the population.

Mary Scanlon: Have you done that already? Do you know the state of lifestyle problems in the Highlands? You would need to know what it is now to know whether any improvement has been made.

Roger Gibbins: That is right. We undertake lifestyle surveys every five years, and we have just done one in the past year. The results of that survey are available to us now.

Mary Scanlon: Have you done that in Lochaber, which you mentioned specifically?

Roger Gibbins: Yes. It has been done across the Highlands. We will also ascertain the impact of our various services through the standard measures of morbidity and mortality that are available to us through the normal collection of data. We will be able to track information using those data too.

Mary Scanlon: Have you done those surveys for Helmsdale? Will you be using the information to make any changes in your spending priorities?

Roger Gibbins: The purpose of the information is to tell us about the lifestyle characteristics of the population and therefore where we need to target health improvement measures, including those to improve smoking habits, diet and sexual health. That is what the information is designed for and that is how we will use it.

Caroline Thomson: We have mentioned hidden deprivation. One aspect of that lies in car ownership. That is traditionally a measure of wealth, but cars are an essential in Highland. Many people will spend less money than they otherwise would on food in order to keep a car on the road, because there may be no other way for them to get to work, for example.

The seasonal nature of the tourism industry is also particularly relevant in Highland. A large number of people are out of work for large periods of the year and they often have to do two, three or more jobs to make a living. We need a much more sophisticated understanding of the broader determinants of health and of what gets in the way of people making healthy choices. That might involve the distribution of food or the distance of

homes from shops. The better we understand such factors—which is what we are working towards—the better we can meet the needs of the population and improve their health.

We have had some really good, positive meetings with our Highland wellbeing alliance partners, which include the local authority, Communities Scotland, the police and voluntary organisations, about us all combining to get the very best value for the public pound—for money that is allocated to all public agencies, not just to the NHS in Highland.

Dorothy-Grace Elder: Are you expanding on training and recruiting nurse practitioners, or do you find it extremely difficult to recruit senior nurses?

I would also like to return to the difficulty in recruiting general practitioners for certain areas. Are you perhaps imposing an age barrier? If the doctor is older, the doctor's partner may wish to give up work and the child education problem may not exist in such cases. Are you advertising in Europe and not just in Britain?

Richard Carey: I can give you an example to illustrate the situation with the recruitment and retention of medical staff. We have recently employed a 62-year-old consultant anaesthetist from Norway, who has been working in northern Norway. We advertise posts worldwide, and there are no barriers. We welcome the opportunity to employ appropriate people regardless of their age. That individual has already made an important contribution to the anaesthetic service in Wick.

On your other question, about the recruitment and retention of nursing staff, we are fortunate in the Highlands in that we do not have some of the recruitment and retention problems that seem to exist in other parts of the country, particularly in the south-east of England. There are a number of reasons for that. One is that this is a very nice place to live and work; another is that we make a particular effort to develop and train our own staff.

12:45

We do not have a shortage of intensive care nurses because we develop and train our nurses in high-dependency areas and then move them into intensive care. That means that we have a ready supply of appropriately qualified nursing staff. We have a number of specialist nurse practitioner posts. We have recently appointed three neo-natal nurse practitioners who are providing important services to the Highlands, particularly in the training of midwifery staff on neo-natal resuscitation.

We have also employed emergency nurse practitioners in the accident and emergency service, specifically in Fort William because, with people falling off mountains, the incidence of trauma in that area is remarkable. That is an important augmentation of the clinical service that the medical staff provide.

Ken Proctor: I want to pick up that point from the primary care angle. The committee will be glad to hear that the previous four doctors that we have taken into Highland NHS Board are all over 50 years old. That reflects the fact that the sort of practitioner who comes to the Highlands often has aspirations and reasons for practising in the area that are different from those of people who choose to practise in Glasgow or Edinburgh. The same point might also apply to acute care. We encourage that, because those people have cut their teeth elsewhere. If they are going to be remote and rural, they at least have some skill and experience already and are not wet behind the ears.

Dorothy-Grace Elder: It also shows that they are very sensible.

Ken Proctor: I would like to think so.

I should also point out that all adverts are placed in the *British Medical Journal*, which is available on the net and therefore worldwide.

Dorothy-Grace Elder: So if it is not the age factor and if you are advertising worldwide, the whole thing is still a puzzle, is it not?

Ken Proctor: Yes. It is multifactoral.

Margaret Jamieson: How much joint working do you undertake? You have already mentioned working with local authority partners and the voluntary sector. Given that that is the way forward and in light of the comment that the board is trying to ensure that everyone uses the public pound in the best possible way, it strikes me that the coterminosity of the local authority and the health board areas might work to your advantage and mean that you can develop such joint working more quickly than in other parts of Scotland.

Caroline Thomson: That is absolutely right. Our coterminosity with the local authority is a key factor in helping us to develop joint working.

I should expand on the Highland wellbeing alliance, which is our vehicle for producing and monitoring the community plan. Although the partners in the alliance meet reasonably frequently, some agencies such as the police and Highlands and Islands Enterprise are not coterminous with us. That said, we do not let that get in the way of effective working. We are very ambitious about the whole health-gain agenda and about improving our population's health. It is obvious to our partners that health is a tool for economic well-being. We need a healthy and well-informed work force, well-educated children and

job opportunities to ensure that people who choose to return to the Highlands after attending further education courses elsewhere have a job to come back to. We happen to think that we live in the most beautiful area in the country. However, people often cannot find employment here, and it is vital for Highland NHS Board to work with our enterprise company to bring more jobs to the Highlands.

We also have two joint committees: one for community care and another for children and young people. We attach a lot of importance to those committees and the senior teams from the health authority and the local authority attend their meetings, which might include representatives from user groups and members of the youth parliament. We can point to some significant successes that have come about through such joint working. However, we are not complacent about such success and strive to do better in future. That said, we are quite far down the road in understanding people's agendas and the issues on which we can work together to produce the desired benefits for all public agencies.

Margaret Jamieson: Have you started using shared facilities? For instance, some aspects of social work services might also provide health benefits, which would mean that both services would not have to run separate facilities in a community.

Caroline Thomson: Ken Proctor will be able to supply more detail. I can say that we have a joint future team. We have members of staff who work together all the time. Health, education and social work have a joint post for children and young people. We also have people on secondment from other agencies—all the public agencies in Scotland—who come to look at the community planning process and community safety. We are alive to the need to provide opportunities for people who work within public bodies to gain experience so that they can further stretch and hone their skills. Often, critical mass is such that we need to provide innovative ways of expanding people's experience.

Ken Proctor can probably give some examples of joint working.

Ken Proctor: We have not mentioned community hospitals—

The Convener: My next question was going to be about community hospitals.

Ken Proctor: My apologies for taking the wind out of your sails. Our community hospitals are terribly important. At the moment, we do not use them to our full benefit, but we must do so. We see coterminosity becoming a reality in our community hospitals, where nurses, doctors, the physiotherapist, the visiting consultant and social services often all work together, not only during the day but out of hours. The community hospitals show how we might coalesce to form a more safe and sustainable service than we have at the moment.

Many general practitioner surgeries around the patch are in health centres that were built relatively recently. Having come here only 18 months ago, I am quite impressed with the majority of the health centres—although not all of them—because they are modern establishments. You would be amazed at the people who work out of the health centres. You can bump into all sorts of people from health and social services.

Joint working is already happening on the ground, but the higher level linkages that Caroline Thomson mentioned also need to be made.

The Convener: My question was whether Highland is, if anything, further along the line in implementing joint working because of its situation. My impression from visiting community hospitals and rural health centres is that what you have said is true. You seem to agree that joint working is more advanced in Highland than it is elsewhere. I hope that you can take the joint working agenda forward a bit more.

Mary Scanlon: I asked about what Dr Gibbins said at the beginning of today's meeting, but because my question was lumped in with other questions, I did not get an answer. Dr Gibbins said that Highland NHS Board had had an uplift of £17 million, of which £3.5 million was allocated for prioritised development. What were those priorities? Were they the clinical priorities that the Scottish Executive set or were they the board's priorities? What consultation was undertaken in allocating the sums to those priorities?

Roger Gibbins: The priorities were a mixture of both. Through the process that Derek Leslie described, we developed the local health plan, which brought together local and national priorities. Perhaps Derek Leslie will touch on the expenditure.

Derek Leslie: Again, we have obviously failed miserably in trying to make our investment documentation a model of clarity. We tried to set out the investment, which included some significant things. For example, we upgraded the cardiology service at Raigmore and we continued our investment in renal services. As there were issues around mental health, we invested in advocacy. Perhaps I could provide the committee with a written answer that would give a breakdown of the £3.5 million.

There was a series of investments across a range of things, some of which had a part-year effect last year and will have a full-year effect this year. Some of the investments were must-dos,

some were about responding to service pressures, and some were quite minor new developments. For example, the osteoporosis scanning service that was introduced in Dingwall is something that we have been trying to set up for some time.

I want to pick up the point about hydrotherapy, which is a service that Highland provides. A hydrotherapy pool is attached to the rheumatology service in Dingwall. The NHS in Highland put some £20,000 towards that pool. There is another hydrotherapy pool in Nairn.

Mary Scanlon: That is a long way from Lochaber.

Derek Leslie: I fully appreciate that. The point was made earlier that hydrotherapy is not seen as a priority in Lochaber. People probably want investment in other things in Lochaber. I do not want members to think that we do not provide hydrotherapy services. Our input is to support the physiotherapy input to the hot bath.

I want to mention pain control. In response to the cancer plan, we are committed to a palliative care needs assessment during the next three months, which will inform our priorities for pain control in Highland.

The Convener: The performance assessment framework was covered earlier, but will the witnesses put a little more meat on the bones and tell us how they envisage working through the PAF, which is a new process? What has been done so far and what changes in systems have been made to reflect the PAF? Will the PAF be better for the board? Margaret Jamieson is keen that the PAF should be more than simply a tick list. What will the board get from the PAF that it did not get from the old accountability review? The old review focused on whether the books were balanced. We hope that the new accountability framework will focus not only on balancing the books—although that is important and must be done—but on service delivery.

Roger Gibbins: I will start, but Derek Leslie has done most of the detailed work on the issue, so he might want to come in. We welcome the development of the review process from the form that the convener described to something that is more rounded and transparent and which is based on information about services, access and delivery as well as financial information. The development will lead to a more mature and effective discussion with our colleagues in the Executive about how we are doing and what we must do better.

I have two or three things to say about the PAF. As Brian Devlin said, the governance structure that we have set up to support our NHS board replicates the main areas in the PAF. For example, we have governance committees on patient and public participation, on health improvement and on staff governance. We want to consider and scrutinise those domains and, through the governance process of non-executive involvement, hold the system to account on delivery.

We carry out detailed analysis of the information that emerges from the PAF. I am sure that members are aware of that. Basically, the information shows boards' performance against the Scottish average. Because we are dealing with an average, half of the boards are above it and half are below it. It is unlikely that performance will be above average on every indicator in the PAF. We must understand what the information tells us. Statistical nuances might mean that, although simplistically we might be shown to be below average on a graph, because of the low numbers of people in Highland, we would know that we were moving in the right direction. On other issues, our performance might be above average, but we might not be happy with that for a number of reasons.

13:00

We do a lot of detailed analysis of the PAF indicators to ascertain which of them we should be concerned about and what actions we must take. If we are presented as below average on some indicators—which might appear superficially to be a problem—we try to understand why that is the case. If we feel that the reasons are statistical rather than related to performance, we take account of that and discuss the matter with the Executive. The detailed work that we are doing at the moment will allow us to focus on the areas that we need to improve.

My final point is that, by necessity, the PAF indicators cover only a small number of areas of NHS performance. Our governance committees are asking, "Do the indicators cover the areas that are important? Are there other important areas in which we do not perform well that we need to address?" We are introducing our own assessment measures and indicators to bolster the PAF.

The Convener: That is interesting. Are there any gaps in the accountability framework? How can you plug them locally? If you find gaps, it would be worth while making the Executive health department aware of them, so that expansion in future years will be able to address them. This is just the beginning of an on-going procedure.

Roger Gibbins: We want to examine in detail patient and public engagement, which were discussed earlier. We do not feel that the indicators in those areas are robust or get to the heart of the philosophy of patient and public engagement, which is where we want to go. That is a big area. We want to do more work on that

and more work could be done on it generally.

Brian Devlin: We have examined the public consultation part of the PAF. We feel that it is a floor, rather than a ceiling. As a health community, we will use the PAF indicators, but we will also develop our own effective local PAF indicators, because we do not feel that the PAF is challenging enough for us. That will get us away from Margaret Jamieson's concerns about tick-box exercises. We are trying to use the indicators as a major cultural driver for the NHS in Highland. More work needs to be done. We have communicated that point to the Executive, but it is useful to bring it up today as well.

Derek Leslie: From a planning point of view, I endorse Margaret Jamieson's remarks that the health service should not be an industry. For me, the issue is about sore-thumbing service and quality issues. We must find a way to publish the PAF material—which is still at a developmental stage—that makes it meaningful, not only for the public but for some professionals. We need to engage directly with the information and statistics division of the Scottish Executive.

I return to Brian Devlin's point. From our point of view, the

"Percentage of planning/steering groups across NHS Board with 50:50 staff:user/carer/public ratio"

is such an input-oriented indicator that it could be completely and utterly meaningless. One strong member of a community who was very influential in a group with 50 professionals could make a bigger impact than if the ratio was 50:50. Some indicators are very input oriented and do not tell us a great deal. Others are—to use our language—sore thumbs. They tell us where investment should go and what should direct prioritisation. That is how we would like to use the indicators.

We would also like to ensure that anything that we publish from board meetings enables the public and people who take an interest in health to discern what the messages are. At the moment, some of the indicators are difficult to publish without putting many qualifiers around them. To be fair to ISD and the Scottish Executive, I should say that they are working with health boards and health services to refine the information so that it is delivered in a reasonably analytical way.

The Convener: So you see the shift to a different system as a lever for cultural change—I think that that is what Brian Devlin said—and as a device that makes you examine inputs. Outputs, outcomes and seeing what has and has not worked are most important to us all. Will you focus on those more than you have in the past?

Derek Leslie: Yes. That ties in with the flavour of some of our debate. That is how we account for results, rather than inputs. I have been in the health service for a little while. We often struggle with the fact that it is easy—and, I suppose, politically helpful—for people to say that they have appointed so many nurses, so many doctors, so many of this and so many of the next thing. However, what is important for people who access the service is that an impact is made on the concerns that we have discussed, that they obtain a response and a service, that quality improves and that waiting times drop. We are trying to orient ourselves towards outputs rather than inputs.

The Convener: I can see that that is politically helpful, too.

Mary Scanlon: I will move from sore thumbs to sore teeth and mention an enormous issue in the Highlands, which has not been mentioned. It is impossible to access an NHS dentist in Inverness. Last week, I heard from a lady who received an appointment that is two years away with an NHS dentist in Nairn. We have the dubious honour of being top of the rotten teeth league for caries among 15-year-olds in Scotland and I understand that screening in the Highlands is below the figure in the statutory guidelines. We are talking about equality of access and outputs. What is Highland doing to address that serious problem? Barely a week goes past without another story appearing in the Highland papers, as more dentists move from the NHS to private provision.

Ken Proctor: That issue goes back to red tape, regulations and what we are allowed and able to do with the service. Dentists are allowed to go private, so they do. That gives us a problem. The positive statement is that nearly 20 per cent of dentists in Highland are salaried dentists whom the trust employs, which compares with the national figure of 4 per cent. Hamish Wilson has hauled me over the coals and asked why on earth that is the case. The answer is that the Highlands desperately need dentists. Next week, we will employ another new dentist in Thurso, and others will follow, to plug gaps.

As we have said, it is difficult to find professionals to work in remote and rural areas. The issue is multifaceted, but we are doing our best to address it. The percentage of employed dentists will have to rise considerably before we can say hand on heart that all patients are able to access the service. The other point is that patients fall out of the private dental service and land on our plate. We cannot be proactive about that. We tend to be reactive, so delay always exists and blocks always occur.

The other positive statement concerns NHS 24, which will help a little on the dental side, by providing access to emergency advice. We are establishing a system that can catch people who require to be seen by a dentist.

The Convener: Only last week, the Parliament debated modernising primary care and redesigning services. NHS 24 is part of that, but other innovations are being undertaken in minor surgery and other matters. Such initiatives may have been covered in the facts about the use of community hospitals and other action that is being taken. What will happen with primary care redesign in the Highlands and with NHS 24?

Ken Proctor: NHS 24 is purely a vehicle. There is a great misconception that NHS 24 will replace doctors. It will never replace doctors. We will always need doctors, nurses and others. However, NHS 24 will allow us to begin to have more joined-up access to the system, which is piecemeal at present. We all know that quality varies throughout the country. NHS 24 allows equitable access and gives advice in a standard way, unlike the present situation. NHS 24 is a vehicle that we can use, but it is not the answer.

The future of health care in remote and rural areas will come about when health care professionals amalgamate in larger groups that go out into the community to provide the service. It is not safe for individual practitioners to work in isolation. I have to say that I do not think that we have had the last of inquiries like the Shipman inquiry. Our plans all involve greater integration of teams, better communication and using peer support to provide services to communities, rather than relying on isolated individual practitioners, be they nurses, doctors or anyone else.

Dorothy-Grace Elder: I have a question on breast cancer. One of your statements says:

"The audit data shows that overall, the percentage of patients who receive a diagnosis within the two weeks of the first clinic visit is slightly outside the essential minimum limit of 80%."

How far outside the minimum limit is the percentage? It is essential that women are given news as fast as possible. Is there a shortage of radiology staff? There is a problem throughout Scotland, but I wondered whether the situation was worse in Highland.

Richard Carey: At the moment, the breast cancer service is provided by one specialist, who is based at Raigmore. One of the priorities of NHS Highland is the appointment of a second breast care specialist. I hope that, following the announcement of cancer money in May, and assuming that we can attract an applicant, we will, in the near future, have a service provided by two specialists rather than one.

We fall slightly outside the waiting time target because the consultant cannot be present 365 days a year. As the Clinical Standards Board for Scotland report says, we are only slightly outwith the target. Usually, a high percentage—in the high 70s—of patients would be seen within the time frame. Ideally, and with a second consultant in post, we should be able to exceed the target that has been set by the CSBS.

Dorothy-Grace Elder: You have revealed that women in the Highland area are dependent on one consultant—although that is soon to be two—but do you have an adequate number of breast care nurses?

Richard Carey: In the past two years we have appointed a specialist breast care nurse. That was part of a service review. We plan to use the cancer money to appoint a second breast care nurse. We hope to make that appointment this year.

The member mentioned radiology staff. We are fortunate that we do not have a problem at the moment—touch wood—with consultant radiology staff. We have managed to recruit a full establishment of radiologists. That includes support for the MRI service, which, as I mentioned, is coming on stream during the year.

The Convener: Thank you. That brings us to the end of the questions. I will recap what you have agreed to give us in writing. If anyone remembers anything that I have forgotten, please say so.

You are going to give us further written submissions on staff recruitment and retention, possibly considering issues of training, as well as information on Arbuthnott and the indicators of rural poverty. It might be useful for the Scottish Executive to review such indicators, so anything that you give us we will pass on to the Executive. You were also going to provide information on the situation in relation to self-inflicted injury and suicides and the various issues surrounding that. Derek Leslie agreed to provide a list of the £3.5 million of innovations. It might also be useful if Malcolm Iredale could give us more information about the cost cube, how it works and what it will be used for.

Mary Scanlon: We were also seeking further information on how alcohol problems are being addressed.

The Convener: Okay. You will also give us information on deprivation, alcohol and mental health issues.

Richard Carey: I think that Dorothy-Grace Elder asked for information on pain services. Should I send that to the committee or directly to the member?

The Convener: All information should come to the committee, through me. I thank this morning's witnesses for tackling all our questions and giving us their submissions. I thank also the members of the public who turned out to see a parliamentary committee in action. I hope that you found it to be

a useful experience. I thank not only our Parliament staff for putting everything in place to allow us to work in a different arena from usual, but also the Highland Council staff for their support and welcome to Inverness. This is the first time that the Health and Community Care Committee has held a meeting outwith Edinburgh. We plan to go to Glasgow in the next few weeks.

I have had an interesting and enjoyable experience, as, I hope, have the other committee members. I am sure that we will be back in Inverness in the future.

Meeting closed at 13:16.

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