HEALTH COMMITTEE

Tuesday 30 September 2003
(*Afternoon*)

Session 2

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CONTENTS

Tuesday 30 September 2003

HEALTH COMMITTEE
8th Meeting 2003, Session 2

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Mr David Davidson (North East Scotland) (Con)
*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Shona Robison (Dundee East) (SNP)
*Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

*attended

COMMITTEE SUBSTITUTES

Robert Brown (Glasgow) (LD)
Paul Martin (Glasgow Springburn) (Lab)
Mrs Nanette Milne (North East Scotland) (Con)
Ms Sandra White (Glasgow) (SNP)

THE FOLLOWING GAVE EVIDENCE:

Malcolm Chisholm (Minister for Health and Community Care)
Dr Peter Collings (Scottish Executive Health Department)
Mr Trevor Jones (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Graeme Elliot

ASSISTANT CLERK

Hannah Reeve

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 30 September 2003

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:00*]

Item in Private

The Convener (Christine Grahame): Welcome to the eighth meeting in 2003 of the Health Committee.

The first item on our agenda is consideration of whether to take item 4 on our agenda in private. Item 4 relates to the consideration of our draft stage 1 report on the Primary Medical Services (Scotland) Bill and while, at the moment, discussions about draft reports are normally held in private, we should note what Mike Rumbles said last week about his wish to have such discussions in public at some point.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): After I raised that point last week, we made good progress on the document in private session. Given that there is not a great amount of controversial discussion to be had by the committee in relation to the report, might we consider finishing off our consideration of the report in public? At every meeting at which a draft report is to be discussed, the committee is asked to agree to deal with the matter in private. If we always agree to discuss such reports in private, we are making a mockery of the process.

Mr David Davidson (North East Scotland) (Con): I understand where Mike Rumbles is coming from, but if the report is to be agreed on by everyone on the committee, we should be able properly to fine tune the essence of the matters on which members agree. As a number of changes have been made to the report that we are to discuss, I would prefer to discuss it in private so that we can deliver it to the Parliament.

The Convener: Are you happy with that on this occasion, Mr Rumbles?

Mike Rumbles: Yes.

The Convener: I have noted the views that you have expressed.

Do members agree to discuss the draft report in private?

Members *indicated agreement.*

Subordinate Legislation

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 9) (Scotland) Order 2003 (SSI 2003/409)

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) West Coast) (No 10) (Scotland) Order 2003 (SSI 2003/410)

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (Orkney) (No 3) (Scotland) Order 2003 (SSI 2003/429)

14:02

The Convener: I welcome the Minister for Health and Community Care. He will be with us for most of the afternoon while we deal with subordinate legislation and, later, the budget process.

No members have commented on the orders and the Subordinate Legislation Committee has made no comments on them.

Do members agree to deal with the three orders together?

Members *indicated agreement.*

The Convener: Minister, would you like to say anything about the instruments before moving the motions?

The Minister for Health and Community Care (Malcolm Chisholm): I was told that that would not be required. I have a prepared speech; nevertheless I could just move the motions, if you like.

The Convener: That would give us more time, minister. As the instruments are not contentious, it would be helpful if you could just move the motions.

Motions moved,

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.9) (Scotland) Order 2003 (SSI 2003/409) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.10) (Scotland) Order 2003 (SSI 2003/410) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (Orkney) (No.3) (Scotland) Order 2003 (SSI 2003/429) be approved.—[*Malcolm Chisholm*.]

The Convener: The question is, that motions S2M-324, S2M-325 and S2M-409 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST

Davidson, Mr David (North East Scotland) (Con)

ABSTENTIONS

Grahame, Christine (South of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)

The Convener: The result of the division is: For 5, Against 1, Abstentions 2. You sprung that on me, Mr Davidson.

Motions agreed to.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.9) (Scotland) Order 2003 (SSI 2003/409) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.10) (Scotland) Order 2003 (SSI 2003/410) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (Orkney) (No.3) (Scotland) Order 2003 (SSI 2003/429) be approved.

Budget Process 2004-05

14:05

The Convener: I welcome Trevor Jones, who is head of the Scottish Executive Health Department and chief executive of NHS Scotland, and Dr Peter Collings, who is director of performance management and finance in the Health Department.

I invite members to ask questions of the minister with regard to the budget process.

Mr Davidson: I refer the minister to the choice of portfolio priorities. We have noticed that you have 14 portfolio priorities and 12 national priorities. Can you tell us why there is a difference? Can you list in order of preference the priorities that you have put in the budget?

Malcolm Chisholm: You will find that there is quite a lot of overlap between the priorities on page 79 and those on page 71. The statement of priorities was given out to NHS boards nearly a year ago and we are considering certain adjustments to it. For example, I am flagging up the idea that public involvement in the coming year ought to be patient-focused, and people who listened to me in the debate on 18 June will know why. The portfolio priorities came a few months later, on the back of the spending review. If members think that there are contradictions between the two sets of priorities, I would welcome their comments, but as far as I can see the two lists are entirely compatible.

Mr Davidson: There was another part to my question on your priorities in the new list. Do you have any ranking for them at all?

Malcolm Chisholm: In general, we are trying to narrow the range of priorities. The debate about the number of priorities has manifested itself, particularly south of the border, in a debate about the number of targets. Our approach to those matters is to have a limited number of priorities and a limited number of targets, rather than overburden the service. As is well known, if everything is a priority, nothing is a priority. You tempt me to put them in rank order, but I think that it would be foolish for me to go down that route. It is well known that the areas covered are all important priorities, and we cannot reduce the list to just one or two specific issues.

I may be able to answer your question in a different way, because there are certain fundamental overarching movements that are important and underlie all the priorities. For me, the idea of service redesign underlies a lot of our objectives, so the fact that that is first is significant. Service redesign will be relevant for cancer, for

mental health and for coronary heart disease and stroke. It will also be relevant for waiting times, for delayed discharge, which is topical today, and for 48-hour access, so there is a certain sense in service redesign being at the top of the list.

When it comes to the priorities that I have flagged up for the second session of the Parliament, the fact that my first health debate was on patient focus and public involvement sends out a strong signal. Public involvement was flagged up last year; the agenda is not only about patient choice but about a range of other issues around patients being more involved in the development and design of services. It is about more heed being paid to the experience of patients, and that is the other key driver that runs through all the other priorities that are listed. You have tempted me to flag up priorities, and I have flagged up service redesign and patient focus.

Mr Davidson: That is very kind and I appreciate it. Perhaps, as we are now discussing the budget process, you could put some numbers to one or two of those priorities for us. What sum of money have you put towards patient priorities, and how will that be distributed among health boards? Can you give us an indication of whether there are any other administrative costs, either at departmental level or within health boards, for dealing with those new targets and initiatives?

Malcolm Chisholm: I do not know whether you are referring specifically to the idea of patient focus, but you can correct me if I am wrong. One of the problems with the budget, apart from the fact that the majority of the money in the budget is distributed to boards for them to make decisions about, is that it is not possible discretely to divide all the priorities into specific programme areas. As I said in my previous answer, the priorities run through all the programmes, so we cannot disentangle patient focus and public involvement. There are specific sums of money for parts of that work, but we want it to come through the work of the boards in all those areas.

Waiting is another key issue for the health service and for the Health Department. For similar reasons, we cannot disentangle the waiting budget. We can say that we are giving a certain amount to the waiting times unit and identify the budget of the Golden Jubilee national hospital, which will help to deal with waiting, but most of the money for waiting is mainstreamed in board and trust budgets. It is not possible in budget terms to draw a circle around many priorities.

Mr Davidson: I think that I understand you correctly. You are saying that you have not deliberately lumped sums of money with themes but have made those themes the basis on which health boards should make decisions about how to use their existing resources.

Malcolm Chisholm: We are doing a bit of both. I may as well mention the figures that have appeared today showing a reversal of the significant falls in the number of delayed discharges that have taken place in the previous 12 months. I am greatly concerned about that negative development and we will address the matter urgently. Indeed, the Deputy Minister for Health and Community Care met representatives of various boards and local authorities this morning.

The point of mentioning delayed discharges in this context is that £30 million has been earmarked specifically for dealing with the problem. One feature of the health budget is that it interrelates, sometimes in difficult ways, with local authority budgets. We ensured that the money was routed through health boards, but the bulk of it is spent by local authorities on the kind of community care services with which the member is familiar. There are issues that we need to consider further to ensure that all the money is spent on the objective of reducing the number of delayed discharges.

We can point to sums of money that are set aside for specific purposes in some areas, but not in others.

Mr Davidson: How much of the £30 million that you have identified and discussed will be used to equalise payments for care in care homes in the voluntary and private sectors with payments for care in local authority care homes?

Malcolm Chisholm: I am glad that the member raises that issue. In community care there are many funding streams that work together. The Health and Community Care Committee made a big contribution to the development of the free personal care funding stream, about which we all know. Local authorities are receiving considerable amounts of extra money—£80 million more than they received just two years ago—for care home fees. There is also a third stream of money to deal with delayed discharge by creating extra capacity.

We must do three things simultaneously in community care through local authority budgets: we must pay for free personal care, expand capacity and pay more for places. There is a debate about the third issue, because fees have risen considerably. We know that there is variation, as a recent study highlighted. We are tackling that issue, but significant extra money has already been made available to pay for extra places, as compared with what we were spending two years ago.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I would like to ask about public involvement.

The Convener: We will address that issue later.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): We know that the Executive seeks to achieve a measure of equity in the way in which it allocates funds to NHS boards, through use of the Arbuthnott formula. However, on our patches we have discovered that NHS boards have considerable discretion in how they allocate their budgets in their areas. Do you recognise the danger that the good work that is done at national level, through Arbuthnott, may be lost because of decisions at local level? Will you consider requiring NHS boards to demonstrate that any gains that they make under the Arbuthnott formula reach the most disadvantaged groups?

Malcolm Chisholm: Trevor Jones should address that issue, because he is responsible for conducting performance reviews with boards. Scoring in the performance assessment framework is published on the web for everyone to see. Part of the answer to Duncan McNeil's question is that we monitor how money is spent on certain objectives and priorities.

The Arbuthnott formula is intended to determine distribution of funding at Scottish level between boards, rather than to direct spending within boards. We have priorities that will influence spending within boards. We also have the overarching priority of addressing health inequalities through our health improvement agenda. That is our objective.

However, the purpose of the Arbuthnott formula is not to direct boards on how they should spend their money; it is purely a formula that is used to distribute money among boards. The question of how that money is spent by boards is dealt with in various parts of the performance assessment framework, which Trevor Jones will touch on if he so wishes.

14:15

Mr Trevor Jones (Scottish Executive Health Department): I should first point out that, when one thinks about how a health board allocates money, one will see that we use the Arbuthnott formula as a basis for giving the overall sum of money that is available to an NHS board area. The health board then has to fund three levels of services. First, it must fund local community services, and we would expect it to take into account the particular needs of deprived and disadvantaged communities. Secondly, the health board must fund a district general hospital service for the whole of its population. Finally, it also has to fund specialist services for its population. As a result, it would not be appropriate for an NHS board to distribute all its funding down to smaller geographical areas. NHS services are organised in a different way: there is the regional basis, the local or area-wide basis, and the local community basis, all of which need to be treated differently.

Every year, we meet each NHS board for a detailed review of how it uses its funding. We measure a board's effectiveness through the performance assessment framework, which looks at the whole of a board's activity, and examine its performance in relation to health improvement, in which funding particular communities plays an important part; access to health services, which also contains a community element; the quality of health services; how it works as an employer; and its financial performance and efficiency measures. We examine a board's total performance, taking into account how it spends money on local communities and funds area-wide services.

Mr McNeil: Perhaps there is a lack of transparency in that respect. For example, we might need a table that shows any gains or losses in the process. I do not think that my question related to all funding; instead, it related to the Arbuthnott aspect of that funding, which in my opinion is not large enough. How do we reach the stage where national priorities are delivered to deprived communities that have not benefited from the formula or where sub-programmes can benefit from it? Is it not time to instruct that those priorities be followed through to ensure that a community's particular need is not sacrificed for a pressing specialist need?

Malcolm Chisholm: Trevor Jones might want to come back on that question. I should point out that all the information about the performance assessment framework is on the website called "Scotland's health on the web" but, if members prefer, we could certainly send it to the committee in hard copy. At least I think that we can do that—there is quite a lot of information. The first section of the framework focuses on health improvement and reducing inequality, which means that we are examining those indicators. Indeed, as I said in the debate a couple of weeks ago, we are seeking to develop more sophisticated indicators of health inequalities.

Mr McNeil: But not below board level.

Malcolm Chisholm: The indicators will show whether boards are managing to reduce health inequalities, which I presume is the objective of your question.

Mr McNeil: I am testing you on your objective, minister.

Malcolm Chisholm: That is the objective.

Mr McNeil: As the Scottish Executive Health Department, you allocate a certain amount of money for deprived areas and to deal with health inequalities. However, when you hand the money over to the health boards, you do not expect them to follow that course.

Malcolm Chisholm: I have made two points in that respect. First, we are measuring boards'

effectiveness in reducing health inequalities, which is the objective of that part of the Arbuthnott formula. My second point goes back to the previous time when I was before the committee. Money over and above that which is allocated through the Arbuthnott formula is also distributed. Indeed, one of the features of the new general medical services contract is that the amount of money that is given to a practice in a particular area takes into account health inequalities and deprivation.

I am not saying that the situation cannot be improved. In fact, the committee will be aware that further work was carried out on the Arbuthnott formula to find out whether it could be made more sophisticated in addressing unmet need. I am keen to consider the whole area of unmet need and the department is working on how we might address that through pilots. One of the issues around health inequalities is unmet need in deprived communities, which I am concerned to address. I am not saying that our approach to the issue is perfect. On the one hand I am describing what happens at present, but on the other I am agreeing with you that we can do more to address inequalities in communities.

Mike Rumbles: I come at this from a different angle from that taken by Duncan McNeil. The Arbuthnott formula does not take into account demand for NHS services. For example, the Grampian NHS Board area that I represent in the north-east survives on nine tenths of the income that it would have if the funds were worked out on purely a per-head-of-population basis. I am not arguing against the Arbuthnott formula, but perhaps it should take demand into account. When is the formula due for re-examination, because it is not satisfactory as it stands?

Malcolm Chisholm: It will be up for re-examination in the next 18 months. We have always said that that will happen. A range of concerns have been raised in your area and in the island board areas, but equally the urban authorities, most notably in Glasgow, have particular issues with regard to what I said in my previous answer. However, the issues will be considered within that time scale.

Mike Rumbles: Is the chairman of Greater Glasgow NHS Board still the chairman of the Arbuthnott formula committee that decides on allocations?

Malcolm Chisholm: He is still involved in making recommendations.

Mr Jones: The next review is an issue that we will have to pick up when the current work programme is completed. Over the next 12 months, we will need to think about the composition of the committee that will consider the resource allocation formula.

Mike Rumbles: My point is about appropriateness.

Malcolm Chisholm: We note the point that you make.

Dr Turner: The minister touched on what I was going to emphasise about the Arbuthnott report. Unmet need is one of the most important things that the report flagged up and I am delighted that the department is doing more work on it.

A little time has passed since I read the Arbuthnott report and Professor Graham Watt's submission on it but, as I remember it, very little money was going into academic research into unmet need in primary care in the great number of deprived communities in greater Glasgow and Lanarkshire. Are you considering specifically awarding more money from the budget for more academic research into that?

Malcolm Chisholm: There are two parts to my answer. There is obviously a research agenda, and a lot of good work has been done, particularly in Glasgow. I remember when Dr Watt gave evidence about that to the Health and Community Care Committee in 1999. I would like to involve a number of people in discussions. It would be invidious to name the individuals involved, because there are quite a lot of them, but they will certainly help with the evidence base. I announced in the health improvement debate that we want to support financially the Glasgow centre for population health, because there is academic expertise in Glasgow on these issues.

We also want to test out work on the ground. I am just flagging the matter up, because we have more work to do on it, but our thinking is that we would like to run pilots on how to address unmet need. We could just give money to boards to do that, but we want to ensure that, if we give money to address unmet need, that is what it is spent on. That might answer Duncan McNeil's point. We think that pilots might help to make the case. The reality is that not everybody is persuaded of the need for that approach, although the committee is, and I am, too. Pilots would be a good way to carry forward the recommendations on unmet need from the Arbuthnott group. We will say more about that.

Dr Turner: What is the time scale for that work?

Malcolm Chisholm: We want to progress things quickly, but we have some further work to do in order to establish in detail how the pilots might best be done. We are involved in that work at the moment.

The Convener: Could I press you a little on the time scale?

Malcolm Chisholm: We want to get the matter sorted out for the beginning of the next financial year.

Kate Maclean (Dundee West) (Lab): Duncan McNeil asked whether there were any tables or figures showing where money goes once it is allocated to board areas. I am a bit concerned about that. I think you said that, if there was evidence of health inequalities being addressed, that would be the outcome that you would expect for the extra money—or for the relevant part of the formula allocation. Outcomes are difficult to measure sometimes. If the figures or data that Duncan McNeil referred to were available, it would be much easier to measure the input and to ensure—using the indicators on which the Arbuthnott formula is based—that specific groups are receiving the money.

Part of the formula addresses the problems faced by older people. The central heating programme is bound to improve the health of older people, but the funding for that programme does not come from the health budget. That is an example of an outcome in one area—an improvement in the health of older people—that does not necessarily come about because of extra money being put in through the Arbuthnott formula. I would be concerned if we were not able to get the right information. I believe that the formula is flawed to a certain extent, because the NHS board areas are so big and it is difficult to ensure that money is spent where it should be in such big, diverse areas. It is impossible to say whether the formula is indeed flawed without evidence on whether the money is properly targeted at the relevant groups.

Malcolm Chisholm: As your own remarks indicate, the matter is complicated. A lot of the actions to address health inequalities will indeed come from the health improvement agenda. That strand relates to other interesting controversies. Part of the Executive's argument is that we need to target resources in order to achieve the maximum effect from the health improvement strategy. Many people in the Parliament criticise us for that, and say that all provision should be universal. It could be argued that we are quite strong on targeting resources for health improvement, which includes the broad health improvement strategies such as the central heating programme.

Kate Maclean focused more on the actual amount of money for the health service, about which there are many complexities. It is a universal service, so there is no question of not treating everybody equally, although a lot of the money might be locked up in a big acute hospital that serves all sections of the population. The matter is complicated. I do not disagree with Kate Maclean's point of principle, which is that there is an issue around the allocation of health service money. That point is directly reflected in the amount of money that will go into the new GMS contract. That allocation will be practice based, so it can be sensitive to local deprivation, for example. I do not in any way object in principle to what Kate Maclean is saying, and we are interested in pushing the frontiers forward through the new work that we wish to carry out on unmet need. As I have said, however, it is a complex area, where things can be difficult to achieve.

I am not sure whether Trevor Jones has anything to add to that.

Mr Jones: I think that that covers the point, minister.

Kate Maclean: There is more equality when it comes to acute services, particularly in relation to someone who has a certain condition or who needs some sort of operation. The inequalities arise more often in primary care.

Malcolm Chisholm: That is being reflected—although perhaps not to the extent that you might wish—in the proposed new formula, which will avoid the problems that you are describing. Mike Rumbles made a point about that earlier.

I would not say that demand is irrelevant. However, if there is unmet need, certain people will not come forward, and an emphasis on demand would not deal with the problem of those inequalities. The issue is complex, but I do not disagree with your point on principle.

14:30

Mr Jones: Inequalities affect the hospital sector as well as primary care, if people from deprived communities present with diseases at a later stage.

Kate Maclean: That is the point that I was trying to make.

Mr Jones: We must have an inequalities agenda for both the acute sector and the primary care sector.

Kate Maclean: The point that I was trying to make is that once people reach the acute sector there is inequality. The primary care sector must address inequalities so that people do not present at later stages. I would have thought that it would be easy to measure where that money was going to.

Mr Davidson: The minister talked about a review of the Arbuthnott formula. Has Arbuthnott worked in that it has produced the intended outcomes as opposed to outputs? What work has been done to measure that? Can the minister give the committee evidence that the outcomes that were projected when Arbuthnott was introduced have been met?

Malcolm Chisholm: Arbuthnott took more factors into account than the previous formula did. The Arbuthnott formula is applied at Scottish level as distinct from NHS-board level. We are interested in the latter level, but Arbuthnott is interested in distributing the money fairly at a Scottish level. That approach is better than the previous one and is the best that we have had, but the Arbuthnott formula is not perfect and that is why it must be reviewed continually to ensure that board areas get their fair share of the Scottish cake. There is also a series of processes, such as our own performance assessment, that can improve. That involves a separate process, which we must undertake on the back of the Arbuthnott formula or a revised Arbuthnott formula.

Mr Davidson: Perhaps I am still hung up from my days on the Finance Committee, but fellow north-east MSPs and I might dispute whether in our localities you are achieving on the ground what you call fairness. However, you have your officials with you today, so I will ask what measurements there are in relation to the budget to demonstrate that the Arbuthnott policy is effective and that you are getting the outcomes that were projected when you chose to implement the policy.

Malcolm Chisholm: Arbuthnott is not a policy. We have a range of policies and priorities, as you pointed out, and we do performance assessment in relation to those. Arbuthnott is not a policy; it is a way of distributing the money in the fairest possible manner.

Mr Davidson: All right—I will rephrase the question. Do you think that the formula is working in that it is delivering the policies that you think should be delivered through it? How do you measure that?

Malcolm Chisholm: I suppose that all that we can do is to compare Arbuthnott with what went before. I think that Arbuthnott is an improvement, but I do not think that it is perfect. Obviously, Arbuthnott causes much controversy, not least in Mr Davidson's constituency area. However, even people in that area who think that Arbuthnott is not fair would agree that Glasgow needs more per head of population than Grampian. People might think that Glasgow does not need as much more as it gets, but I am sure that everybody in Scotland would accept that Glasgow needs more per head of population because of the concentrations of deprivation there. In that sense, I definitely think that Arbuthnott is an improvement.

To balance that, the recognition of rurality is a new feature of the formula that has improved matters in comparison with what went before. Obviously, the formula is an incredibly complex area, and I am sure that it can be improved upon.

Mr Davidson: I presume that you will build into the rurality aspect the new chores for which health boards in rural and remote areas will have to become accountable when the Primary Medical Services (Scotland) Bill gets through in some form or other.

Malcolm Chisholm: Yes, but as you will know from your other recent work, the reality is that that money will be distributed by a different formula. As we know, the money that will go into the new GMS contract will increase by a third what has been available before. We went over all that at a previous meeting. Extra money is going into the contract. I understand people's concerns about out-of-hours provision, but there are funding streams to enable that to be delivered differently.

Shona Robison (Dundee East) (SNP): I want to return to transparency at NHS board level, which you have touched on in answer to questions. There is a budget in which 80 per cent of the detail covers 20 per cent of the spending. Therefore, 80 per cent of the spending is not detailed in the budget. The committee has raised that issue time and again. Although it could be argued that prospective planning information is available through the local health plans, that information is not collated to give us a national picture. Additionally, we often get sight of those plans only halfway through the year, so they are not prospective at all. What progress have you made in addressing that issue and what further detail can we expect in the budget document for next year?

Malcolm Chisholm: The issue is what information is in the budget document and what information is available. I am sorry that what I sent you was sent later than it might have been, but the work is not—

The Convener: On that issue, I am grateful for what you sent. Unfortunately, it arrived in hard copy on the desks of MSPs—some of whom had to travel quite a distance—at lunch time. If such information is to be of use to the committee in dealing with the budget next year, it should be sent to the committee early, before stage 1.

Malcolm Chisholm: I apologise for that. As I have said, the information has not been updated completely, which is what we were trying to do. When I realised that that was not going to be possible, I thought that it would be better to send an incomplete document rather than nothing at all. I apologise for the fact that the document is not complete and for the fact that it was not sent to you earlier.

I have asked about the information that is available myself, as I am aware that some of the tables that were in the budget document last year are not there this year. I was told that there is a

consistent format for the document and that there was an issue about the health section's being too long. I think that there has been some standardisation of the level of detail that is given in the budget document. That is one issue.

The other point that I am trying to make is that there is a range of other material about a range of issues that we can make available to the committee. At the moment, we are homing in on the further information.

The fundamental problem of transparency in the health budget is due to the fact that the majority of the money goes to NHS boards, as Shona Robison pointed out. Information on the boards' spending is available, but it tends to be contained only in the boards' reports, which come out later in the day rather than prospectively. Trevor Jones may be able to say more about that.

Mr Jones: NHS boards are separate statutory organisations, and it is for them to make decisions about local spending priorities. That information is in the public domain. It is contained in the boards' annual accounts and the financial reports that they take to their public NHS board meetings throughout the financial year. At those meetings, decisions are made about spending. All the local NHS boards' spending decisions are in the public domain; however, those decisions remain for the local board to make.

Shona Robison: Would you not agree that a lot of that information tends to be retrospective rather than prospective? It has been my experience that, although we can know the detail of the spending once it has been spent, it is difficult to get a national picture of prospective spending—in fact, we cannot get that. Perhaps the Health Department could collate the information to give us a nationwide picture of the prospective spend. That would be extremely helpful.

Malcolm Chisholm: Trevor Jones may know about the time scales. The Parliament starts its budget process early. We started a bit later than usual this year, for obvious reasons, but we tend to announce our budgets early. I am not sure when NHS boards would normally have such information available.

Mr Jones: The boards' budget process starts around November, in advance of their knowing what their firm cash allocations will be. By March or April, they begin to finalise their budgets. A number of boards will forecast a deficit for the year, as their spending intention is above the amount of cash that is available. Through April and May, they will bring their budgets into line with the resources that they have got. By June, NHS boards should have a clear financial plan for the coming year. All of that information is available locally, and we receive boards' plans throughout the summer. Around this time of year, we start to get a feel for the detail of individual NHS board spending plans.

Shona Robison: So, it should be possible for you to collate for us a nationwide prospective spending plan.

Malcolm Chisholm: We are a year out of synch. You are talking about the NHS boards' plans for this year, whereas we are considering our plans for next year. Is that right?

Mr Jones: That is right.

Shona Robison: Sorry. So you are.

Mr Jones: It depends on which year you are talking about.

Shona Robison: So you are saying that that proposal would not be possible because of the delay.

Mr Jones: Every local health plan contains a five-year forecast of expenditure. We could work with the committee on whether we could base something useful for the committee on those five-year plans, which are in the public domain and are published locally. We could work with the committee on bringing the plans together to provide a national perspective.

Dr Turner: I am the new girl here, and I thought that it would be nice to see where we have come from, where we are and where we are going, and to work out a cost-benefit analysis. I naively thought that we would have something like spreadsheets that I would have to learn and understand. In fact, we receive policy documents, more or less. If we did not have the advice from our adviser, collating all the information would be difficult. I support Shona Robison's request. The information for which she asked would make the committee's work more meaningful. We should have more information, on time.

Malcolm Chisholm: I understand your point. There are the two issues about what is expected in the budget, but that does not need to be the end of the matter. The issue about boards arises every year. Some of the issues are frustrating for me, too. If we can make more of the information about board spend available to the committee, I know that that will make the committee's job more meaningful, because that involves the bulk of the budget. I imagine that such considerations apply to other matters—the obvious example is local government, which has an impact on many of our priorities, too.

Mr Davidson: The Health Department sets targets and is responsible for monitoring them. We are talking about transparency, so could we see at an early stage of future budget processes the results of your monitoring of prior targets?

Malcolm Chisholm: Trevor Jones can go into detail on that. That information is available through performance assessment.

Mr Jones: We monitor all the published targets and there is no reason why we should not discuss with the committee how to present that information. The performance assessment framework, which provides the overall assessment of an organisation's performance, is published on the website called "Scotland's health on the web", so those data are available. However, it might be useful if we took the committee through that.

Mr Davidson: To be fair, I am looking for a simpler, more user-friendly document for the committee, because the committee is working with only a tiny window of opportunity on the budget, unlike the Finance Committee. It would help to have that information up-front.

Malcolm Chisholm: In principle, that is a good suggestion. Part of the problem is that a welter of information is available. We need to home in on what is most useful to the committee and how we can provide it.

The Convener: I think that Shona Robison and others were asking for the prospective local NHS board spend and a comparator across the board areas, so that we can descend a level from the bulk amount that boards receive. When would you have the data to make a spreadsheet on that available to the committee?

Malcolm Chisholm: The last two questions have addressed two issues: the prospective five-year financial plans and—

The Convener: I was thinking of just the information for 2005-06.

Malcolm Chisholm: The problem that I flagged up is that the detail is available for this year, but I understand from what Trevor Jones said that the boards are not as far ahead as we are in the Parliament. Therefore, we could collate detailed information for this financial year but, apart from the five-year plans, I understand that detailed plans have not been made for the next financial year. Is that correct?

Mr Jones: That is right. The five-year financial plan shows the overall financial status of the NHS. That would not be shown in levels of detail for individual boards. I formed the impression that the committee was looking for that. We can construct something around that from the published data.

The Convener: We will think that over.

Malcolm Chisholm: On the second point, we can try to provide information on targets.

14:45

Mr McNeil: The initial question was on transparency. We have highlighted the need for transparency at committee level but it is surely equally important that we get transparency at board level.

Mention was made earlier of the scope that boards have to identify and pursue local priorities. How do we get to a stage of transparency where there can be a dialogue with the community about the part of the budget that is left? Much of the budget will be claimed through junior doctors' hours, compliance with the European working time directive, wage increases and so on. We need to get to the heart of that problem. How do we square the massive headline figures on the money that is going into the national health service with providing transparency about the reality on the front line?

Malcolm Chisholm: I would certainly support more transparency all round. It would be entirely helpful to our public involvement agenda if there was more information on, and understanding of, what the money is spent on in each NHS board area. For example, the drugs budget has been in the newspapers this morning. I suppose that it is just a distinctive feature of NHS board budgets that, of the significant increases that boards have received, somewhere over 1.5 per cent will go into the drugs budget, which rises year on year. That is a particular feature of the health budget. The more transparency that there is about all those things, the better.

Mr McNeil: My observation is that the priorities of the trust or board or whatever are dealt with by the managers and specialists. I do not see how the community influences the debate in any real sense at the moment. If people knew how much money the health authority had for new developments and plans, they could be included in the debate. However, at this point, the public are not much involved at all, because the different sums of money are not even defined.

Malcolm Chisholm: There is certainly a wider public involvement agenda. I do not disagree with Duncan McNeil that discussion about resources should be part of that, but the other fairly obvious thing to say about the health budget is that about 70 per cent of a board's budget goes on staffing costs. The other pressure on the system comes from pay increases and the simultaneous expansion of the work force. When the extra staff and the extra pay are added together, they are obviously the most significant feature of local NHS board budgets. However, I do not disagree with what Duncan McNeil has said. He might ask what I am going to do about that. We certainly want to make progress on improving information and transparency about board budgets at local level.

Mr McNeil: How will you do that?

Malcolm Chisholm: We have already discussed what information could be made available to the committee, but the reality is that the issue is not really about bringing things out of the shadows. Much of the information is already available in board papers, on websites or in documents. The issue is more about how we make that information more accessible to people. That is probably the territory that we need to explore.

Does Trevor Jones want to say more about that?

Mr Jones: That is right. Most NHS boards will have very open discussions about their spending priorities. I guess that what we need is consistency across the service in how that works. We need to build on best practice to involve communities in the budget process.

The Convener: Have members any other questions on that issue?

Dr Turner: We keep on talking about public involvement; it comes through in everything that we have discussed. However, the public out there are, I suppose, a little bit jaundiced every time they hear that, because they doubt that it will happen.

The public also accept that a lot of money goes into the NHS's attempts to give them a message, but people frequently feel that they are not being listened to. The public say what they want the NHS to hear; the service says, "I am listening," but then goes off and does something else.

The feedback that MSPs get from doctors in the community and from the general public is that a lot of money goes into the NHS communicating information. I am thinking of the toolkit, "Building Strong Foundations: Involving People in the NHS", which somebody handed me a copy of. It was about an inch thick. It was presented in a thick plastic container and was very heavy because it included three heavy documents. The person had found out that it cost £85,000 to distribute a copy of the toolkit to every practice, library and department to which it was circulated. People have given me feedback on other documents. They say, "I picked up this glossy document. Will you please have a look at it?" Forty such reports were hanging around in one department. It was obvious that no one was picking them up.

People are also aware that the NHS uses a lot of outside consultancy firms. The cost of that might be great, or it might not, but the public believe that a great deal of money is spent in order for their opinions to be ignored.

People welcome public involvement in NHS decision making. How will you go about achieving that? Which decisions should the public be involved in? When the public's view conflicts with that of local health service officials, how can the difference of opinion be resolved?

Malcolm Chisholm: The first—

Dr Turner: Before I let the minister answer those questions, I also want to ask whether there is a way of finding out from the NHS accounts how much all the outside consultancies cost. How much does the paperwork that is handed out cost?

The Convener: I think that you have asked about 30 questions, Jean.

Dr Turner: I am talking about the material that people are bombarded with. Perhaps the minister could let me know from the accounts what those costs are.

Malcolm Chisholm: Trevor Jones might want to pick up on the particular issue of consultancy. A lot of more general issues were raised. The first thing to say about public involvement is that it is not nearly good enough. The second thing to say is that it is better than it used to be. However, that is not ground for complacency or self-congratulation. I am aware that I am repeating myself, but the third thing to say is that it is helpful to distinguish between the different parts of the agenda.

As Dr Turner flagged up the issue of public involvement, I will concentrate on that. The broader patient agenda was the first issue that I spoke about in the Parliament. I spoke about patient involvement in developing services and about listening more to patients and responding to their experiences in the development of services and care. For me, that is very important.

Let us stick with the wider public involvement agenda, particularly in relation to service change. We know that that was not done well in the past. We have issued new guidance in draft form. Although it is a big improvement, we are looking to see how it can be improved further. We want the best possible and most meaningful involvement with people at the earliest possible stage. We know that we have a lot of ground to make up in that area.

Dr Turner referred to one document in particular. A lot of work is going on, some of which is aimed at supporting the service in improving its practice. The public involvement team, which comprises a relatively small number of people, works in that area. We have to do something to improve the way in which the service operates and to have a few people working in that area is a good investment.

Most of the costs will be staff costs, although in certain cases, documents to disseminate best practice will also be produced. People can always pick out one document, give the cost and ask whether the money could not have been spent on

something else. I understand that, but I think that Dr Turner will find that the cost of documents in respect of the best-practice budget is not excessive.

The important principle is to support the culture change that we want to bring about. In the past, the health service operated in a way that was far more paternalistic in its approach to patients and local communities. We are talking about a massive culture change. At the end of the day, we need to get a whole lot better at what we do. Even with the best possible public involvement at the earliest possible stage, there will still be difficult decisions that are not accepted by everybody in an area. That is partly because people might disagree; they might not hold the same view about proposed changes. The reality is that a whole lot of considerations around service change have to be taken into account, the most important of which from my point of view are quality of care and patient safety.

Another important issue is the best use of available resources. I include staff in those resources as, even with an expanding work force, we have to use staff in the best possible way. I know that the committee is going to look further into changing working practices. Some of the external requirements, such as the working time directive, are not irrelevant to that discussion and, at the end of the day, we cannot ignore those factors. We have to explain them better to the public—that is part of the bigger picture that we were talking about in relation to finance—and involve people at an earlier stage.

However, even with a vastly improved level of public involvement—and I accept that we have a long way to go in that regard—there will still be hard decisions to make that not everyone will agree with.

Mr Jones: Was Dr Turner asking about the use of consultants for service change?

Dr Turner: I was talking about the outside consultants who are bought in.

Mr Jones: One of the difficulties is the need to define who is a consultant in those circumstances. A quantity surveyor or architect who is employed in relation to a major capital scheme would be a consultant. Another example would be commissioning a company such as MORI or a voluntary organisation to conduct a survey of the public's view independent of the health board. Although we do not collect centrally the cost of all such bodies that are used by NHS boards, we can say that the boards would use consultants only for functions for which the skills are not available in-house and that the competitiveness of the consultants would be tested by seeking quotations and tenders.

Dr Turner: I am surprised that you do not collect figures on the amount that is spent on consultants.

Dr Peter Collings (Scottish Executive Health Department): We have examined the problem of defining what is meant by a consultant in relation to various parts of the public sector. A difficulty relates to the fact that, these days, most of the firms that are involved in this general business area provide a wide range of services, which means that we can no longer tell by a firm's name what sort of work it is being used to do. If a board were to embark on a major piece of work, we would expect that such information would be evidenced in the papers authorising that piece of work. We have considered collecting the information centrally, but we have failed to come up with a consistent way of doing so.

Dr Turner: I think that it might add up to quite a bit of money if health boards throughout Scotland are using such consultants regularly. I would have thought that the expertise would in the past have been available within boards, but it seems that there has to be some outside expertise—perhaps a couple of people to assist people within the board who have some expertise—when a board is examining acute admissions, for example. To me, anybody who is not on the payroll of the board would be an outside consultant.

Mr Jones: When I joined the health service, all health boards employed quantity surveyors and architects and had large estates departments. Over time, as it was demonstrated to be more cost effective for the NHS not to employ such people but to use professional staff from outside the board for particular functions, the NHS moved those services out into the private sector. Using such professionals only when we needed them for particularly complex work provided better value.

Dr Turner: Are assessments still being made to determine whether that system provides value for money? That process should be on-going: it should not be accepted that the arrangement still provides value for money just because it did at one time. The public feel that far too many outside consultancy firms are used. If you are unable to produce figures to refute that belief or to prove that it is cost-effective to use consultants, the public will continue to believe that.

The Convener: I suggest that we have exhausted that seam of questioning, but it might be worth examining that issue at another time, because it is relevant.

15:00

Janis Hughes (Glasgow Rutherglen) (Lab): I come at the situation from a slightly different angle—I believe that people can be expected to make informed choices only if they are given as

much information as they need beforehand. We have spent a lot of money on consulting people and although I accept that the process is better than it was before, it is by no means perfect. The difficulty is whether such consultation represents good use of money when, at the end of a consultation period, decisions are made to implement initial proposals that have not changed substantially, if they have changed at all.

I accept that the minister has issued new draft guidance; that is certainly a start, but are we making the best use of resources by spending all that money when the public's perception is that nothing will change at the end of the process? It is not about when or how we consult; it is about how we evaluate the public's comments on, and input to, the consultation process. Is the minister considering those questions? Until we consider how we evaluate public input, we will never win over the public when we try to explain why change in health care is necessary.

Malcolm Chisholm: It is crucial that we evaluate the feedback and report on it, which has not always happened in the past. Perhaps the most important thing is to involve people much earlier. It does not have to be the case that one goes out to public consultation on a matter with a particular proposal in mind—sometimes it is best to discuss the dilemmas, problems and choices much earlier and to get the public's input before a definite proposal is formulated. That is part of the way forward.

I am mindful of past failures of the consultation process. We all see failures around us from time to time. It is not a terribly easy area in which to solve all the problems, but the committee can be sure that we have acknowledged that consultation is a key area where we need to transform the way in which we engage with local communities.

One of the other issues that Janis Hughes flagged up is the money that is involved in the consultation process. Its cost is not an argument for not undertaking the process and it is not very significant in relation to ward budgets. However, I know that people will always have questions about a particular consultation or document that supports the process. At the end of the day, cost is not the key issue; people want to be involved in consultation and we have to do it better.

Consultation does not take away some of the difficulties, but it helps people to understand situations better and to feel that they have had their say, although there will still be difficult choices that not everybody will agree with. Whatever we do, that is inevitable.

Mr McNeil: We would be interested to hear some firm proposals about how we will support community involvement and lay participation in the process. We welcome what the minister says about the experience of patients and their involvement, but much of the controversy arises from a point of crisis in the process of change. Recent experience shows that there is no real weighting in the case of community interest versus specialist interests. The specialist interests are there at the beginning of the process, they decide the framework, they decide the limitations and they decide the boundaries. Everyone else is then expected to conform to the process. The current experience is that the public tries to influence a process that has already been decided and which the specialists defend. I would like to hear some proposals today that will describe how we will support community interests over specialist interests.

Malcolm Chisholm: That is one pattern and I am sure that it has happened over time, but there are other patterns. One of the things that we must do is to learn from best practice—I suppose that we try to disseminate good practice in many areas.

By chance, at a lunch-time meeting someone described to me an innovative open-space event that took place recently in Perth, at which were evident many of the issues that Duncan McNeil describes in relation to difficult choices. I was told how novel the approach was and how it was a breath of fresh air in comparison to traditional modes of consulting the public. Although I flag that up as an example, I do not mean to say that the same difficult choices do not have to be made in that area. The approach was commended to me. We need to capture best practice.

Neither do I believe that the interests of the public and of staff are quite as diametrically opposed as Duncan McNeil says, which might be a bit unfair to staff in the health service. Some of the pressures come from external factors. I have already referred to the working time directive and the related issue of junior doctors' hours. There are some external issues that have to be addressed and it is in the interests of patients, as well as those of staff, to address issues to do with the length of the working day and the working week.

We must ensure that we listen to communities much more effectively than we did in the past but, of course, communities want to listen to local clinicians. Although communities might not always want to agree with the views of health professionals—whether they are nurses, allied health professionals, doctors, or auxiliary staff—they respect their views because those people work in the service and have an important contribution to make. There is not always the stark conflict of interests that you describe.

The Convener: I will halt you there—I suspect that the problem is that we have not really heard specific proposals about engaging the public in consultation. I will give the specific example of the Primary Medical Services (Scotland) Bill, which we have been dealing with at stage 1. We were trying to work out how much patient consultation had been involved in that bill—perhaps you will be able to tell us.

Malcolm Chisholm: The Primary Medical Services (Scotland) Bill is the exception that proves the rule, because you know as well as I do that that bill is unlike any other bill that has been before the Scottish Parliament, in the sense that it seeks to enact an agreement that has been negotiated already. That is unprecedented.

In response to your question, draft guidance is available, on which I gave evidence to the committee some time ago. You might think that I am taking too long to produce the final guidance, but the reality is that that is because I think that we have more work to do on it. I do not want to introduce final guidance until I am sure that we have captured all the good practice that is used and the good experience. The service is now following the draft guidance. That is fine in the interim, but I want the guidance to get better.

There is in different parts of Scotland a lot of work on trying new ways of consultation. Yesterday, we agreed that the top item on the agenda for the next NHS board chairs meeting would be discussion of that very issue, because we know that we still have a lot more to do to achieve the situation that we want. The answer to your question is that there is draft guidance; there will be final guidance soon, but let us not have that until we know that we have captured all the best ways of doing things.

The Convener: We look forward to receiving the final guidance. The only thing that I would say on the Primary Medical Services (Scotland) Bill is that, although it represents the implementation of a contract, it is legislation that will impact on people's lives through their GP services. I am trying to read what you said, which was—I think—that there was no consultation on the bill, because it is the exception that proves the rule. I presume that that means that there was no public consultation.

Malcolm Chisholm: When I gave evidence to the committee, I said that there would be extensive consultation on the implementation of the contract. It is hard to see how there could be public consultation on something that had already been agreed in negotiation across the table. The consultation will be on implementation of the contract, but the agreement on that was negotiated at UK level and a bill was produced to deal with the contract's legislative consequences. That is not the usual process for the work of the Parliament.

The Convener: If Duncan McNeil's question is short, I will let him in before Helen Eadie and David Davidson.

Mr McNeil: The question is, if you believe in public consultation, how do you make it happen, in particular at challenging times of change? How do you ensure that local clinicians and senior consultants participate in the process? That does not seem to happen; it has failed miserably.

How do we ensure that the Executive's guidelines on consultation, which provide support for lay people, are taken up and used effectively? How many people have taken advantage of the consultation guidelines and been able to draw up community plans? I would be heartened to hear that we were going to tackle that issue seriously, rather than dismiss it as a figment of my imagination.

Malcolm Chisholm: Everything that I have said today agrees with what you just said. I pointed out that the Primary Medical Services (Scotland) Bill is slightly different from most of the other issues that we are discussing. I agree with you—every word that I have said today about the subject shows that I am dissatisfied with what has happened in the past. Things are getting a bit better but we have much further to go.

One of the main things that I consider when I examine service-change proposals that come to me is the effectiveness of public engagement and involvement in making those proposals. Major service-change issues come to the centre so that we can consider the substantive proposals and examine the procedures that were followed in arriving at them. I am slightly surprised to hear what Duncan McNeil thinks about that: I disagree with him.

Helen Eadie (Dunfermline East) (Lab): I ask you to factor in to future budget planning closing the loop in public consultation. I have nipped your head about that in relation to public consultations that have taken place in my area. For example, the last time Fife NHS Board met Fife MSPs, I made the point that it is all well and good to consult people, but not going back to them to explain what decisions have been taken, and why, angers them even more and builds on the resentment that other members have described. People feel that no weight is given to their views, so it is vital that we build feedback into next year's plans.

Malcolm Chisholm: I assure you that feedback will be a feature of the final guidance. Reporting back is essential, although it is not the only thing that is essential. I have been emphasising that people must be involved at the earliest possible

stage because past perception—and reality—was that proposals were made, after which there was formal consultation that did not change anything. We are trying to get away from that and the best way to do that is to ensure that people's views are taken as early as possible so that they can be fed into the development of options.

Mr Davidson: You mentioned the open-space event that took place in Perth on behalf of Tayside NHS Board. There are some very serious issues there about, for example, how the board will roll out the mental health services that are required under the new legislation. We seek assurances from you that you will not only hold such innovative events—I heartily approve of them—but that there will thereafter be only a short time before a report is issued that lists the options that are available to the health board, what the health board's decisions are, and why it did not accept some options but went with others. People who attended the open-space event are already asking when they will hear what the input was, what the options are and what will be delivered. I focused on mental health issues, but I am not saying that Tayside NHS Board will not roll out the services.

The simplistic view that comes from throughout Scotland is that there is little point in holding consultations if there is no established framework for getting the information back to the public so that they understand what is going on and know whether they were listened to.

Malcolm Chisholm: That repeated in more detail what Helen Eadie said. I agreed with her and I agree with you. However, we should not assume that what David Davidson suggests will not happen with the open-space event. We should pay tribute to Tayside NHS Board; it was that board's event and it should get the credit for it. I am sure that the board will be mindful of the points that David Davidson raised. Indeed, I shall draw the board's attention to those points.

Mr Davidson: I have already made my points, minister. It is your position that we are trying to draw out.

15:15

Malcolm Chisholm: I obviously applaud the good practice that I have seen in Tayside, and I agree entirely that what David Davidson described should happen. The boards obviously have a lot of responsibility for such matters, so it is not right for me to become involved in the substantive issues at an early stage if I have to make a decision later. However, I am saying quite clearly that the centre is more determined to be engaged with the process issues. In fact, we are looking far more closely at the procedures that are adopted, because it is self-evident that there is no point in our coming up with all sorts of good proposals and guidance if they are not followed. We will do that, of course, but I do not have reason to believe that Tayside is failing at the moment in that regard.

The Convener: Before we move on, I have been passed a note by the clerk asking whether members would like a short intermission—as they used to say in the cinema—or whether you wish to continue. I am in your hands.

Mike Rumbles: Let us press on.

The Convener: Very well. I did not ask the minister, I am afraid, but whether we break or not is in the committee's hands, not his.

One of the issues that we have been asked to address by the Finance Committee is end-year flexibility. I appreciate that you have a limited pot, with about £10 million to allocate, and that you examine priorities and must work out whether to give the money to cancer, to heart disease, to obesity or to some other area. In examining whether you have done the right thing with that money, the committee would need to know what happened with the money last time. If you put the money into cancer, what did that buy and what did it achieve as an outcome? I think that our predecessor committee asked you for a time scale for coming to us with such data, so I would like to know how that has progressed. If we have those data, we can check them against the figures the next time funding is allocated.

Malcolm Chisholm: The main reference point is the table on page 7 of the draft budget. We do not want any self-congratulation from the health department, but it should be observed that EYF is very low compared with previous years. It stands to reason, therefore, that the health department's end-year flexibility—or underspend, as it is sometimes called—is extremely small. We have the largest budget, but we also have one of the smallest underspends, which I think is evidence of good management of our finances in the previous financial year. The corollary of that is that there is not a lot of money to play with. In fact, all that money is sitting in boards' budgets and will be spent by boards—

The Convener: That was not what the question was about. The question was: if you have that money and decide to allocate it to certain projects—which is very worthy—how do you know that you have spent it in the right place? How do you measure the cancer programme's work or the heart programme's work, so that next time round the committee can either agree with or challenge your allocations?

Malcolm Chisholm: The point that I am making is that we are not allocating any end-year flexibility. All £24 million—an incredibly low figure compared with the figures from two years ago—is not being allocated. It is in the boards' money and

will stay there and be spent there. In a sense, end-year flexibility is not much of an issue in health, because all that it means is that the money is spent by boards in April or May rather than in February or March. The figure of £24 million is, as far as I know, the lowest ever. It is much lower than it used to be. That money stays with the boards. The point that I am making is that there is no end-year flexibility money to make decisions about at the centre.

Kate Maclean: Is that £24 million in the base budgets for next year?

Malcolm Chisholm: It is carried over in the boards' budgets.

The Convener: You allocate funding to specific projects, which is very commendable, but we cannot scrutinise the end-year flexibility that has simply been allocated to cancer or to some other area. How can the committee, and you, measure whether that money has had a certain outcome, compared with using it elsewhere? With a limited budget, it might have been better to put the money somewhere else, but how do we track it?

Malcolm Chisholm: Cancer is a good example. Not all the information, apart from the headline amount, is in the budget document, but there are monitoring reports every six months and every single penny of the extra £25 million that goes into cancer every year can be tracked. That is obviously not the whole of the cancer budget, but all of the extra cancer strategy funding of £25 million is reported on in great detail in six-monthly monitoring reports, so it can all be tracked on a continuing basis.

The Convener: The question is not about the allocation, minister. Perhaps I am not explaining this very well. The question is about whether money from a limited budget has produced a better outcome than would have been the case had you put the money somewhere else. How can we measure that?

Malcolm Chisholm: That can be measured in two ways. We keep an eye on cancer statistics, but no one would claim that investment in the past year has changed those statistics immediately, although the bad cancer figures are obviously not as bad as they were, so we are making progress. The key point is that we can see what the money is being spent on. A lot has been spent on staff. You may ask how I can evaluate the contribution of one extra nurse specialist or one extra consultant, but most people would agree that such members of staff are beneficial for cancer patients. The amount spent on staff can be quantified; indeed, I quantified some of it during a recent debate on cancer. A lot has been spent on equipment. Also, you can track other budgets such as—

The Convener: I am sorry, minister, but this is not about what the money is spent on but about measuring the outcomes. If you are saying that those outcomes are difficult to measure, how do you prioritise?

Malcolm Chisholm: We can measure some of the outcomes. I have referred to mortality figures, which can be tracked over time, but we can also track waiting times for cancer patients. It is therefore possible to demonstrate that waiting times for radiotherapy have come down significantly through investment in new linear accelerators. Waiting times are still too long but, at the Beatson oncology clinic, for example, times are a whole lot shorter than they were two or three years ago. We can therefore track waiting times and, over a longer time, we can track mortality figures.

The most difficult thing to track is quality of care. Patients are interested not only in how long they wait but in the quality of their care. Some of that can be tracked by national monitoring or inspection bodies—in particular, by NHS Quality Improvement Scotland, which will report on specific cancer services. Its reports on breast cancer, lung cancer or whatever can be tracked. We are getting into new territory when we measure patient experience—the way in which people are related to and treated—so that can be more difficult to track. Talking to patients and listening to them is important so that we get feedback. There are many different ways of tracking outcomes; I have gone through only some of them.

The Convener: No one else seems to want to ask a question on this issue so I will make two final points. First, can your department tell us how much has been allocated to specific projects in a financial year and what were the outcomes?

Secondly, although I appreciate that outcomes can be subtler than waiting times and waiting lists, can your department give us an analysis that shows that best use has been made of money that has been spent on specific programmes? Has money been spent in the proper areas? I am not talking about a simple numbers game; rather, has any analysis been done that might allow us to say in a particular instance that best use was not made of the money spent? For example, there has been an advertising campaign to encourage people to eat reasonably. It is reported that that campaign—with the man using a fish as a phone, and all that stuff—has not succeeded. That report is anecdotal but the committee might have data on the matter. Is there a more stringent, more analytical way of finding out whether money on such programmes is being spent properly? Of course, we are talking about precious public money.

Malcolm Chisholm: Obviously, we want to evaluate programmes, and we do so. No doubt, we could do that more extensively—although people might in that case ask us how much time we intended to spend on evaluation as opposed to other things. However, in principle, I do not disagree with the convener's points. We do a lot of evaluation already.

I will stick with the example of cancer. We can consider the extra money that is going in, but the issue can become a bit more complicated. When it analyses health board budgets, the committee might be interested to know that there is no separate cancer budget. Cancer overlaps with many other areas. There is a debate to be had on that. Some people will argue that different diseases should have programme budgets. That is an interesting argument, but it can be difficult to disentangle the allocations for different diseases in a board's budget, because they can all overlap in the hospital.

We will track and monitor specific allocations such as the cancer money and the new money that we have announced for dealing with coronary heart disease and stroke. We will find out what effects that money has had and how effective it has been. We will also evaluate the healthy eating campaign. As I point out in my letter in today's edition of *The Herald*, no one is claiming that the healthy eating helpline is any more than one part of a large jigsaw of policies to promote healthy eating. Over time, we will watch how much it is used and what effect it has. When the helpline was first advertised it was used a great deal, but it is not used so much when it is not advertised. That is a fairly obvious point, but we will evaluate the effectiveness of the helpline along with the other parts of the health improvement strategy.

Kate Maclean: I want to ask a technical question about end-year flexibility. The £24 million of EYF this year was already allocated to boards, so it is still with them. Last year, EYF was £49 million. Was that money allocated to boards or was it moved from other budgets? If so, where was it targeted? If health is such a big priority for the Executive, why is the amount of EYF this year less than half the amount last year? I do not know whether you will be able to answer those questions.

Malcolm Chisholm: Wait a minute. Trevor Jones can deal with your questions about the £49 million, but I cannot believe what I am hearing—for years we have been criticised for having big underspends. Health is a big priority for us and the reduction in EYF shows that we have managed health spending well this year.

Kate Maclean: That depends on your answer to my first question. Was money moved from other departments to create the £49 million figure last year or did it all come from underspend in the Health Department?

Mr Jones: None of the underspending that has occurred in health has moved to other departments or vice versa. Health underspend remains in the Health Department. This year the underspend is smaller because we are committing resources faster and closer to the limit. Health has a budget of approximately £7 billion and an underspend of £24 million. That is as close as one can get to breaking even when managing a budget. We cannot overspend—we must live within our resources. The underspend is one third of 1 per cent of the health budget. I wish that I could get so close to breaking even when forecasting spend from my monthly salary. Spending is getting tighter because there are financial pressures on the NHS and health boards, so underspends are falling.

Kate Maclean: Given that last year EYF was not moved to health from other budgets, I am happy with the size of this year's underspend. Was the sum of £49 million left with boards or was it targeted at other areas?

Mr Jones: I do not remember precisely, but we can supply the committee with that information. The vast majority of the money was left with boards. That is committed expenditure—it is not sitting unspent. The cash is committed on issues such as staff costs and will be absorbed by 1 April.

Kate Maclean: Will it be spent on dealing with issues such as unfilled vacancies?

Mr Jones: Yes. If a board appointed a member of staff on 1 December, in that financial year it would spend only one third of the funding for the post, but the following year it would need 12 months' expenditure. For that reason, there would be underspending in the first year.

Dr Collings: From March to April there is also an element of slippage in spend on capital. Money needs to be carried forward to deal with that.

The Convener: Are you content, Kate?

Kate Maclean: Yes.

Mike Rumbles: I am particularly interested in the relationship between the budget and the partnership agreement. In his foreword to the draft budget document, the Minister for Finance and Public Services says that the document

"explains how we intend to meet the commitments outlined in 'Partnership for a Better Scotland'."

However, I have looked through the whole document and have been able to identify only a few bullet points in which the Executive says how much money it will spend on its commitments on health.

The health section of the partnership agreement is the biggest section of all and contains 54 bullet points. I am interested in finding out where the figures are. I expected to be able to open the draft budget document and the partnership agreement and to be able to identify the expenditure and public investment that are required to achieve the policy aim of providing free eye and dental checks, for example. However, I have found it very difficult to do that, except in about three cases. You have mentioned the investment of £30 million a year to provide 1,000 community places. That is exactly the sort of thing that I am asking you about. That is one example, but there should be many more. How can I check that what the Executive says in the partnership agreement is being funded?

15:30

Malcolm Chisholm: There is one self-evident point to make by way of preamble. The draft budget came out before Andy Kerr made his statement in Parliament only two weeks ago so—and I imagine that this is true for all departments—the budget documents could not reflect the money that was announced in that statement. Such a late announcement could not be factored into the document.

Secondly, we cannot disentangle every commitment and have a separate budget round it. It is like a previous point that I made: we cannot always disaggregate a budget. The first commitment in the partnership agreement is to do with waiting times for in-patients, and it then goes on to deal with out-patients. Although there are budgets that are relevant to that, such as those for the Golden Jubilee national hospital and the national waiting times unit, I cannot point to a specific budget that will address that issue.

Mike Rumbles: I am sure that you will recall as well as I can that in the negotiations between the two governing parties every item had a price tag, so I am surprised that we do not see that in the documentation. It is a simple question. I know that the civil servants produced that information in the negotiations and I expected that, in this era of openness and transparency, it would be reflected in the budget documents, but it is not, and I wonder why not.

Malcolm Chisholm: The other point to make is that, as Andy Kerr pointed out in his statement, we still have some announcements to make in relation to these issues. Tom McCabe will make one tomorrow about digital hearing aids. A related point is that there are existing budgets for many of the matters to which you refer, so the issue may be how we will supplement them. Indeed, that is what Tom McCabe will say something about tomorrow in relation to digital hearing aids.

In addition, some of the work is still being done. We have made commitments on eye and dental checks. The parliamentary session is four years, so some of the expenditure will be in the fourth year and will not be reflected anyway in today's budget. Work on the precise phasing is still being done; therefore, so too is work on the precise spending that will follow. The same applies to personal health plans, which are a new idea. We are doing the scoping work on that at the moment.

In due course, we will be announcing specific allocations for some of those things, but many of the issues do not involve massive sums of money in themselves. The big commitments on waiting and so on are massive financial commitments that are embedded in the mainstream budgets of boards. Part of the information is available, and more announcements will be made on some of the specific commitments to which reference has been made.

Mike Rumbles: I raise the issue because it would be in everyone's interest to have transparency. In fact, it is in the interest of the Executive to say, "These are our commitments, this is our funding and this is what we are doing." The Executive should be more open and transparent.

Malcolm Chisholm: Okay. Further announcements will be made, but perhaps we need to produce a specific response to your point when all the announcements have been made, so that it is transparent. However, I add the caveat that it is quite difficult to disaggregate specific budgets. I would be interested to see the figures to which you referred, but it is difficult to have a specific budget for some of the commitments. I will stick with my example of waiting.

Mr Davidson: I return to the aims and objectives of the health and community care draft budget. Two or three questions leap out of that. Target 10 in the draft budget is to

"Bring 12,000 nurses and midwives into the NHS by 2007."

How many are currently in training, bearing in mind the fact that that is less than four years away?

Malcolm Chisholm: New people are coming into the NHS through training, but an important issue now is returners. We have made great progress with our return-to-practice programmes over the past year in particular. Several hundred people are coming back through that route. The aggregation of the new people and the returners makes up the figure of 3,000. This year, we are significantly increasing the numbers who are starting to train as nurses, by an extra 525. Improvements are showing up in the numbers in initial training and in retention work, with its big agendas of continuing professional development and return to practice.

Notwithstanding some of the issues to do with nurse numbers that were raised last week, the reality is that over the past two years there has been a very significant increase in the number of qualified nurses in the work force. As I said in response to Shona Robison's question at question time two or three weeks ago, data from the latest six-month period showed that the work force contained more than 900 extra qualified nurses and midwives. I do not remember any previous six-month period in which that has happened.

However, although improvements are beginning to show, I accept that there is still a long way to go. All I am saying is that the figure of 3,000 is a combination of the new people who are coming through and those who have rejoined. We are boosting training sufficiently, and I am confident that we will exceed that figure. Indeed, the question for me is not whether we can achieve that 3,000 target, but by how far we can exceed it.

Mr Davidson: So we are talking about £112 million or thereabouts for nurse training, an element of which is obviously taken up with college or university fees, support and so on. Is there a separate figure in the budget for attracting people back to the profession?

Malcolm Chisholm: The difference in that case is that nurse education and training are paid for through the Health Department.

Mr Davidson: I understand that, but does the budget contain a separate figure for attracting returners into the profession and giving them CPD?

Malcolm Chisholm: The return-to-practice initiative is part of the "Facing the Future" budget, which amounts to £5 million and forms part of one of the longer budget lines. Perhaps Peter Collings or Trevor Jones will be able to tell me which line it is. We were asked to give level 3 lines in this budget document; obviously, level 4 lines would give greater detail and would include some recruitment and retention work in nursing. Is it included in the "nurse education and training" line?

Dr Collings: Yes.

Mr Davidson: Thank you.

You say that an unmet need for free personal care assessment will be fulfilled. The figure in the budget for community care is just £55.19 million over the next three years. Nothing has changed over that time. What money will flow in to uplift the amount that will be spent in the department?

Malcolm Chisholm: This is a source of continuing difficulty because the vast bulk of community care money is not contained in the health chapter of the budget. Instead, it is buried in the local government figures, which are sometimes even more difficult to disentangle than the health figures. As a result, the community care spending in the health chapter is a marginal part of the overall community care budget. Certainly, the personal care money will go through—

Mr Davidson: That is why I recommended in 1999 that the two budgets be merged. It would have allowed us to find out what was going on.

Malcolm Chisholm: That is a policy point for which you would have to advance other arguments. However, I acknowledge that there is a debate to be had on that matter.

Mr Davidson: Some figures have not yet been announced for certain items right across the budget. The small amount of EYF money that has been allocated to health boards is not included in the budget. You are not saying that there will be huge amounts of new money, but there still seems to be very little movement in a number of areas in the printed draft budget, with increases that are less than the rate of inflation. Are you intending to postpone some of the activities set out in your action plan until another year and then make announcements in perhaps a year's time or will you dip into the substantial new reserve money? Perhaps Dr Collings is better placed to answer that question.

Malcolm Chisholm: Obviously the situation varies from line to line. You can ask about any particular budget line you want, but you should bear it in mind that, just because the budget is increasing, it does not necessarily follow that every line has to increase by the same amount or, indeed, increase at all. Part of setting priorities is to ensure that the correct lines are increasing. That said, if lines have already been substantially increased, the key might be to keep them at a particular level. That was the significance of the announcement that I made in the cancer debate. We have already given funding a big boost; the important thing now is to ensure that the money remains ring fenced and spent on cancer services. As I said, the situation differs from line to line.

Mr Davidson: I want to clarify this point for the *Official Report*, because we will obviously want to go back and look at what has been said. You said just now that you saw no need for a line to increase, even though a new priority had been set. Does that mean that priorities within an existing budget stream have been readjusted?

Malcolm Chisholm: My point was that I do not see why every single line should increase by the same amount or by any amount. It might be quite reasonable that some lines are the same. If we want to target the increase into a particular area—

Mr Davidson: I do not argue with that principle.

Malcolm Chisholm: The delayed discharge line has increased by £10 million this year, which is

necessary. Today's figures are very disappointing. The extra £10 million that is going in will help, although there are other issues that we need to address. Delayed discharge is one line that is increasing, but we cannot increase every line.

Mr Davidson: I do not dispute what you are saying. From an accountancy or management point of view, it is wise to make such statements, as they do not raise expectations. I understand from what you are conveying to the committee that, although you have new priorities, there might not be new money to back them and hard choices will therefore have to be made. I think that that is your message.

Malcolm Chisholm: Hard choices always have to be made in every budget, and certainly in the health budget. I have been saying that in relation to hepatitis C over the past few days.

The Convener: That was a political answer. I have a question about pages 72 and 73 of the draft budget. The heading "Closing the opportunity gap" appears on page 72 and, opposite it, on page 73, there is the heading "Equality". I note that £49 million is to go to vulnerable groups. That is less than 0.5 per cent of the health budget. Nevertheless, it is there. Helpfully, the paragraphs under the "Equality" heading specify funding. There is a difference between that and the text that comes under the "Closing the opportunity gap" heading. Could you provide us with more specification in this area in next year's budget documents? For example, the document mentions

"reducing the proportion of women who smoke during pregnancy and increasing the proportion of mothers breast-feeding".

It goes on to say things about young people and others. Could some kind of detail be included there? The aims are all very laudable, but I wonder whether some figures could be attached, as has been done for the equality agenda on the following page? There is some overlap between closing the opportunity gap and equalities, but the two do not overlap completely.

Malcolm Chisholm: There are two issues there, relating to outputs and inputs. Some of the output issues will be dealt with under the information on the performance assessment framework. On inputs, we can look into what you suggest. Some of the health improvement money is obviously targeted towards closing the opportunity gap, so I accept the point that it would improve that section of the document if we had some figures there.

The Convener: That would be very helpful. That was a tiny hit, so we will move on.

Shona Robison: We welcome the NHS Quality Improvement Scotland initiative, which aims to bring an end to postcode prescribing. The question is whether that will be enough. I am sure that there are examples of areas where there is still postcode prescribing, despite the input of the Health Technology Board for Scotland and the Scottish medicines consortium.

What evidence is there that the implementation of advice from those groups is making a difference? Could you make that evidence available to us? Do you agree that there is still an argument for decisions to be mandatory? Is there not also an argument that more tracking of resources—as well as decision making—should be undertaken by the bodies that I mentioned? It strikes me that a problem arises if finances are not available to implement the decisions. That is where local decisions, and therefore access to treatment, will differ. What are you doing about that?

Malcolm Chisholm: A lot of work is going on in that area, but I repeat that, even with the existing situation, which is not ideal, the amount of the increase in funding for NHS boards that is going into prescribing is more than 1.5 per cent. If predictions are right, that is set to rise as new drugs come on stream. The rising costs of the drug budget form a significant element as regards health finances and the difficult choices to be made.

However, we are certainly not shying away from the issue of postcode prescribing on the ground that dealing with it has some costs attached to it. We make clear in the partnership agreement that we will deal with the issue. It refers to

"ensuring drugs approved by NHS QIS are made available in each health board area."

That is already policy. There is an important further strand to that, which we talked about quite a lot at the meeting of NHS board chairs yesterday. In addition to the approval given by NHS Quality Improvement Scotland, which replicates the work done by the National Institute for Clinical Excellence in England and deals with drugs once they have been around for a couple of years or so, new drugs are considered by the Scottish medicines consortium. We certainly want to make further progress on that matter because we know that area drug and therapeutics committees in different board areas still make their own decisions in many cases. That is a new frontier, as it were. We discussed that yesterday and want to make quick progress in ensuring that the decisions of the SMC, as well as the recommendations of QIS, apply throughout Scotland.

15:45

We have made some progress on the issue of postcode prescribing, but we want to make further progress. It is unfair that drugs are available in one

part of Scotland and not in another. We are actively involved in improving the situation, but we must obviously remember that costs are attached to doing that.

I do not know whether Shona Robison is suggesting that specific money should be allocated for new drugs. That is obviously a more difficult issue, which relates to the question of what is and is not ring fenced. We must accept that drug budgets are a massive issue for boards to manage. They will have to fund certain new drugs that are approved by the bodies that we have set up to do that. Boards should also address other aspects of the debate about drugs. It may well be that they should be considering drugs that should not be prescribed any more as they are not thought to be as effective as others.

I know that Trevor Jones answered questions about managing the drugs budget at the Audit Committee this morning. I do not know whether he wants to reflect on that.

Mr Jones: The important issue is how we develop the Scottish medicines consortium. Should its recommendations be compulsory and mandatory throughout Scotland? How do we ensure that the SMC is linked effectively into the management of NHS boards? The membership of the SMC includes a chief executive and a finance director. How do we get a common implementation plan to introduce new drugs throughout Scotland, so that there is no inequality and access to drugs does not depend on where people live?

As the minister said, we had a very good discussion with NHS board chairs yesterday. I will take the matter forward with the SMC and with the area drug and therapeutics committee in each NHS board.

Shona Robison: Will that culminate in data being available to the committee showing whether there is a fair and consistent implementation of advice throughout Scotland?

Mr Jones: I guess that if we move in the direction that I am suggesting in relation to the SMC, such information may be available to the committee in the consortium's reviews of new drugs and how those drugs should be introduced throughout Scotland.

Shona Robison: It is a matter not only of how they should be introduced but of whether they are introduced. The committee would like to have that information. When will it be available?

Mr Jones: We will have to think about how to do that.

Shona Robison: Yes, but will you make a commitment to go away and come back to us on the matter?

Mr Jones: Yes.

Mike Rumbles: The partnership agreement states:

"We will end postcode prescribing by ensuring drugs approved by NHS QIS are made available in each health board area."

The partnership agreement is unequivocal and the Government's commitment is clear. Correct me if I am wrong, but does that not mean that no NHS board will be able to say to its GPs, "You may not prescribe this drug even if it is on the approved list"? That is what we mean by postcode prescribing. If the drug is on the approved list, the decision must come down to clinical judgment. That is how I understand the commitment.

Malcolm Chisholm: We cannot interfere with clinical judgment. However, it would not be allowable for the prescription of such a drug to be explicitly forbidden and if it were not prescribed at all, people might ask questions. We have to watch that we do not interfere with clinical judgment, but there is no reason why the drug should not be prescribed at all in a board area.

The point that I am making is that we are building on and perhaps even going further than the partnership commitment, as we are now saying that we want the Scottish medicines consortium to be brought in as well as NHS Quality Improvement Scotland.

Mr Davidson: I do not think that Mr Jones will be terribly surprised at what I am going to ask. In the Health Department's review of the costs on the drugs budget, not only inflation but prescribing trends are taken into account. I presume that the department will also consider the cluster occurrence of different conditions that require expensive interventions. How will that be built into the Arbuthnott formula? It has nothing to do with the formula as it exists. An area such as Grampian could have a large number of people requiring three or four very expensive treatments, whereas—for the sake of argument—Forth Valley NHS Board might not face the same costs. Nevertheless, the Arbuthnott formula is being used to distribute the money within the drug budget. Is there going to be some clear agreement?

I presume that the department is working to show that the benefits and savings from the use of new drugs in the acute sector—as opposed to the primary care sector—help to balance the books on a cross-subsidy basis. As the minister said earlier, it is difficult to talk about the care budget because it comes out through local government as well as through the Health Department. This is another of those situations in which there is a mix of acute and primary services.

Mr Jones: You will recall that our policy is to take away the barriers between primary and

secondary care. By 1 April next year, the whole of Scotland will operate a single NHS system, without the barriers between acute trusts and primary care trusts. We will expect NHS boards to manage the total funding that they receive and not to have the pressure that currently exists between the separate statutory bodies. That policy, again, takes us into thinking about the total patient experience and thinking much more about how an individual patient travels from primary care through the secondary care sector back into primary care and perhaps into social work care—that is the concept of managed clinical networks. The distinction between the acute and primary care sectors is becoming less and less important.

We do not have a proposal to refine the Arbuthnott formula to pick up the drug costs of specific clinical conditions. I am not sure that that level of sophistication is necessary in a resource allocation formula.

Mr Davidson: Does that mean that there could be an increasing role for managed clinical networks?

Mr Jones: Yes.

Mr Davidson: Many of them will represent more than one NHS board area. Will that be a way of managing the budget?

Mr Jones: The budget will be managed at an NHS board area level, but for services with a strong tertiary element—a strong specialist element—we expect boards to come together in regional groupings to address the way in which services should develop. We expect there to be a funding mechanism between the boards comprising the regions, which will allow us to provide sensible funding for specialist services. Part of our development is, therefore, the development of regional planning.

Mr Davidson: When will your papers on how you are going to manage the problem be published or announced? You are doing some work on it, as you said in your answer.

Mr Jones: A draft version of the regional planning proposals, which the NHS board chief executives have developed, are currently being finalised and will come to us formally probably within a month.

Janis Hughes: I would like to move on to the subject of waiting times and the progress that is being made on them.

The budget document details the targets and the progress that is being made towards reducing waiting times. I want to ask specifically about cancer care. The target that is to be achieved by 2005 is welcome. However, the baseline measure column on page 82 states that no data are available and the progress column states that data will not be available until the quarter ending December 2005. How will you know whether you are on course to meet the target that you have specified in the budget document? If you do not have measurable evidence of whether you are on target to meet that target by 2005, we will not know until 2006 whether that target has been met. Is that satisfactory?

Malcolm Chisholm: There are several gaps in the waiting times data, but we are taking action to address those. Out-patient waiting is a good example of where the data have been totally inadequate in the past; the same applies to cancer care, which you are describing. We can track progress because we can get information about the different stages and about delays but, in the past, that information was not recorded officially by the information and statistics division as we would wish it to have been. Perhaps Trevor Jones will have more to say about that, but we are generally aware that we have to work to get more comprehensive, official, published data than have been available in the past.

Mr Jones: That is right. We have to work directly with NHS boards to identify how performance in cancer treatment is changing. If there is no routine data collection system in place, we work directly with NHS boards and identify how the service is developing.

Janis Hughes: I am really asking how you know that the target is achievable if the current audits are prospective and will not be evaluated until 2005. You have set a target that

"the maximum wait from urgent referral to treatment for all cancer cases is no more than 2 months by 2005."

If you do not know what the current situation is, how do you know that that target is achievable?

Malcolm Chisholm: There has been a lot of clinical involvement in the setting of that target, which is the same for the UK as it is for Scotland. The general view of clinicians is that the target is reasonable and achievable. However, I accept what you are saying about the current problem with data to back up that target.

Janis Hughes: The link between the targets and the budget plans is such that you are setting objectives and aiming for targets and the draft budget is giving us an idea of what progress has been made. How much of the 2004-05 budget will be spent on delivering the waiting times targets?

Malcolm Chisholm: I will let Trevor Jones attempt to answer that because, as I said, it is quite difficult to disaggregate the budget for waiting times. The figures are locked up in the big staffing budgets for particular trusts and out-patient care is locked up in primary care budgets. A lot of the redesign work being done on out-

patient waiting times is about things being done differently with primary care. Money for waiting times targets is all over the place—in the primary care budgets, in the trust budgets and certainly in the staffing budgets. That is my general preamble; Trevor Jones might be able to say whether the figures can be disaggregated. Certain streams of money are supporting the budgets to deal with waiting times; and the money going into the Golden Jubilee national hospital is an example of that.

Mr Jones: We cannot identify how much of the NHS budget is spent on addressing waiting times. For example, how many NHS beds in one hospital should be classed as waiting time beds? It varies depending upon the number of emergency cases that are coming into the hospital and the number of planned cases being addressed. We can obviously describe some of the direct costs, such as surgical services, but we cannot put a number on the cost of addressing a waiting time target.

Janis Hughes: I understand that it is difficult, but do you know for certain that addressing waiting times is the best use of what is a fair amount of resources, as opposed to using them in health education projects, such as encouraging people to give up smoking so that they do not have to be admitted in the first place? How can you evaluate whether the money that is being put into waiting time initiatives is the best use of resources?

Malcolm Chisholm: Obviously a judgment has to be made. I always say that waiting times is not the only issue that patients are interested in and then I proceed to talk about the wider quality agenda. However, no one in this room will question the fact that patients are also interested in waiting times.

I know that some people might take a different view and say that we should not set waiting time targets at all. However, within the wider quality agenda, we should set a standard that we expect to be met for all patients and that is what a maximum waiting time is. That is certainly not the only objective or the only subject in which patients are interested, but all MSPs will know from their mailbags that waiting is a big issue, so it is reasonable, even in our framework of having fewer targets, to have certain targets for waiting that all patients should expect us to meet.

16:00

Janis Hughes: In response to questions, you have talked a bit about nurse training, but I am particularly interested in the budget line called "Education & training other". We welcome the increase in the budget to address skill shortages, but one of my concerns is that the £6.14 million in the 2003-04 budget is more or less at a standstill in the budget for the following two years. Your letter responding to our questions from last week talks about how the budget for a number of allied health professionals comes from the Scottish Higher Education Funding Council, which might be part of the explanation.

We are increasing the nurse education and training budget, but we are not increasing the budget for other training. I appreciate that the bulk of finance for training allied health professionals comes from another section that is outwith the health budget, but you are talking about continuing in-service training. Why is that budget at a standstill for the next three years? If we are encouraging more people into those professions, I presume that we will have to provide more money for in-service training.

Malcolm Chisholm: We must watch the different budget lines, because over and above the two that you mentioned is the massive budget line for NHS Education for Scotland, which will increase to £225 million next year. That is highly relevant to our discussion. Much of that will go into the medical work force, but it is not exclusively for that work force.

You are right that the distinction between nurse funding and the funding of allied health professionals means that most of the money that is spent on training allied health professionals is in other budgets. Recruitment and retention initiatives for allied health professionals have received an increase, which will be included in those lines, but that increase will show up in the first year and be carried forward in the next two years.

I take your point, but we are confident that we can attain the partnership agreement commitment to an extra 1,500 allied health professionals. We are confident that we can do that within the budgets that have been set.

Janis Hughes: That is where my concern lies. Your letter says:

"The 'Education and training other' line includes funding for implementing the commitment in 'partnership for care' to learning development and careers within NHSScotland"

and

"funding for the continuation training for allied health professionals".

If we are to recruit that number of new allied health professionals, my concern is that we will not have the money to continue to train them when they are in post.

Malcolm Chisholm: I am taking over the chair of the group that examines recruitment and retention of allied health professionals. That group's first meeting since the election will take

place on Monday 20 October. I have chaired the nursing group for the past two years, so I have been more closely involved in nursing recruitment and retention issues.

I will examine closely the issues that relate to allied health professionals. If more requires to be done on the recruitment and retention of allied health professionals—we are not necessarily talking about large sums of money—I would be prepared to consider that, if I thought that you had drawn attention to particular problems. At the moment, the resources will be in those lines.

Mr Davidson: The cross-party group on mental health wrote to the committee to ask about the cost of implementing the Mental Health (Care and Treatment) (Scotland) Act 2003. We agreed that the issue would be part of our budget discussions, but we need the minister to play his role because we need some information from him.

On page 85 of the budget document, allowance is made for £4.75 million in 2004-05 for the costs of implementing the Mental Health (Care and Treatment) (Scotland) Act 2003. The minister will recall that the Finance Committee rejected the financial memorandum for the then Mental Health (Scotland) Bill as inadequate on the basis of the evidence that the committee took at that time. Does the minister think that the figure given is the actual cost of implementing the act? If not, will the rest of the money come from other budgets or agencies that we do not yet know about?

Malcolm Chisholm: As you will remember from the financial memorandum, some of the mental health money flows through local authority budgets. The £4.75 million is not the sum total, but the Health Department share.

The issue is also connected with the question that Mike Rumbles asked earlier. In addition to a general commitment to mental health provision, the partnership agreement flags up particular innovative approaches to addressing crisis episodes, such as 24-hour support services. That will be highly relevant to the implementation of the mental health act. We will certainly make an additional allocation to mental health provision from the money that was announced by Andy Kerr two weeks ago, but we must do further work on exactly how we want that money to be spent and on what services it should provide.

What I am saying is that that mental health line will be supplemented by the large amounts of money within other budgets that is spent on mental health. Although that started from a low base, all the indications are that boards have made significant increases in mental health spend over the past two or three years. In addition to those, there is the mental health money within local authority budgets and the additional money for partnership agreement commitments that is still to be announced.

Mr Davidson: Is that £4.75 million in the Health Department budget sufficient to meet what was laid out in the mental health act?

Malcolm Chisholm: Obviously, the line reflects what was laid out in that act, but it will be supplemented in the ways that I have indicated.

Mr Davidson: Will any work be done on modifying the mental illness specific grant, which seems to have been frozen for the next three years?

Malcolm Chisholm: I certainly unlocked that. I was concerned about the grant a year ago and provided for a 5 per cent increase, which is now being carried forward at the new level. As happened before, when the grant ran at one level for several years and was then increased, it is now running at the new level. I am pleased that we provided the increase after the grant had been frozen for so long, but we have announced just the one increase up till now.

Mr Davidson: Is there no intention to inflation-proof the grant?

Malcolm Chisholm: That is not the way in which that grant has tended to operate, but we will take that into account as part of the mental health picture. The other issue that is relevant to this is the report that Dr Sandra Grant is to publish on the current state of mental health services, in particular in relation to the Mental Health (Care and Treatment) (Scotland) Act 2003. We will obviously want to read carefully the advice in her report.

Mr Davidson: Has the shortage of community psychiatric and psychological support staff that exists out there been addressed within the training budget lines, because we do not see it in the budget increase lines that you have talked about?

Malcolm Chisholm: I have already flagged up the NHS Education for Scotland budget. A budget of £4,115,000 is provided for psychology in the disaggregated budget of NHS Education for Scotland, so that is a factor. Work is being done to increase the number of clinical psychologists as part of the much wider mental health work force picture. The mental health work force will be the first pilot for a key part of our new work force strategy, which will take an integrated and team-based approach to the development of the work force. A big piece of work is being done on that. We are conscious of the need to develop the mental health work force but, as I said, some of that money is supported by other budgets.

Mr Davidson: That is within the existing budget. We are not talking about training here; we are talking about employment out in the community.

Malcolm Chisholm: Obviously, employment will be within the budgets of boards and trusts.

Shona Robison: I assume that Sandra Grant's report will have budget implications. Is that the additional allocation to which you referred, or will you provide an additional, additional allocation?

Malcolm Chisholm: We want to allocate some extra money to mental health but, as you will see from the tables, there is not an enormous amount of unallocated money lying around. There is some, because it would be foolish to have none—you know how many extra demands arise even within one year. It is sensible to have a certain amount unallocated, but it is not an enormous sum. Mental health is one obvious area in which we have to judge how much extra money we want to put in, by taking account of the partnership agreement commitment and Sandra Grant's report.

Shona Robison: Expectations have been raised that there will be a response to Sandra Grant's report, which looks at unmet need, resource gaps and all of that. Why produce the report in the first place, if there is no intention of meeting unmet need? If insufficient resources are being allocated at the moment—and you indicate that that might be the case—how do you intend to meet the unmet need that is referred to in Sandra Grant's report?

Malcolm Chisholm: Let us wait and see what the report says. I have already indicated that we need to consider some extra money for mental health, although it may well be—we do not know yet—that Sandra Grant's report will raise issues about how the existing considerable resources for mental health are spent. There is a long-running issue about the balance between the amount that is spent in the community and the amount that is spent in psychiatric hospitals. Let us wait and see what her report says. We will certainly respond to it.

That illustrates one of the issues around health budgets. Yes, we have to keep some unallocated money but, equally, if I kept too much money unallocated I would be criticised today. We have to strike a balance.

The Convener: I and other members have asked you what evidence you have on outcomes to show that money has been wisely applied. I am looking at table 5.05 and the money for research in 2004, which is just under £15 million. As I understand it, the chief scientist office, which receives that money, is the main source of research grants in health in Scotland. Your budget is £7.8 billion, and the amount of money that is going into the chief scientist office to do research—which I hope will provide the evidence base that we are all looking for—is 0.2 per cent of the entire budget. Is that enough?

Malcolm Chisholm: Again, the issue is the way in which these things are presented. The figure in the table is slightly misleading, because it represents about a third of the budget of the chief scientist office. I do not have the precise figure in my head, but something like £33 million goes to trusts to support the research that is done in a clinical context. I know that the overall budget of the chief scientist office is £45 million-plus. I do not have the exact figure in my head.

The budget line that you describe refers to specific project funding over and above that. Supporting research within the health service is the biggest part of the chief scientist's budget. I agree that that is another example of how some of the budget lines are not ideal in explaining the whole situation.

The £15 million is funding for specific projects, for which people bid. The process of deciding on those bids has been improved over the past year and—connecting with the wider theme of public involvement—there is now a public panel that feeds into the process of deciding how the money for research is allocated.

Dr Collings: At the top of page 76 of the draft budget there is a line for research support, which shows other parts of the budget.

Malcolm Chisholm: So the two figures should be added together to get the overall budget.

The Convener: I am not being difficult, minister, but my point is that if we have evidence it will assist you. That seems to be a pauchle to spend on research.

Malcolm Chisholm: I understand entirely the point that you make. There are many lines within the budget on which I would like to spend more money. I know that people think I go on a bit about this, and that I am hard-hearted because I am not spending more money on research and hepatitis C and cancer but, at the end of the day, we are spending significantly more money on all those three areas than we were last year or the year before. We just have to make some choices because, if I come here and announce a major expansion of the research budget, you will immediately ask me from which area of patient care I have taken the money. I cannot disagree with you, but I cannot agree with you either, because we have to make those hard choices.

The Convener: In my view, more money spent on research, analysis and evidence might mean that we spend money better than we do at the moment. I appreciate the complexities, but we may be penny-pinching in the wrong place.

Malcolm Chisholm: I do not disagree with you. One thing that I have done since becoming Minister for Health and Community Care is

increase the research budget, for exactly the reasons you gave. I gave extra money to the chief scientist office, I increased the money for clinical trials in cancer, and we provided the money to ensure that Scotland has the opportunity to join the national translational cancer research network, which we hope to announce soon. We are aware of the issues and we are increasing the research budgets but, at the end of the day, I cannot increase them as much as I want to, because I would then have to make a dreadful decision about which area of care to take funding from.

The Convener: I appreciate that, minister.

Thank you for your time. It was a marathon session, because we have only one opportunity to question you.

We move into private session, as we agreed earlier. I ask members of the public and the press to leave the room.

16:16

Meeting continued in private until 16:20.

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