HEALTH COMMITTEE

Tuesday 27 April 2004
(*Afternoon*)

Session 2

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CONTENTS

Tuesday 27 April 2004

HEALTH COMMITTEE
11th Meeting 2004, 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)

COMMITTEE SUBSTITUTES

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

*attended

THE FOLLOWING ALSO ATTENDED:

Alex Fergusson (Galloway and Upper Nithsdale) (Con)
Pauline McNeill (Glasgow Kelvin) (Lab)
Mr Mark Ruskell (Mid Scotland and Fife) (Green)
Mr Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)
Ms Sandra White (Glasgow) (SNP)

THE FOLLOWING GAVE EVIDENCE:

Catherine Clark (Scottish Executive Health Department)
Peter Collings (Scottish Executive Health Department)
David Palmer (Scottish Executive Health Department)
Adam Rennie (Scottish Executive Health Department)
Julie Wilson (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 2

Scottish Parliament

Health Committee

Tuesday 27 April 2004

(*Afternoon*)

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

Subordinate Legislation

Regulation of Care (Fees) (Scotland) Order 2004 (SSI 2004/93)

The Convener (Christine Grahame): I open the 11th meeting this year of the Health Committee and ask everyone to ensure that all mobile phones and pagers are switched off.

Item 1 on the agenda is subordinate legislation. We will consider the Regulation of Care (Fees) (Scotland) Order 2004 (SSI 2004/93). I draw members' attention to paper HC/S2/04/11/1. The minister has responded to the committee and Catherine Clark and Adam Rennie, from the Executive, are present to answer any further points of clarification that members may wish to raise. I remind members that nothing more can formally be done with the order, because the time for a motion to annul the instrument to be lodged and considered by the committee has elapsed. However, I invite members to comment on the minister's letter.

Shona Robison (Dundee East) (SNP): The minister says:

"It is for providers to decide how to fund fee increases, through securing efficiency savings, by seeking additional funding from any commissioner of the service, or by passing them on to users."

My concern relates to the very small organisations that will struggle with the fee increases. The three options that the minister has outlined are not realistic for small organisations.

On the first option—"securing efficiency savings"—we know that small organisations, especially the small voluntary organisations, have probably already secured efficiency savings time and again. On the second option—

"seeking additional funding from any commissioner of the service"—

given the fact that the commissioner is, quite often, a local authority, to suggest that the cost should be passed on to local authorities, which are already fairly strapped for cash, is unrealistic. On the third option—

"passing them on to users"—

I would be concerned about that as a solution.

In addition, I have two specific questions. First, in the fourth paragraph of his letter, the minister says:

"I am aware that some small providers claim they will have to close down, but there is no hard evidence to suggest that this is happening, even among services already at full cost fees."

I would be interested to know how the minister has sought evidence on that. Community Care Providers Scotland has provided me with evidence that suggests that some of its members are having difficulties and are expecting to have greater difficulties once the Scottish Commission for the Regulation of Care has to become self-financing.

Secondly, the minister says:

"We will continue to keep a close eye on the impact of fees".

I would like to get an idea of how the minister intends to do that, especially for some of the smaller organisations. Will he set up direct communication between the Health Department and those organisations? How does he intend to pick up at an early stage the hard evidence that is emerging?

Adam Rennie (Scottish Executive Health Department): There are quite a few points there, focusing heavily on the problems for small organisations. I will say two general things about that issue. The Executive conducted a full consultation on the proposals, which implement the policy on full cost recovery that was set out and debated fully when the Regulation of Care (Scotland) Bill was considered in the first parliamentary session. The fee structure contains specific provisions for small providers. For instance, it allows the aggregation of part-time workers, so that they do not all get counted individually, and the discounting of volunteers in recognition of the particular circumstances of small organisations.

You ask why the minister says that there is no hard evidence of closures arising from the impact of fees. The answer is simply that, as the letter says, the Executive does not have that hard evidence. We are not aware of large numbers or even significant small numbers of closures. I should also make the general point that fees are one of the costs that providers of care services bear. All sorts of things can impact on the costs of providing a care service and fees are one of them.

What plans do we have to keep an eye on the position? We have fairly regular contact with members of Community Care Providers Scotland, which you mentioned, and they are quick to tell us about any problems that are coming along.

However, I should draw a distinction between organisations' saying that something will be a problem and that problem actually materialising.

You also asked how we will

"keep a close eye on the impact of fees".

Each year, we will need to do a full consultation exercise, with a regulatory impact assessment, on any proposals on fees. We will be coming forward with proposals for fees in 2005-06 and 2006-07. For each of those years, we will be pulling together information about the predicted impact. We might be in a position to mount some kind of research exercise so as to get a handle on that, but it is early days as far as that is concerned.

Mr David Davidson (North East Scotland) (Con): The last sentence of the third-last paragraph of the minister's letter mentions a possible structure

"where a provider is providing more than one type of service and where there are potential savings in some of the administrative functions."

Perhaps you could provide us with details of how that translates into charges.

Much depends on the rate of the care commission's activity. Some of the evidence from providers—I am not suggesting that this applies to providers of any particular size—indicates that they feel almost as though there are too many inspections, that inspections rapidly follow on from one another, that nothing changes, that the boxes are ticked and that the providers still get the bill. Will there be a review of levels of activity? The committee obviously wants the care commission to take proper care and attention and to use due diligence. Is anything to be done on that? There seems to be an open-ended commitment simply to reclaim through fees any costs that the commission comes up with.

Adam Rennie: That raises two distinct points. The first is to do with combined charges. The commission has introduced a combined charge for initial registration for housing support services and care-at-home services, which commenced only in December last year. I do not have the numbers to hand, but I will explain the way in which the system works. The commission treats the combined service as though it were one service. It adds up all the staff in the combined service and applies the appropriate category of fee. For instance, it would be possible for a relatively small housing support service and a relatively small care-at-home service to be added together and be counted as one, still relatively small, service, which would save an entire registration fee for one of those small services. Putting together those services might bring them into the medium-sized service category, but that would still represent a saving on their being counted as two separate services.

The commission is considering how that general philosophy might be applied to the annual continuation fees for services in that position. Priority was given to dealing with registration, because that was an immediate issue for care-at-home services following commencement of the scheme at the end of last year. The commission will be thinking more widely about other service areas in which that approach might be applied but, for the moment, the biggy, as it were, is combined housing support and care-at-home services. That is where the shoe could pinch most.

The second question concerned the activity rate of the care commission. The commission clearly cannot go round inspecting for inspection's sake. It does not have a blank cheque; it must agree its gross budget with the Scottish Executive every year, so ministers can control the level of the commission's activity.

We and the commission are keen to move towards a more proportionate, risk-based approach to inspection activity, which balances the need to provide a certain level of reassurance with the need to address the risks that are out there and that vary widely from service to service. In particular, we are looking for such an approach to be taken in inspections of child minding and the day care of children. I am aware that there is some concern about that area.

I should point out that the commission is not carrying out exactly the same work as was carried out before; it is inspecting against a new set of national care standards. I am sure that members are familiar with those standards, which were introduced by Scottish ministers and deliberately specify what service standards should be from a user's point of view. If the commission is to inspect against such standards, it needs to spend some time with users. Indeed, having been on a care commission inspection and having heard what other colleagues have said, I know that commission staff on inspections spend time talking to users in a way that perhaps did not happen before. However, such an approach requires commission resources.

The key point is that any approach to inspection has to be proportionate and risk based. The commission seeks to move in that direction wherever possible.

Mr Davidson: If the minister has placed additional burdens on the care commission, has that been followed by any revenue from the Scottish Executive Health Department or will those burdens be funded through the recovery of fees?

Adam Rennie: Are you talking about the national care standards?

Mr Davidson: Yes.

Adam Rennie: When the commission was set up, its budget was scoped to take account of national care standards. In effect, there was some initial pump priming from the Scottish Executive. However, it was made clear during the passage of the Regulation of Care (Scotland) Bill that the intention was always to move to full cost recovery except in cases in which there were explicit public policy reasons for subsidising the fees. For example, the fees for child minding and the day care of children have deliberately been kept low.

Mr Davidson: I presume that that is under review.

Adam Rennie: I am sorry. What do you presume is under review?

Mr Davidson: The changes in cost activity and the balance of the budget.

Adam Rennie: I am sorry, Mr Davidson. I am not sure that I follow the question.

Mr Davidson: Well, you have said that the service is expanding and that some allowance was made when the commission's initial budget was scoped. Will there be a review of whether the scoping was sufficient to fund the activity in question?

Adam Rennie: We are not specifically reviewing that aspect. I do not think that there has been any suggestion that the commission does not have a big enough gross budget; indeed, if anything, the reverse is the case. Now that the commission has been established, there is a considerable need for it to focus on proportionate and risk-based assessment. I hope that such an approach will reduce rather than increase costs.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Every time there is a push in finances, the patient or the person who is being cared for suffers, because it means that there are not enough staff to cover things. That happens regardless of whether we are talking about people in their own homes, in hospital or in nursing homes. Indeed, I heard of a child with special needs who had to stay at home for three months because there was no nurse to cover their trips to the nursery.

Although I welcome the fact that you are examining the receiving end of things, it is clear that cost-effective changes will take time to implement. People who receive care have told me that provision is patchy and I hope that you will take that into consideration in your investigations. Perhaps it might be worth following a patient's journey from the moment at which they start to need care to the moment at which they actually receive it to find out whether the service reaches expectations.

The Convener: I do not know whether that is a question for our witnesses.

Dr Turner: It might not be.

Adam Rennie: I am sure that such a study would be worth while. However, it is outside the immediate scope of the discussion, which is about care commission fees.

The Convener: Nevertheless, the matter has been placed on record.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): There is no hard evidence that some smaller operations would need to close down because of the fees. I am sure that the Executive is in regular contact with the care commission. Has the commission made any representations about the increase in fees causing a significant problem? Does it believe that there will be an impact on the provision of care, to which Jean Turner alluded, in that increased efficiencies might have to be made to meet the increased fees?

14:15

Adam Rennie: I am not aware of any representations from the care commission on those points. It would be fair to say that the commission is not enthusiastic about full cost recovery, because it is concerned about the impact that that policy will have on its relations with the providers that it regulates. The impact will be that the providers will perceive the commission as becoming increasingly expensive, at least until the full cost recovery ceiling is reached. I shall ask my colleague Catherine Clark to comment, but I do not think that we have received any specific representations from the commission on the points that you mentioned.

Catherine Clark (Scottish Executive Health Department): No, we have not.

Mr McNeil: If the problem had been significant, would you have expected representations from the commission?

Adam Rennie: Yes. I would have expected the commission to say to us, "This is going to be the impact."

Mr McNeil: Does the fact that it has not done so put the problem into perspective?

Adam Rennie: Possibly. One hesitates to draw too much comfort from the absence of something but, in so far as one can do so, it is a helpful straw in the wind.

Mr McNeil: Has the care commission raised any concerns about the impact on patient care of the efficiencies that are suggested?

Adam Rennie: The commission is clearly concerned to ensure that it is given sufficient

resources to do its job properly, as are Scottish ministers and the Scottish Executive. Nobody has any interest in imposing on the commission reductions in resources so that it cannot do its job.

Mr McNeil: Given the confident response from the Minister for Health and Community Care, would not it be useful at least to discuss those issues with the care commission? How are we to monitor the situation if we are not having those discussions and are not aware of the commission's view on fees?

Adam Rennie: I did not say that we were not aware of the commission's view on fees; the commission responded to our consultation on fees. However, I am not aware that the commission has said anything to us on the specific points that you were concerned about with regard to the levels of provision.

The Convener: Perhaps that is a matter for the inquiry later in the year, when we shall look at responses to the consultation document. When we carry out our post-legislative scrutiny of the Regulation of Care (Scotland) Act 2001, we will consider who responded and what their responses were.

Kate Maclean (Dundee West) (Lab): It was suggested earlier that the care commission might carry out inspections for inspection's sake. Have there been any formal complaints that that has happened? Some of the anecdotal evidence certainly hints that over-inspection may be being carried out in order to collect enough fees to make the care commission self-financing. What would be the mechanism for a formal complaint and what checks are in place? Presumably the minimum inspection standards are laid down in some kind of regulation, together with the checks for ensuring that the inspection is not excessive. I am not suggesting that there are excessive inspections, but I would like to reassure members of the public.

Adam Rennie: I shall ask Catherine Clark to comment on that in a minute. On your general point, however, I can tell you that the minimum levels of inspection that are required are laid down in the Regulation of Care (Scotland) Act 2001, with the minimum being one inspection per year for services except for those providing overnight accommodation, where there must be two inspections a year, at least one of which must be unannounced. That is the standard that the care commission is working to.

The commission has no vested interest in going around carrying out gratuitous inspections in order to raise money, because it does not charge every time it turns up. If a service is registered with the commission, it pays an annual continuation fee. That is the same whether it is inspected once or, if the commission has grounds for concern about the levels of provision, 10 times. Where the commission finds something wrong in a service, it will certainly not say, "We've done our annual inspection, so we won't go back until next year." It could go back the next day or the next week, depending on the gravity of the situation. The commission is not engineering inspections in order to generate money; its finances do not work in that way. I ask Catherine Clark to say whether she is aware that we have received any complaints about the care commission's method of inspection.

Catherine Clark: No, I am not aware of any particular complaints. There is a mechanism, which Scottish ministers have approved, for making a complaint about how the commission has carried out its duties.

Kate Maclean: So the accusation from some care providers that the care commission is carrying out extra inspections to make money is unfounded, because it is impossible for the commission to make more money; it costs more money to carry out more inspections.

Adam Rennie: Precisely.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I want to clarify points made in Malcolm Chisholm's letter. He makes it clear that the Regulation of Care (Scotland) Act 2001, which the Parliament voted to pass, provides that self-funding through fees would apply from this financial year. He talks about phasing that in over the next three years and gives an example, on which I want to focus, because I am a little confused. He seems to be saying that if the cost to care homes were passed on to the consumer—let us use the word "consumer" rather than "patient" or anything else—that would be an additional 58p a week to the current £346 charge. Is that what he is saying?

Adam Rennie: The minister is not saying that that would be the case if the cost were passed on to the consumer; he is saying that, however the cost is met, it amounts to 58p extra per week on the current rate, which has been agreed by the Convention of Scottish Local Authorities and the care providers, of £346 a week or £406 a week where there is nursing care. The figures are in the letter to put the cost in context.

Mike Rumbles: We are talking about a tiny percentage.

Adam Rennie: Yes.

Mike Rumbles: Does that apply only to this year? Given that there is such a tiny increase this year, what will happen in the next two years if the policy is phased in? In the example, the percentage increase is tiny.

Adam Rennie: The figures that are set out in the order are intended to get all the services

concerned up to full cost recovery levels by 2006-07 on the basis of steady percentage increases each year. The increase to 2005-06 and then to 2006-07—all other things being equal—would be of the order of 58p to 60p a week. The increases would be the same for another two years.

Mike Rumbles: If my maths is right, we are talking about less than 0.5 per cent over three years.

Adam Rennie: I am sure that your arithmetic is correct. I have not worked out the numbers in quite that way.

Mike Rumbles: So we are debating a tiny figure. Is that right, or am I misinterpreting the figures? Have I missed something? I am at a loss.

Adam Rennie: Having been involved in the discussions with Scottish Care about fees last year, I hesitate to describe any increase as tiny, but we are talking about a relatively small amount.

The Convener: The minister's letter says that there is no hard evidence to suggest that some small providers will have to close. However, there is anecdotal evidence and I know that it was trailed in the press recently that 30-plus small care homes might have to close. In paragraph 24 of the regulatory impact assessment, you say, in relation to unintended consequences, to which I referred last week:

> "It is possible that some small providers may have to close … It was always accepted that this might happen, but that risk must be balanced against the expected benefits of the new regulatory regime for users."

How will you monitor the hard evidence so that the committee can inform itself later whether those unintended consequences have come about? It is obvious that the people in the homes affected have to go somewhere.

Adam Rennie: We have a wealth of information from the annual social work statistics collection and the care commission's registration information. A number of different sources can be used. You are right to point out that the regulatory impact assessment drew attention to the possibility that those things might happen. As the minister's letter says, there is no hard evidence, so we flagged up closure as a possibility. We do not yet know whether providers have had to close, although we have the information sources to tell us what is going on. I add the caveat that there could be all sorts of reasons why services might close.

The Convener: That information should be part of a comprehensive note for the committee to help us when we come to our inquiry. We need to know why some small care homes might close, why they might have closed and whether that is attributable to the fee structure. That would be of interest.

I am afraid that I have not looked at the responses. Did the National Association of Inspection and Registration Officers, which represents the people who carry out the inspections, respond to the consultation document?

Adam Rennie: We issued 11,000 or so consultation papers, including to all providers, and we received 137 responses. I do not know off the top of my head—

The Convener: NAIRO is a professional organisation and it is very important.

Catherine Clark: I think that NAIRO responded, but I cannot honestly remember what was said.

Adam Rennie: Perhaps we can tell the committee clerk and send her a suitable link. Would that be helpful?

The Convener: Yes, thank you. That concludes the evidence session. Thank you for your thorough answers.

Budget Process 2005-06

14:28

The Convener: If you are sitting comfortably, we will begin agenda item 2, which is the budget process. I welcome our panel of witnesses from the Scottish Executive Health Department—Peter Collings, director of performance, management and finance, David Palmer, director of finance and Julie Wilson from analytical services.

Janis Hughes (Glasgow Rutherglen) (Lab): It is hard to believe how quickly budget scrutiny sessions come round; it does not seem that it is a year since we last did a similar exercise. One of the points that I want to make is that in both 2002 and 2003 the Health Committee reviewed the budget and made recommendations. During the years in which I have been on the committee, we have always made recommendations. However, as far as we can tell, the majority of those recommendations have not been acted upon. Indeed, our budget adviser informs us that no more than perhaps two or three of the 17 recommendations have been addressed. For the benefit of the committee, will you explain what processes are in place to consider the recommendations that subject committees make about the spending of the various Executive departments? What processes does the Scottish Executive Health Department have for considering and acting on our recommendations and for feeding back to us the progress that has been made?

14:30

Peter Collings (Scottish Executive Health Department): Within the Parliament's budget process, committee recommendations can operate in one of two ways. Formally, the Health Committee's recommendations on the budget process are recommendations to the Finance Committee for inclusion or otherwise in that committee's overall report on the budget. Following on from that, the Finance Committee's recommendations formally go to the Minister for Finance and Public Services, Andy Kerr, and there is a process in place for responding to them.

As far as I can make out—I was not in the Health Department at the time—there has been some inconsistency in how we have handled committee recommendations in previous years. In 2002, we were asked to give a formal written response to the Health and Community Care Committee and we did so. I think that we received no such request in 2003, so we gave no formal written response then—although we did, of course, consider the recommendations. Whether or not the Health Department makes a formal written response to the committee, the process that we have involves discussing the recommendations with the minister and deciding what to do with them.

At the end of last week, and in advance of the minister's appearance next week, the clerk wrote to the minister to seek information on what had been done about the committee's previous recommendations. We intend to reply to that request this week.

Janis Hughes: I understand what you are saying, but one of our frustrations has been that we have not always received sufficient information to allow us to track specific items of expenditure from the top down and to do our job of scrutinising the department's expenditure. I am trying to express our frustration about having to ask the same questions year after year. When the minister gives evidence next week, I hope that he will be in a position to inform us about the processes that the department is implementing. Is that a reasonable hope?

Peter Collings: We discussed the need for such information in a session that we had a few months ago. Following on from that, and following on from discussions between the convener and officials at Victoria Quay, we have made some amendments to the information that we collect. We will provide the committee with a summary of that information once it is available. We have plans to make further changes. We are trying to respond to the requests for information that the committee has made.

Helen Eadie (Dunfermline East) (Lab): I fully expect the committee to make further recommendations as part of the current stage of the budget process. I cannot expect people to respond to questions to which they do not know the answer, but can we be given a guaranteed timescale within which we will get a response to the issues that we raise in our report? For example, would one month be a reasonable timescale within which to get a response?

Peter Collings: Asking for a response within one month is entirely reasonable, but the degree to which that response will be satisfactory will depend on the questions that are asked and on our ability to answer them. I have no problem with that idea. The only thing that will need to be sorted out with the clerks is which responses should come directly to us and which should be routed via the Finance Committee. Subject to that caveat, of course we will be happy to respond.

The Convener: There appears to be evidence that the Health Department is very poor at responding to requests for information. Do you know of any internal performance monitoring that would allow you to confirm or refute that statement? If there are no performance data,

would you introduce such a system? By when would it be in place? It is about getting information from the Health Department. I am not accusing you personally, just the department.

Peter Collings: We have an internal performance measurement system for parliamentary questions and for ministerial correspondence. Those systems show that on time limits, the Health Department is consistently one of the best, or the best, performer in the Executive. We have not instituted a system for requests for information from the Health Committee. If that is what the committee is asking for, I am happy to take the idea away and see what we can do about it.

The Convener: Many questions on health issues receive the response that the information is not held centrally. What is being done about that? If someone wants some information, they have to track it themselves by writing to health boards and giving them a time at which they want the information to be available. What is happening about drawing in information from the health boards and holding it centrally so that members of the Parliament who ask questions can get national answers?

Peter Collings: During the next 12 months, we plan to do a major review of NHS statistics to see whether we need to update what information we collect to reflect what people need to know about the NHS as it is now. Over the years, systems have evolved and many things have been added on, but there has not been a fundamental rethink. We intend to do that during the next 12 months, so we hope that that will help with the statistical questions that members might have. During that review, we will obviously consider requests for information from Parliament, and our ability to answer those requests.

Julie Wilson (Scottish Executive Health Department): Members raised this issue when we had our informal session with the committee in January. Has the committee had a chance to think about the types of information that it wants us to look into? In some instances, the specific information that is requested by a parliamentary question, for example, might not be available centrally but there might be some information available that would fit with the general idea or the type of question that was seeking the information. The committee's adviser was going to do some further work on the nature of the questions that you want to put to us so that we could see from that how much of the existing data could be used as a proxy, or to give a broader idea, even if we could not give the specific information because it is not held centrally. That might be a quicker way of getting at the information that the committee needs.

The Convener: Apart from the fact that we can take up that issue in our report to the Finance Committee, we will return to it after we have been out on the road with our inquiry. The three groups that are going out will get an idea of the facts that we do not have and the information that we need across Scotland. That information will be mapped out across the NHS boards so that we can see what resources are out there.

Mr Davidson: We are now in the budget process and considering either the movement of money or the allocation of new money that is coming into the system through the comprehensive spending review. From a statistical point of view, I presume that ministers have access to trend analysis data that allows them to perceive whether, for example, there is more asthma than there was or the incidence of diabetes is decreasing. The ministers must have that information. Many parliamentary questions are about changes in trends and trend analysis, and I thought that the information and statistics division and the Health Department ran those figures so that they could brief ministers. Is that not the case?

Peter Collings: Julie Wilson might want to expand on that, but we have comprehensive data on questions about hospital procedures, and those data hold up well compared with other countries. Although we have made many efforts to fill it in, the information that we have about the general health of the population and what is going on in primary care is much more limited.

My impression is that many of the questions that we do not have answers for are in those areas, and although we would like to improve what we get at the hospital end, we do not have massive gaps. Data are coming in on new developments, some of which have been published. For example, the role of nurses has expanded, but we were not catching some of the things that nurses are doing that had previously been done by doctors. Most of the gaps are in general practice and in the general health of the population.

Julie Wilson: That is right. A lot of chronic disease management, for example the management of asthma, takes place in primary care. The information and statistics division of the NHS in Scotland—ISD—recently developed continuous morbidity recording, which examines the conditions that people present with in a nationally representative sample of GP practices. Conditions are coded in a hierarchical structure, like the hospital data set. I do not know if asthma is a good example. You could get some elements around respiratory problems, but not the complete detail of what you were looking for. If you asked for information on asthma, and it was contained within the coding that we have, you would have

been given it in the answer. We are doing work with the ISD to improve the clinical coding data sets. The issue might have been one of the specifics that you were looking at, which is why I thought that it would be more beneficial to the committee to work with you on the issues that you are concerned about, look into them, and see what we can do.

Mr Davidson: Members feel great frustration when they look at rising incidences of different diseases in different health board areas, because we need to know what the trends are before we start to question the level of service and the need for supplementary funding. I know that you heard that in the previous parliamentary session from other committees. Are you tackling that issue?

Julie Wilson: Yes. We are trying to expand the data sets, particularly around primary care and the new ways of service delivery. We are working on, for example, clinical dictionaries to enhance recording. A number of developments are in place to address the issues. There is also the strategic review of what we collect, which Peter Collings mentioned. However, if you want particular issues to be looked into quickly, I would be happy to take them away.

The Convener: It will be useful for the committee if the clerks examine the questions that parliamentarians cannot get answers to and the data that we are unable to track, and put together a paper that we can put to our budget adviser. We could discuss that, and either put it to the minister or discuss it again with the members of the Executive team who are here. We all have examples in our head, but we want to draw them together into a paper. It would be useful for parliamentarians. Is that agreed?

Members *indicated agreement.*

Janis Hughes: When we met the witnesses earlier in the year they gave us an example of one recommendation that we had made, which was to increase the mental illness specific grant. It was useful feedback from this committee that led to that helpful thing being done. What kind of suggestions are helpful in that regard? We can tell you what information we would like to see—I know that we are working on that—but what do you think would be helpful suggestions for us to make?

Peter Collings: I return to the annual evaluation report, for which I cannot take any credit. It is the first AER that I have not been responsible for producing. Are the priorities that we have set the right ones? Do we have the right targets or should we have different ones? Is there scope for efficiency savings that we have not spotted? Are there priorities that we are not addressing? Those sorts of questions are particularly helpful. For example, we found that we were not adequately addressing mental illness.

14:45

Janis Hughes: I am sure that we will find many helpful suggestions in that lot.

Shona Robison: It might be helpful if you can tell us a bit more about the process in the Health Department for pulling together your element of the budget. We particularly want to know what information helps you decide on the allocation of money to different programmes. How do you decide how money will be best spent and how do you allocate the money within the budget?

Peter Collings: A point to bear in mind is that as well as being about how effectively money can be spent in different places, such decisions are fundamentally political. For example, the need to meet commitments that the partnership agreement set out is basic to our planning, because ministers have said that those are priorities. Therefore, we must establish the best way of meeting those commitments. For the rest of it, I should point out—I know that this is frustrating for the committee—that most of the money that we give to the NHS is given as large, general allocations. We do not take decisions centrally on many of the things that you are talking about. We allocate money to health boards and they make decisions that take account of local circumstances.

When particular studies evaluate something new, we sometimes put out ring-fenced money. That is often done on the basis of evidence from the chief medical officer and others. An example of how the NHS spends resources is the Scottish medicines consortium, which is the committee that makes mandatory recommendations about new drugs for the NHS. That is done by analysing the benefits and cost of a new drug compared with existing ones. That is an example of the general approach. However, in practice, much decision making is done at health board level or lower to meet local demands.

Shona Robison: I appreciate all that, but the minister must obviously look to you to provide data to enable him to make decisions. We appreciate that, with limited resources, there is a limit to how flexibly the money can be used, particularly on staffing issues. However, there is obviously some flexibility about priorities. Given the lack of information on outcomes, we have struggled to get a sense of how decisions are made about priorities. For example, if a Health Department target is not on course, would information about that be given or would there be a discussion on whether to allocate more money to help meet the target? Or is it not an issue of resources at all? I am trying to get a feel for the money and the

outcomes and their interrelation. Can you see the money directly impacting on the targets? If so, how do you measure that?

Peter Collings: We can do some of that occasionally when targets are specific ones in which we can directly intervene.

We monitor what is happening on smoking, and one of the interventions is health education through advertising and so on, the effectiveness of which is measured. If we are not meeting the target, the ministers will need to decide whether that is because the present set of interventions is not adequate, and we will provide evidence on how effective those seem to be. Is it that they are being effective but that we need to do more and, therefore, put more resources in? That is the sort of discussion that takes place.

The other targets—for example, waiting targets—are, by and large, for boards to deliver. We have set the standard and have said when they are to reach it by. We have regular conversations with them about how they are doing. They provide us, at individual board level, with a profile of what they expect to happen to waiting targets over the months leading up to, for example, 31 December last year and where they expect performance to be each month. If they are not reaching the standard, we have a conversation with them about what needs to be done to determine whether what is needed is more resources or changes to things. We have that sort of conversation around some of the other targets that boards are responsible for.

Mr McNeil: What we have found out, looking at the budget this time and previously, is that there is very little flexibility in the budget and no debate about the contractual rights of consultants, junior doctors and staff. When the health board meets the person, the only flexibility is those targets that you have just described. It is the targets that drift because there is no contractual right for patients to insist on those targets' being met. As a consequence, are patients not always going to be the losers in that type of debate?

Peter Collings: That seems to be based on the suggestion that the money that is being put into, for example, pay and some of the new contracts, is not being put in for a purpose. It is being put in for a range of purposes, one of which is to facilitate changes to try to improve services to patients. Modernising the terms and conditions of people who are employed in the NHS—changing general practitioner contracts to introduce quality measures into the system—is being done with patients in mind.

Mr McNeil: Can you explain to me, in that case, when patients should expect an outcome that will be to their benefit from the recent consultant contracts and the reduction of junior doctors' hours? What year? 2005? 2006? 2007? When?

Peter Collings: On the consultants contract, the immediate benefit—

The Convener: Mr Collings, I am sorry to interrupt you, but I am having difficulty in hearing you over the noise of a fan. Could you please speak into the microphone?

Peter Collings: My apologies.

Vacancies in some specialties in some parts of the country are hard to fill. If we were not maintaining consultants at levels that are competitive with those in other parts of the United Kingdom and internationally, we would not be successful in filling vacancies. The immediate benefit for patients is that, by keeping consultants' pay in line with that in the rest of the UK, we are competitive in the labour market. The other changes are, I agree, longer term. They are about discussions that are going on now about job planning for consultants and whether changing how they are doing the job—how they use their time—could benefit patients. We will have to see how that goes and whether there are benefits for patients out of that. We are monitoring those benefits to see how long they take to emerge.

Mr McNeil: So, you are telling the committee that we have paid this money out to stand still; that you do not know when patients will get the longer-term benefits; and that consultants who have already been paid for this year have not committed to any changes in their contract.

Peter Collings: Different consultants in different boards are at various places in the job-planning process. The ideal was to have it completed by 31 March but my understanding is that that target has not been met everywhere. In many cases, there is a draft job plan for the consultant but it has not been finally signed off yet.

Mr McNeil: Would it be useful for the committee to get a proper update on the progress that has been made in relation to the consultant contract?

The Convener: Our witnesses are nodding agreement, so that is another one for the out-tray.

Mr Davidson: In response to Shona Robison a few minutes ago, Mr Collings, you talked about the fact that ministers obviously have a pot of money that has been held back to add resource where input might be needed to reach unmet targets. For the sake of clarity, can you tell us exactly how much that pot is?

Peter Collings: At the moment, the Health Department does not have a reserve. Therefore, if we want to move extra resources into one area of health spending, we have to find savings in others. If we find that we have a problem in a particular

area, we have to look around the rest of the budget to see whether we can make savings elsewhere. The process of doing that is one of the reasons why the health budget is tending to come out extremely close to being fully spent. Indeed, at one stage last year, there was a risk of there being an overspend. We reallocate money to meet priorities and to deal with particular problems as they arise.

Mr Davidson: I appreciate that it is days since the end of the financial year and that this is not a good time to ask how much is left in the kitty for end-year flexibility. However, at the beginning of the year, is there a deliberate attempt to set aside a sum of money that you can use during the year to ensure that there does not have to be a reduction in other areas and that resource is available to support target achievement?

Peter Collings: There is. However, because of a range of pressures, we do not have that resource for 2004-05. We are trying to manage the budget at the moment.

Mike Rumbles: On resources and meeting targets, I have a question about waiting time targets, which you mentioned. In answer to David Davidson, you have just confirmed that you are not carrying a reserve to ensure that targets are met. That means that, if the nine month waiting-time target is not met, there is no reserve with which to address the issue.

The minister informs us that nobody is waiting more than nine months for their operation but, on Monday, I received a letter from Grampian NHS Board telling me that one of my constituents will have to wait 15 months for their operation but they do not come under the waiting time target.

I understand that the Executive is saying that, if our constituents have to wait longer than nine months for an operation in their health board area, they will be given the operation elsewhere—in Scotland or even abroad—or privately. Your statistics inform the minister that everybody is achieving the nine-month target, but Grampian NHS Board—I will not name the individual, as that would be invidious—tells me that one of my constituents will have to wait 15 months for their operation because the necessary consultant will not be available until then.

You are telling us that you do not hold a reserve to ensure that the targets are met and the minister is telling us that we do not need to address the issue because everybody is meeting the target, yet I have a letter from Grampian NHS Board saying that the target is not being met. What is going wrong?

15:00

Peter Collings: I have two points to make. First, on waiting, one of the reasons why we met the target was that in the run-up to the end of December, when there were backlogs in particular specialties in certain places, we moved some resources within the Health Department budget to ensure that extra procedures were carried out. That involved only a small amount of the overall budget, but that is the sort of thing that we do when there is an issue with a target.

Secondly, I cannot comment on the specific case, except to say that the nine-month target applies to patients with a guarantee, and there are various categories. For example, if the patient is not fit to have the procedure for some reason, or—

Mike Rumbles: Let us discount that one. Keep going.

Peter Collings: If the patient has been offered—

Mike Rumbles: We can discount that as well. Keep going. What are the other categories?

Peter Collings: I pass over to my expert colleague.

Julie Wilson: If a patient is waiting for a specific consultant, it is possible that they are awaiting highly specialised treatment.

Mike Rumbles: They are.

Julie Wilson: Under those circumstances, the board may have applied an availability status code to that patient, saying that they are awaiting highly specialised treatment.

The Convener: I am sorry, but there is a darned fan whirring away and I am trying to follow what you are saying over the rather extraneous sounds around me.

Julie Wilson: It sounds as if the patient about whom Mike Rumbles is concerned is awaiting highly specialised treatment. In such circumstances, it might be considered preferable for the patient to wait a little longer to have a particular consultant operate on them.

Mike Rumbles: That is certainly not the patient's wish in this case, so that cannot be the reason, can it?

Julie Wilson: I do not know the particulars of the case.

Mike Rumbles: If I may pursue this point, convener—

The Convener: You are making a fair point, Mike. Most of us have in our in-trays cases of people who are being told that there is a waiting time target, which they expect to be obtempered, but who find when they try to put it into practice

that nothing like that is happening in their NHS board. Just about every member here will have something in their in-tray like that, and what Mike Rumbles and I are trying to get at is what the targets are worth. When you say that a waiting time is guaranteed, what is that worth when people on the ground are not getting their treatments? How are those targets reached? Is the matter one of personnel; if the consultants are not there, it simply cannot be done? I think that the question is about what the guarantees are worth.

Mike Rumbles: I have one constructive question to add. Correct me if I am wrong, but I understood that the guarantee of waiting times was there so that a patient would not have to wait more than nine months. The convener said that there must be many such cases, but I know of one person who has been waiting for 15 months. It is not the case that that individual does not want an operation. He does. I understood that the Executive was saying to Parliament, and through Parliament to the people of Scotland, that if people had to wait longer than nine months, the guarantee provided for them to have treatment elsewhere in Scotland, to have treatment as a priority from other resources being added to the local health board or to have private treatment for which the Executive would pay.

None of the caveats that you have mentioned so far applies in the case that I am concerned about. Given that, is it your understanding that those patients are therefore entitled to treatment and that it is Grampian NHS board—

The Convener: I think that we have got all that on the record. Now that those questions are on record, I think that you will agree that it is for the minister to answer them.

Please feel free to say something, Mr Collings, but I am happy to leave political decisions to the minister.

Peter Collings: As we have been trying to explain, there are definitions under which the guarantee does or does not apply. Those definitions are written down and are publicly available. In the judgment of Grampian NHS Board, the patient concerned will come under one of the availability status codes. It is hard for us to guess which one, but the sensible thing for any members with concerns about a particular constituent to do is to write to the minister with those concerns. We can then investigate what has happened with regard to that individual and come back to the member.

The Convener: I think that we have all done things like that, but I would like to find out from you or from the minister the categories under which the guarantee applies, so that we can have that information for the next meeting. Members can then raise general issues on that basis.

I caution the committee about the time. I have no objection to taking time over this matter, but we should bear in mind the agenda that lies ahead. I would ask that we all ask shorter, crisper questions, so that we can move along.

Helen Eadie: If we see new treatments or innovations of proven efficacy coming from elsewhere in Europe and other parts of the world, to what extent do we make provision in the Scottish budget to ensure that those new treatments come to Scotland and that we have at least three or four centres where those treatments can be provided?

Peter Collings: That very much depends on the treatment that you are talking about. As the committee knows, we have a systematic procedure for evaluating drugs. If, following that procedure, the conclusion is that the drug should be used, it will be made available in Scotland.

For other sorts of procedure, things are done on a case-by-case basis. We become aware of what is happening in a certain country and we have to take a view on whether it is something of national significance for Scotland. If it applies to relatively few patients, it could be treated as a national service, which we will fund nationally through the Common Services Agency. On the other hand, it might be something for boards to do, or it could be for the profession to spread best practice. A request could be made to us for capital funding to provide specialised equipment. In that case, we would consider the business case for funding that within our capital budget. It depends on the particular circumstances.

Dr Turner: We are all aware that NHS boards are under pressure, not least from the working time directive, the new GP contracts and so on. Last week, our financial adviser went through details for Greater Glasgow NHS Board. Much as we are in favour of doctors being paid a decent sum of money for the job that they do, it appears that the wages bill for doctors is putting extreme pressures on Greater Glasgow NHS Board and the other NHS boards, which are having to take cost-cutting measures to meet the bill. Do you work out the costs of proposals before you decide to implement them? How do you decide whether NHS boards have enough money to cope and whether they have the resources?

It appeared that Greater Glasgow NHS Board had an overspend of nearly £60 million and that it was having to make cuts over the next two years, probably amounting to up to £37 million in the first year, with the rest being made in the following year. That meant that although some patients might get a benefit, there might be cuts for other

patients. That is giving something with one hand and taking it away with the other. Do you make provision for such big proposals?

Peter Collings: Some of the proposals for Greater Glasgow NHS Board are about ensuring that there is space in its budget for the developments that it considers necessary for the next two years. The board's proposals for savings are intended partly to meet a range of pressures and partly to find space for service developments.

On your final question, of course we cost any major proposals before we take action on them. For example, we found the consultants contract extremely difficult to introduce. I have to say that I feel that I am slightly going over the same ground as I went over this morning with the Audit Committee; indeed, I have had the pleasure of spending the whole day in this committee room.

To find out the proposed contract's impact on consultants' pay, we applied a UK-developed model to a UK sample. As we received information from boards about how they intended to apply the contract, it became clear that it would be considerably more expensive than the initial estimates. Boards wanted to buy four hours' work per week per consultant more than our model had assumed. As a result, the actual costs were substantially higher than our estimates. However, it is certainly our practice to make such estimates, and we have learned some lessons from what happened with the consultants contract. For example, we are working very closely with various elements of the NHS on the upcoming agenda for change proposals to try to model them with real local data.

Dr Turner: Thank you for that response. However, some consultants have said that in negotiating their contracts they have lost sessions instead of gaining hours. For example, some of them are now working 10 instead of 11 sessions, which can have a knock-on effect on waiting times, waiting lists, out-patients and all the rest of it. Again it appears that you are saying one thing, but the position is different in practice. Moreover, if the health boards were expecting to receive enough money to cover the introduction of the new contracts, why did they hold back from giving you the information about what they intended to do?

Peter Collings: The job plans are not settled, so there is room for further movement. At the moment, we expect that the average number of four-hour sessions will be 11.4 per consultant, although some consultants will have 10 sessions and others will have more. Of course, that 11.4 figure is not very far beneath the 12 sessions that would get us up to the 48-hour level set by the working time directive. However, given that some consultants will choose to work fewer sessions, the average number of sessions should certainly not reach that figure.

We provided the boards with information about what the contract was looking like as the process continued. As I have said, we had done some work with a UK-developed model instead of a local Scottish model. However, we and the boards did not carry out modelling with local information at an early enough stage. We should hold our hands up in that respect, because we are more responsible for that situation than the boards are. That said, the responsibility is a joint one.

Kate Maclean: I want to follow up Jean Turner's question by asking about the pressure on NHS boards. Obviously, the introduction of consultants contracts represents a huge additional pressure. From my understanding—and as you have just said—the unexpected expenditure that they will incur is not so much their fault. As far as the committee is concerned, other elements in the Primary Medical Services (Scotland) Act 2004 and the National Health Service Reform (Scotland) Bill might also have additional financial implications for boards, even though the financial memorandums said that no costs were associated with those pieces of legislation.

From the committee's point of view, it would be very useful for us to see real information and real data about NHS board expenditure. We hear, as does the public, about a global figure that sounds as if X amount of an increase is going to NHS boards when, in fact, after committed expenditure and additional pressures are taken into account, the amount of money can be quite small.

It would be useful if the committee was able to get data that were produced in a form that made it easy for us to say, "Once all the committed expenditure and additional burdens have been removed, X health board will get such-and-such per cent of extra money." Would it be easy to do that or would it lead to disagreement? I am sure that there would be disagreement between the department and the boards about the additional expenditure, but at least we could see the data in a transparent way that would allow us to make much more informed judgments about the situation on the ground. At the moment, the data are not clear. On the one hand, the minister tells us about the additional money and, on the other hand, our local health boards tell us about the extra pressures. It would be helpful for the committee to have much more transparent information.

15:15

Peter Collings: We could certainly provide something that would give a national view of the pressures. Indeed, the Auditor General has done

some of that work already. A section of his "Overview of the NHS in Scotland" report sets out and quantifies some of the cost pressures on the NHS, and I gave evidence to the Audit Committee this morning on the NHS overview. However, the committee would have to rely on the boards and not the Executive for a translation of how the figures affect the circumstances of each board. There will be cost pressures or, indeed, savings in individual board areas that will not be national issues. The committee could only get the local side of the picture by looking at those figures.

I am happy to say that we could do something for the committee at the national level. However, as I said, the committee would need to ask individual boards for information about their local areas.

Kate Maclean: I understand that almost £50 million or slightly less than that is available for the cost of the consultants contract throughout Scotland. I am aware that the question is really one for the minister next week, but is there any chance that NHS boards will be helped out with the additional expenditure?

Peter Collings: Given that the issue came up at the Audit Committee meeting this morning, I want to correct the record. The figure is slightly more and not slightly less than £50 million. As the member said, the question whether health boards will be helped out is primarily one for the minister. Usually the money that we have is given out as general allocations and we expect boards to manage within those allocations. We are talking to the NHS about how boards can manage their costs and how we can help them with that.

The Convener: I think that the question is a matter for the minister.

Kate Maclean: Absolutely.

The Convener: Do you have a question at the moment, Duncan?

Mr McNeil: No.

The Convener: Thank you.

Mr Davidson: In the first session of the Parliament, the Finance Committee, the Audit Committee and the Health and Community Care Committee agreed that some boards were carrying structural deficits that rolled on from year to year. Although some action was taken at the end of that period, how many boards will go into the new 2004-05 financial year carrying forward a deficit? What criteria does the department have in place to review the recovery plans, which must be agreed by the minister?

Peter Collings: As the member will be aware, we will not have a firm position until we have the audited accounts, which we do not have yet. On the most recent returns from boards, of the 15 main health boards, three report that they will have significant deficits at the end of 2003-04, five report that they will have significant surpluses and seven boards are too close to call, in the sense that their deficits or surpluses are so small when compared with their overall spend that they could move either way at the audited outturn.

Mr Davidson: Where recovery plans exist, against what criteria are they reviewed? Obviously, recovery plans must be agreed by the minister, but I presume that the department uses a set of criteria to judge whether a board's recovery plan is realistic. For example, a proposed course of action that would reduce clinical outcomes might not be realistic. Will you explain that to us?

Peter Collings: We have a process of escalating intervention. For boards in which we have identified a problem, we meet them at least monthly to discuss their position and to review how they are progressing against the recovery plan.

There are two sides to our evaluation of recovery plans. First, we consider the impact that the plan will have on services. The first action that the board ought to take is to examine what it can do about the costs of non-clinical services, which are not direct services to the patient. We expect that to be the first thing in a recovery plan. Secondly, we expect boards to examine what the risks are. The reason for a board's getting into a difficult financial situation is often because previous plans made insufficient allowance for various risks that might have an impact on the board. We are particularly interested in that aspect.

With the board, we must reach a view on how quickly it is feasible for the board to achieve recovery without that having an unacceptable impact on clinical services. That is a matter of judgment that requires the circumstances of the individual board to be taken into account.

Mr Davidson: If a board decides not to increase or even to reduce certain clinical activity or to have a go at its drugs budget—those are often things that keep people out of hospital, so a balance must be struck—what position would the department take on such a move? It is alleged that some boards could plan for cutbacks simply by saying that they will not fill posts. By its nature, that means that there would be no capacity to provide further treatment.

Peter Collings: On drugs budgets, we expect all boards to comply with ministers' policies, especially our policies on postcode prescribing. In general, cutting the drugs budget would not be a way forward. However, we would expect boards to review the effectiveness of their prescribing and to

consider whether, for example, sufficient use is being made of generic drugs.

We deal with other proposed changes on a case-by-case basis. If a major service change is proposed, we expect that to be done primarily for clinical rather than for financial reasons. Major service changes are normally subject to public consultation and must normally come to the minister for approval.

Mr Davidson: What would happen if a board decided that it would not fill posts that arise in the activities that it carries out?

Peter Collings: We would want the board to have evaluated the impact of any such proposal and we would discuss with the board whether or not that impact was acceptable. If the posts were unfilled for a good reason, such as because the activity could be carried out in other ways, that would be different from a straight cutback in activity.

Shona Robison: I want to probe some of those questions a bit further.

The fact that three health boards are reporting significant deficits is fairly straightforward. Five boards have significant surpluses and I would be interested to know which ones they are. However, I will leave that aside. Seven boards are too close to call. Were all of them, or most of them, heading for a deficit until they had to cut services in order to be on budget? If you do not have that information, can you get it for us?

Peter Collings: The boards were in varying situations through the year. Some of them had budgets that looked okay for pretty much all the year. Others were affected by things such as the court judgment that part-time workers had to receive backpay for public holidays, which threw their budgets out of balance part-way through the year. A range of work was done to sort that out. Boards took action to manage their budgets and we gave extra funds to some boards in March, based on the normal distribution formula. That has helped the financial positions of boards that had been forecasting deficits.

Shona Robison: Would it be fair to say that all, or nearly all, of the seven would have had a deficit if they had not had to cut services or redesign them, or however it is termed?

Peter Collings: Boards have had to find ways of making savings. In some cases, those savings will have been not in direct patient-contact services at all but in administration or procurement, for example.

Shona Robison: Can you give us more detail on where savings have been made so that we can see the national picture?

Peter Collings: I would not have that level of detail about boards that are living within their means.

Shona Robison: Why not? Surely, if they have managed to stay on budget, but only by doing X, Y and Z, you should know what X, Y and Z were—especially as they might have impacted on some of the national targets.

Peter Collings: When we have serious concerns about boards, we become heavily involved and look at their plans to sort things out. However, when boards have found, during the year, that spend has got out of line with the budget, and are then—as is quite common—going through a process of bringing spend back into line, we would not normally become heavily involved. It would be for the local board to manage that process.

Shona Robison: I am not trying to be difficult. I am not asking the Scottish Executive Health Department to intervene and become heavily involved. All I am saying is that you should really have a picture of what is happening locally, especially if money is being shifted away from patient care. Such things impact on other things that the department is trying to do. If you have that level of information, it would be useful for the committee.

Peter Collings: I do not have the sort of detail that you are asking about. However, when we discuss financial situations with boards, we ask whether any issues are threatening the meeting of performance targets. We have already discussed waiting times, which was the main target and was especially relevant during the financial year that has just finished, because of the key date. We were given assurances that boards were not taking action that impacted on waiting times.

The Convener: I wonder whether we might put the same question to the minister as well.

Kate Maclean: My question is in the same vein. I am intrigued about the five boards that have surpluses. If those surpluses are significant, is there any specific reason for that? Some boards have deficits and some have surpluses; is any analysis done of the reasons for that before you decide on allocations for future years? Much of the funding is earmarked for wages and other commitments, but I wonder whether the reasons for surpluses are analysed. Given the response to Shona Robison's question, the answer will probably be no, but I find it intriguing that five health boards can close their books at the end of the financial year with a surplus.

15:30

Peter Collings: The normal process is to expect public bodies to stay within their budgets. If they are set a target to stay within, the chances are that they will slightly undershoot their expenditure.

As for future allocations, we do not want to introduce perverse incentives. We do not want to return to the time of strict annuality, when all wards were painted in February and March whether or not they needed to be. Therefore, although we ask for the information, we do not think it appropriate to reduce boards' funding simply because they have managed their finances effectively.

Kate Maclean: My background is in local government, so I understand what you say about what used to happen. Were any of the surpluses significant? How significant would a surplus have to be before you started to ask questions?

Peter Collings: Most of the surpluses were small; they were between 1 and 2 per cent of the budget.

Mr McNeil: Boards can have their own recovery plans that they get on with. Do they always consult you on those plans, or do they consult you only when they are in a financial crisis?

Peter Collings: Boards are required to consult us only when they have specific financial problems, but as a matter of course, they often talk to us about financial arrangements and what they plan to do.

Mr McNeil: However, they are not required to do that. If the boards talk to you before having a formal discussion on a recovery plan, they do not need to have the same consideration for the impact on patients. As Shona Robison said, if a board asked the minister to agree to a recovery plan, one of the minister's criteria would be the impact on patients, as a result of which he might not agree to a plan. If a board produced a plan in-house, patients might be affected without there being an impact on the board.

Peter Collings: If a board were planning to do something that had a major impact on patients, we would expect that board to tell us about it before doing it.

Mr McNeil: That relates to a major impact. If a board's current performance on waiting times was better than the minimum guarantee and a recovery plan lengthened that waiting time to match the minimum guarantee, would that be acceptable?

Peter Collings: We expect boards to work towards reducing the figure from nine months to six months, so at the moment, the action that you describe would be unacceptable, as we expect progress in the opposite direction.

Mr McNeil: That may be another issue for the minister. I am aware of an impact on waiting times up to the minimum guarantee. Given what you said, I am surprised that boards can get away with that.

Helen Eadie: The committee must deliberate on the programmes that it would like to prioritise for additional funding. To do that, we need to know whether the money that is available is being used wisely. What data do you have with which to judge efficiency under each budget heading? Can you divide your answer into data for NHS boards and for other parts of NHS Scotland, such as the Scottish Ambulance Service and NHS Education for Scotland?

Peter Collings: I will kick off, but I hope that Julie Wilson will help me out. In a costs book, we have a good deal of data about the costs of specialties and activity in specialties down to individual hospital level. We are kicking off a major exercise to perform more benchmarking than we do at present, which will involve benchmarking within Scotland and benchmarking Scottish performance against that of other countries. We have a lot of work in hand to improve matters.

Julie Wilson: We had an informal session with the committee's adviser in March on the type of information that might be useful to the committee. We have looked out all the information that was requested at that meeting. We can share with the committee an analysis of expenditure by care programme. For example, if the committee wants to get into more detail rather than just the figures for hospital and community services, we can break down the figures into acute services, maternity services, care of the elderly, mental illness services and so on. We can also link those figures into activity to try to get an idea of efficiency trends over time.

One issue that we are trying to resolve is that many of the more modern methods of service delivery such as nurse-led clinics and out-patient services with a procedure are not captured by the historic activity trends. We have been working with the ISD on a major programme of data development and we started publishing material in February.

A range of activities is under way, including a review of the statistics that are included in what we publish and, within that, a more detailed review of financial information that aims to get a better handle on the value-for-money and efficiency questions in which the committee is interested. That will include further work on the costs book and on the performance template—which I explained and for which I looked out data—to try to improve our, and the committee's, understanding of that material. That work will feed into the benchmarking exercise, which will allow

us to get a better handle on relative efficiencies and value for money. We would be happy to share all that information with the committee as the work progresses.

I am keen to meet early on with the committee's adviser. We have offered him the opportunity to feed into the performance template review and to work with us on the efficiency and value-for-money agenda. If the committee wants to do so in time for the next budget round, it would be good to start work on that now. The committee might want to have a follow-up meeting shortly with Andrew Walker on those issues.

Helen Eadie: That would be helpful, convener.

The Convener: The committee and the budget adviser could discuss that at a pre-meeting. I am sure that some people understand the finances better than I do—my head birls sometimes when I look at figures. All lawyers are the same, although they will not like me for saying that.

Mr Davidson: The committee is interested in the prioritisation of future additional resources. In considering how additional moneys from the comprehensive spending review might be allocated, one option is to give money directly to health boards by allocation and—to use the minister's words—to leave that to local management decisions. The other option is to ring fence money for specific purposes, which could be ministerially set targets. Although that is a matter of policy, we are interested in the mechanism. How does your department view the balance of those options in the prioritisation of new moneys? How much influence does performance outcome measurement have when those decisions are made?

Peter Collings: I am not 100 per cent sure that I understand the question, but I will try to give an answer. It is entirely for ministers to decide whether we put out additional money as part of the general allocation or as ring-fenced money. Either option is open to us.

In general, money is ring fenced for one of two reasons. First, there could be a view that it is a particular national priority to do something about an issue in relation to which, therefore, the amount of local discretion should probably be limited. Secondly, if something is new and ministers actively want it to be taken up within the NHS but there are doubts about whether that would happen if it went through the health board process, we may either fund some pilot schemes or ring fence money nationally for a time-limited period to get it off the ground. Those are the circumstances in which we tend to think about ring fencing money. If it is something that we just see as part of business as usual for boards, we normally prefer not to ring fence the money.

Mr Davidson: Do any consultations with boards take place while the minister is making up his mind whether to allocate money directly or to ring fence it?

Peter Collings: We are trying to move to a no-surprises relationship with the NHS. The minister meets the chairs of NHS boards every month and we meet the chief executives every month. Usually, unless there are specific reasons not to do so, we will discuss any such issue with the boards ahead of taking action.

Mr Davidson: Is that a yes?

Peter Collings: Yes. We would normally consult the boards, although one cannot guarantee that that would always happen. If something appears in an election manifesto, the process is different, but if the normal process is followed, we have a no-surprises relationship and expect to discuss matters with the health boards.

Mr Davidson: Perhaps this question is a bit light hearted, but does that mean that the boards get sight in advance of some of the press releases that announce new initiatives?

Peter Collings: We normally talk to the boards less about the press releases and more about the substance of the initiatives. There might be circumstances in which we would show the boards a draft simply because the press release is about an initiative that they want to know how to handle locally when it comes out nationally. Usually, however, it is the substance rather than the handling of new initiatives that we share with the boards.

Mike Rumbles: How do you measure the effectiveness of the money that is allocated to health boards under the Arbuthnott formula?

Peter Collings: Fundamentally, that translates into a question of how effective health boards are.

Mike Rumbles: No. My question is very specific. Your job description says that you are the director of performance management. I am asking you how you measure the effectiveness of the extra money that is allocated to health boards under the Arbuthnott formula. I am asking about the effectiveness of the money allocation.

Peter Collings: We try to measure how effectively the boards are delivering for patients, as that is the purpose for which the money is allocated. We have a range of indicators about the performance of the boards, all of which directly or indirectly link back to the organisations that are delivering for patients.

Mike Rumbles: So, you are saying that there is no specific measure of the effectiveness of the additional money that is allocated to health boards through the Arbuthnott formula. That is specifically

what I wanted to know. Correct me if I am wrong, but I thought that that money was being given to the health boards specifically to address issues of social deprivation, rurality, and so on. How do you measure whether that social deprivation is being addressed?

15:45

Peter Collings: We recently published information on performance in local areas, which looks at health inequalities in particular. The Arbuthnott formula is about allocating the total amount of money that is available for general allocations to health boards. The formula uses various indicators, some of which are deprivation indicators, but we do not allocate a certain amount of money for deprivation. We have recently put up money specifically for that because there was concern about unmet need, and we have put up money for pilots on unmet need. We then make up figures for the overall performance of boards, including performance on health inequalities.

Mike Rumbles: If I may, I will pursue the point once more because I am still not clear on the answer. I will put the question differently. Are you saying that when the money is allocated, you do not assess the effectiveness of that money? You assess the effectiveness of the board in its general role, but there is no analysis of the effectiveness of using money in a particular way. That is what I am asking.

Peter Collings: A board's function is to use that money to provide services for patients, and we assess its effectiveness in doing that. We do not label pound notes and say that they are for particular purposes.

Mike Rumbles: I understand. You are talking about a general top-up of money.

The Convener: I took the money to be part of the formula and not a top-up. As I understand it, there is no special pot for characteristics such as deprivation; they are included in the formula and separate information cannot be teased out. Is that what you are saying?

Julie Wilson: May I explain? I helped to develop the Arbuthnott formula.

The aim of the Arbuthnott formula was to fund the differential needs of boards according to the founding aim of the NHS, which was equality of access for those in equal need. We start with a population driver, which we then adjust for the age-sex profile of the local residents. We make further adjustment for differential levels of deprivation, because there is evidence that areas of higher deprivation have more need. The figures are then adjusted further for the excess costs of service delivery as a result of remoteness. The aim is to try to divide up the finite pot of money by using the characteristics of the boards that best meet patient needs. Thereafter, the performance assessment framework takes a range of indicators of how well the boards are doing in delivering patient care for their local residents. That is how we complete the picture.

Arbuthnott is not about additional funding. Extra funding can be redistributed using the Arbuthnott formula because it is the mainstay formula for the general allocation. However, the aim is to allocate the money on the basis of equality of access for those in equal need and then to performance manage the boards' delivery thereafter.

Mike Rumbles: You are talking about equality of access for those in equal need. You just said that you consider issues such as sex.

I will give you an example. The constituency profiles have just been published. In my constituency of West Aberdeenshire and Kincardine, people live for longer than is the case almost anywhere else. However, you are saying that if they live longer, they will need to have access to the NHS and its services for longer. From what you have said, I would imagine that the Arbuthnott formula would contain a factor that would address that need, but that does not seem to be the case.

Julie Wilson: It is, but in Grampian's case, that factor is probably counterbalanced by the relative affluence of the residents. The formula is really a balancing act. Each of the 15 boards has a different profile in terms of the youth of its population, deprivation and the excess costs of remoteness. In Grampian, any age profile would be counterbalanced by its relative affluence compared with other parts of the country.

Mr McNeil: You were involved in the development of the Arbuthnott formula, so the arguments that you have heard will not be new to you. Some boards still believe that the formula does not take account of all the relevant factors; Argyll and Clyde NHS Board, for example, has issues with deprivation and the fact that it is a rural area. Some of us believe that the formula does not fully benefit the people whom it was intended to benefit: those who are deprived and who suffer poor health. What opportunity do boards, MSPs and others have to raise such concerns and would they be acted upon?

David Palmer (Scottish Executive Health Department): Perhaps I could come in at this point.

The Convener: I am so glad. I was longing to hear your voice.

David Palmer: My boss is doing so well.

The Convener: That is why I was being tactful.

David Palmer: The Arbuthnott group came up with the formula that we use to distribute resources. The formula is updated every year to take account of changes, mainly in factors relating to population, age and sex—the kind of factors that Julie Wilson mentioned—and it produces a target, which I try to achieve through the distribution of resources. Every year I try to move boards gently, to avoid turbulence, towards their target position. For example, at the moment NHS Greater Glasgow is £30 million over its target, so I could not resolve that overnight; that would have to be done steadily. The formula is in place and we are working on it at the moment.

When the Arbuthnott group finished, we set up a group called the standing committee on resource allocation, which considered specific issues around unmet need in particular. Issues relating to the acts, funding and primary care were on its agenda, but it did not touch them. The group has reported and its findings are freely available on "Scotland's health on the web". That phase of the work finished a few months ago. At the moment, I am considering how we revise the formula to update it and take account of any late information that is available and factors that we can build in. When a group has been set up to consider that—I have not spoken to the minister about this yet, so he does not know—

The Convener: He does now.

David Palmer: Yes. We will set up a group with a remit to consider the formula. The way that I operate, which is how the previous standing committee operated, means that we will be open with the committee and the public and we will take on board your views. It might take us a few months, but we will set up the group later this year and you will all have a chance to put across your views and feed in your comments.

Mr McNeil: I am sure that we will take that opportunity.

Mike Rumbles: I am sure that you will hear from us.

Mr Davidson: Has the Arbuthnott formula been applied to the general medical services contract, which covers general practitioners' services?

David Palmer: No. The Arbuthnott formula is not being applied strictly to the new GMS contract. The principles within it are being applied, but there is a separate Scotland-based formula that has to take account of the national negotiations on the contract.

Mr Davidson: Does that mean that the formula is creeping in slowly?

David Palmer: What do you mean by that?

Mr Davidson: Will the general principles of Arbuthnott be applied over time to the new GMS contract?

Peter Collings: The general principles of the formula will be applied in relation to equality of access for those in equal need, which Julie Wilson expanded on, but there is a significant amount of phasing in to be done. Within the GMS contract, the formula is being applied at practice level rather than at board level.

Mr Davidson: Over what period will that be completed? Nobody really knows what will happen with the changes or how they will pan out. I appreciate your openness in saying that the new arrangement is coming through, but will you tell us how long it will take to deliver it?

Peter Collings: The present contract sets a floor to prevent practices losing out from the new arrangement, and that will be maintained throughout the period of the contract. I do not know whether there has been any discussion of what will happen with phasing in beyond that. At the moment there is a minimum practice income guarantee, which is a no-losers provision in the contract.

Mr Davidson: There is obviously a subtle change in that the health board, rather than the minister, is now accountable for one half of the contract. If the Arbuthnott formula is applied, does that mean that some health boards will win and some will lose out from the total application at board level in the way that some services will be rolled out under GMS?

Peter Collings: They will not lose out financially, in the sense that the GMS funding that is being distributed is in essence ring fenced from the rest of the budget.

Mr Davidson: That is very helpful. Thank you.

The Convener: That concludes this evidence-taking session. Thank you all very much. It is unfortunate that we have been in a hot room with bad acoustics. I suspend the meeting until 5 past 4.

15:55

Meeting suspended.

16:08

On resuming—

Petitions

The Convener: Let us settle down and batten down the hatches. We have a lot to get through, and I hope to get through it all. I will take members through the petitions. I refer the committee to paper HC/S2/04/11/2. Members also have all the other relevant correspondence and, in some cases, the *Official Report* from the previous meeting at which the petitions were discussed.

Epilepsy Service Provision (PE247)

The Convener: Petition PE247, from Epilepsy Scotland, is on co-ordinated health and social services to benefit people with epilepsy. I ask members to look at the paper on possible action. What should we do with the petition? I shall give the elderly and the infirm among us, as well as David Davidson, a moment to assemble their documents. Can I have views, please?

Mr Davidson: Although petition PE247 is geared towards epilepsy, it highlights a number of issues about co-ordinated health care and social services across a range of conditions. Could the clerks pull together the range of such petitions that have come to the committee this year, so that we can examine whether we can discuss the generality?

There are obviously serious concerns about that specific petition and what it covers, but there are other considerations that have also to be balanced in any future discussions. It is not a case of putting off a course of action; it is just a matter of putting the issue into the right environment for discussion.

The Convener: I refer to paragraph 4 of the letter of 31 March 2004, from Trevor Lodge on epilepsy specialist nurses. It states:

"The petitioners, and indeed the Committee, have asked about the results of the Executive's census of specialist nurse provision. The information has now been gathered and is being prepared for publication, but unfortunately the process is not yet complete. The Committee will recall that it is not exclusive to epilepsy nurses. The results will be made available to the Committee as soon as possible."

That is something that we may want to track. Otherwise, what do we do with the petition?

Helen Eadie: We could continue the petition in the light of that action.

The Convener: Should we continue the petition until we have that information, which we can then forward to the petitioners?

Mr McNeil: There will be recommendations that we take up a number of petitions as the subjects of inquiries. If we decide to do that, is there a pool into which we can put such petitions when we think that we want to consider them further in an inquiry? As we go through them, we continually run out of time and cannot plan for them. Is there a place where we can pool them or park them and then come back to those that we believe are worthy of consideration in an inquiry? That way, we could balance one against another and plan our work properly.

The Convener: One of the things that we want to do is to have an audit of petitions so that, when the time is right, we can go back into a pool of petitions and pull issues into our current work programme. As you know, we would love to take on lots of those petitions, but we have limited time. However, I agree that many of them are extremely worthy, and it may be possible to draw them into other areas of our work or to have inquiries on them in their own right.

Kate Maclean: I am unhappy about the letter, which states at the end that

"the planning and management of services is … best carried out at local level".

I agree absolutely with that, but the letter goes on to mention

"the unified budgets made available to NHS Boards, which will be increased by 7.25%, more than twice the rate of inflation, in the coming financial year".

I worry that the public will think that boards have 7.25 per cent extra money to spend on improving services and starting new services. As we have already discussed today in relation to the budget, most of that money is committed, as there is extra pressure on boards because of consultants contracts and the new general medical services contracts. It is worth putting it on the record that there is not actually 7.25 per cent extra for boards to spend, which is the impression that one would get from reading that letter.

The Convener: That is a worthwhile point. It is also worth confirming that the petitioners have copies of all the correspondence that we receive.

Mike Rumbles: This is the first petition that we are considering, and I cannot remember exactly how many there are—

The Convener: There are 20.

Mike Rumbles: If there are 20 petitions before us now, there will be another 20 in the next quarter and another 20 after that.

The Convener: Let me stop you there. There will not be another 20 next time, because we intend to cut down on the number of petitions that we continue. A number of the petitions that are before us today are new. We will not have 20 next time because it is hard to do justice to them.

Mike Rumbles: If that is the case, that is helpful, but it is easy for us as MSPs—because we are not inclined to say no to people—to decide to do this or that with a petition. The recommendations that are made are either that we take up a petition as an inquiry or that we take no further action in relation to the petition—it is not recommended that we simply take no further action. The petition calls on us to ensure that there are co-ordinated health and social services to benefit people with epilepsy. My point is that we should be saying to the people who present petitions to us, "We've heard what you say and we believe that it is worth our looking at the issue. Since you have raised the issue with us, we will look at it, but as far as the petition is concerned, we will close it." I am not saying that we should do that in this case, but I am saying that it could be done as a matter of course.

The Convener: That would be quite appropriate in other cases.

Mike Rumbles: That way, we will not raise people's hopes.

The Convener: Absolutely—it is not a problem. Furthermore, we have the caveat that we have a log of petitions and, if we have the opportunity—perhaps in an inquiry—we can absorb relevant petitions into whatever we are doing at that point, if possible. We are doing the best that we can with limited resources.

However, we have not yet finished with PE247. Do we agree to await responses to the issues that have been raised and to return to the matter when they have been received?

Members *indicated agreement.*

Chronic Pain Management (PE374)

The Convener: We have also dealt previously with this petition. I suggest that we simply hold on to the petition until we have Professor McEwen's report. There seems to be little point in our doing anything else at the moment. Do we agree to follow that course of action?

Members *indicated agreement.*

16:15

Myalgic Encephalomyelitis (PE398)

The Convener: I welcome Alex Fergusson to the committee. He is here to speak to petition PE398. The recommendation is that we take no action on the petition until we have seen the health board progress reports on implementation of the short-life working group, on the understanding that the clerks pursue responses from health boards prior to the committee's next consideration of the petition. We would not close the petition until we receive further information.

Alex Fergusson (Galloway and Upper Nithsdale) (Con): I do not want to take up the committee's time. I could not ask the committee to do anything other than what you are doing, given that we have not yet received responses from the health boards, which were due on 19 March. There has not been an Executive announcement on that and I do not see how the committee could take any steps until that has happened.

The Convener: I commend your pursuit of the issue.

Does the committee agree to follow the recommended action?

Members *indicated agreement.*

Deceased Persons (Law and Code of Practice) (PE406)

The Convener: We understand that new legislation might be considered by the Executive after consultation on issues that relate to the concerns that are expressed in petition PE406. The deadline for submissions to that consultation was 27 September 2003; findings will be released some time after the summer recess. I therefore suggest that we hold on to the petition until the first meeting at which we deal with petitions after the summer recess. Does the committee agree to do that?

Members *indicated agreement.*

Autistic Spectrum Disorder (PE452) Psychiatric Services (PE538) Autism (Treatment) (PE 577)

The Convener: We will deal with petitions PE452, PE538 and PE577 together. We are not awaiting reports on the petitions, so we should come to a conclusion on them today.

Helen Eadie: The committee could simply write to the Scottish Executive with a call for it to set up an advisory committee, as PE538 requests. We could also ask the Executive to set up an autism-specific facility, as called for in PE577.

The Convener: I notice that Kate Maclean is frowning, but I do not know whether she is expressing a view.

Kate Maclean: Could Helen Eadie repeat what she suggested? I was frowning with puzzlement rather than disapproval.

The Convener: Helen Eadie suggested that we follow the first two recommendations in our papers.

Kate Maclean: I see.

Dr Turner: Autism is an important subject and many people's lives are affected by having an autistic child or adult in their family. I do not know what we can do to find out what the Executive is doing in relation to the provision of diagnostic and support services to people who are labelled as being autistic.

Shona Robison: I notice that the last paragraph before the options in the paper on the petitions says that, on 3 March, the Executive announced funding for a variety of autism-related initiatives—a press release is attached—and that the petitioners' comments on the announcement have been invited. It would be useful to know whether the petitioners are satisfied by what has been announced and, if not, whether they still believe that their needs will be met only by what they request.

To be fair, parents who have autistic children have a variety of views about the best delivery of services. Some would favour a centralised centre but others might differ; it is difficult to come to a conclusion about who is right. It would be ideal to have choice; that would be the best situation.

Mr Davidson: On petition PE538, it would be helpful to find out what the Scottish Executive position is on setting up an advisory committee, because such a committee could be charged with considering a range issues in relation to autism. We would need to see some kind of response on that before we could call for an autism-specific medical treatment facility, because a number of issues on recognition and capacity need to be addressed before such a facility, which is what petition PE577 calls for, could be set up.

Janis Hughes: I agree with Shona Robison and David Davidson. It would be useful to see the petitioners' comments on the recent announcements, but I note that the correspondence from the Executive is basically about research. We have not asked for the Executive's comments on an advisory committee or an autism-specific medical facility. The first step would be to seek the Executive's comments on those issues.

The Convener: I have my concerns about an autism-specific facility because I have met parents who would really not be happy about one. There is a range of views on the matter.

I take it that the committee agrees to get the petitioners' comments on the announcement—we have only comments—and that we will also write to the minister to find out his views on setting up an advisory committee, and continue the petitions.

Members *indicated agreement*.

Helen Eadie: We got one response, from the petitioner for petition PE577.

The Convener: We have one and we await two others.

Helen Eadie: The petitioner has also given us an informative enclosure.

Heavy Metal Poisoning (PE474)

The Convener: Petition PE474 is from James Mackie and concerns heavy metal poisoning. I ask for committee members' views on the petition.

Janis Hughes: The information that the Executive has supplied is thorough and comprehensive. I was previously unaware of much of it. We could ask for the petitioner's views on the Executive's response, but given its comprehensive nature, I am not sure what further action we could take on the petition.

The Convener: The petitioner has not seen that letter from the Executive, so we require his comments.

Does David Davidson have anything to add?

Mr Davidson: No—I agree completely.

The Convener: Jean, are you content now?

Dr Turner: Yes.

Helen Eadie: Might the committee endorse the principle that every reply that we get from the Executive be forwarded automatically to the petitioners?

The Convener: The reply has just come in. I have just checked that, because what you suggest usually happens. We have not had the reply for the period of time that the date on it implies. We know to our cost that that sometimes happens when we get letters from ministers.

Aphasia (PE475)

The Convener: Petition PE475 concerns aphasia. I ask for committee members' views.

Mr Davidson: There is an issue here about national standards. I am not sure that we have got a very full response from the Scottish Executive on the matter. This might be a situation in which we are told, "This information is not held centrally." The Scottish Executive needs to undertake a mapping exercise on roll-out of services in this area, and that needs to be put before the petitioner.

Helen Eadie: A letter to the committee states:

"Speakability, the organisation that represents people with aphasia, has not been asked to participate or contribute to the planning of services."

That is an important issue, and representations should perhaps be made to the Scottish Executive on the matter, requesting that Speakability be included in any planning of services. I remember

being present on the day when Speakability gave evidence to the Public Petitions Committee. That was a moving experience, as a number of aphasia sufferers were there.

The Convener: That letter, which is dated 3 March, did not go to the minister; I think that it should have done. We will send it as an attachment. I take it that David Davidson's mapping proposal is to do with the second option on the paper that is before us? It suggests that we should

"call on the Executive to place a requirement on health and social care professionals to record aphasia specifically and separately regardless of cause".

Is that what you were aiming at?

Mr Davidson: Yes—more or less.

The Convener: We are trying to find out about the occurrence of aphasia and to establish whether it arises in clusters, so that we can get some kind of handle on it.

Mr Davidson: We should also try to find out how treatment is handled locally. We should find out what service provision exists in the various areas.

The Convener: So, we want to find out about service provision, occurrence and the placing of a requirement on health and social care professionals to record aphasia specifically.

Members *indicated agreement.*

The Convener: We will run the letters—those that are not just standard enclosures—past members, to ensure that they reflect the committee's view.

Digital Hearing Aids (PE502)

Mike Rumbles: On PE502, there seems to be—

The Convener: Before we go on, I want to ask the clerks to check what correspondence has gone out to the petitioners.

Mike Rumbles: There seems to be some confusion within the Scottish Executive, judging from its response. The letter is headed "PETITION ON DIGITAL HEARING AIDS", but it does not go on to refer to digital hearing aids at all; it refers to "neonatal hearing screening". That is crackers. Somebody needs—I don't know what they need.

The Convener: They need a digital hearing aid—or perhaps a visual aid.

We must take the matter up with the minister. We will ask for a response to the specific issue and suggest that the Executive's response was sent in error. We will be kind.

Mental Welfare (Complaints Procedure) (PE537)

The Convener: PE537 is from Alexander Mitchell, and is on the complaints procedure in mental welfare.

Mr Davidson: I have tremendous sympathy with people in the situation that is described, but this is a matter for the Scottish public services ombudsman. I appreciate that that office has only recently been set up, with different divisions coming together. I wonder whether Professor Brown might be asked for further comment. I do not believe that we can sit in judgment on a complaints procedure. We must be satisfied that the complaints procedure exists, that it is accessible and that it is operated correctly. I am not sure whether we are the right committee to sit in judgment on that.

Janis Hughes: I agree with that. I noted the correspondence from the cross-party group in the Scottish Parliament on mental health, whose convener states:

"the members agree that the Ombudsman is in the very early stages of coming into being and time is required to allow the process of settling in."

Given that the cross-party group focused on those particular issues, I tend to agree with its observations. On that basis, I believe that we should not continue the petition.

16:30

Dr Turner: I have a great feeling for people who have complaints about the NHS, because it takes so long for many of them to get answers. I was a little disturbed about the observation at the bottom of the first page of the ombudsman's letter, which says:

"it would be unlikely that firm conclusions could be reached on what was said or done nearly 6 years ago."

You are a lawyer, convener: you know that many cases might go on for six years before they get to court. Professor Brown is implying that it would be difficult to get information on the case after nearly six years. Obviously, the NHS still has a long way to go in how it deals with complaints in order to ensure that they never reach the stage of litigation or of going to the ombudsman. I do not know all the petition's background details, but I would hate to think that there was a time bar on such matters. Would not the NHS deal with a case that was more than 12 months old? The ombudsman's letter states:

"the ombudsman would not normally consider a complaint which was more than 12 months since the events complained about occurred."

It could easily be 12 months before a case could be got off the ground and get to the ombudsman.

The Convener: You should focus on the words:

"not normally consider a complaint".

Perhaps it would satisfy you to know whether there were specific circumstances in which a time bar would not be mandatory, which would allow the ombudsman to consider cases that were beyond the 12-month limit. I am cautious about saying that the words "not normally" might refer to trivial complaints as opposed to serious ones, but I believe that that might be relevant.

Mr Davidson: I remind the committee of what I said earlier, which was that we should write directly to Professor Brown to ask her for a view because the petition was originally dealt with before her post was established and the current mechanisms put in place. We could ask her for a definitive answer about what she regards as her role in this particular case. Perhaps we could expand that into finding out what the rules are about reopening cases.

The Convener: Yes. Would that satisfy members? We can focus on the words "not normally" to give us a kind of steer on that.

Helen Eadie: Can we enclose Adam Ingram's letter when we write to Professor Brown, and ask her to comment particularly on his reference to independent advocacy? It would be useful for us to be reassured that independent advocacy is used in cases such as this.

The Convener: I am happy to do that. We will also copy to Professor Brown the letter from the convener of the cross-party group on mental health.

Landfill Sites (PE541 and PE543)

The Convener: The next petitions are new petitions PE541 and PE543, on landfill sites. The Public Petitions Committee referred the petitions to the Communities Committee for consideration and that committee has forwarded them to us to consider the health implications. Therefore, we are like a secondary committee in this case. I ask members to consider the guidance paper on the petitions and to give their views.

Helen Eadie: I am minded to seek the support of colleagues to give the issue priority and to take the guidance paper's second suggested option, which is to agree that, because of the cross-cutting nature of the petitions' subject matter, the Communities Committee should investigate the public health implications and the Health Committee should appoint a reporter to attend the relevant meetings of the Communities Committee. Many of us, including me, have in our constituencies areas that are similar to the one in Karen Whitefield's constituency. There is an issue here about a community's mental health and well-being—which are not usually measurable—as opposed to the more obvious environmental health issues that arise in such contexts.

We should take on board a report that I read a couple of years ago from Dr Bull—or Professor Bull—who comes from the United States of America. He said that the areas that tended to be dumped on were always the poorest communities and those that were least able to act as their own advocates. Certainly, that is what happened in Karen Whitefield's constituency. It is also happening in my constituency, the northern part of which includes one of the poorest areas in Scotland. I feel very strongly about the issue.

The Convener: I am trying to recall whether you are still a member of the Public Petitions Committee.

Helen Eadie: Yes, but I am talking about a report of about five years ago.

The Convener: Do you still serve on the Public Petitions Committee?

Helen Eadie: Yes.

The Convener: I see. I was just trying to recall whether you were informed about the petitions for other reasons as well.

Shona Robison: I take it that the Communities Committee has agreed to investigate the public health implications of the matter raised in the petitions.

The Convener: No. The Communities Committee has asked us to look into the health implications. It is looking into other issues that relate to the petitions.

Shona Robison: Right. So—

The Convener: That was a very hostile "Right".

Shona Robison: We will suggest that consideration of the petitions should be the other way round, although there is no guarantee that the Communities Committee will accept that suggestion. All that we can do at this stage is return the petitions to the Communities Committee and ask whether, due to the pressures of our work load, it would be prepared to look into the health implications if it had our full support and co-operation by means of a reporter being appointed and so on.

The Convener: I misled you.

Shona Robison: I do not think that we can do anything else about the matter given that the Communities Committee has not yet said yes.

The Convener: Right. Is it the committee's view that the Communities Committee should investigate the public health implications but that, subject to a suitable volunteer being identified, we

are content to send a reporter to meetings of that committee to report back to this committee and to make an input into the investigation?

Mr McNeil: Yes. I nominate Shona Robison.

The Convener: Without descending into frivolity, if we are to take that course of action, I have to ask for a volunteer. We cannot simply do what we propose without appointing a reporter, and we should do that today.

Shona Robison: Helen Eadie is very knowledgeable on the subject.

The Convener: Is Helen Eadie content to be the reporter?

Helen Eadie: Yes.

The Convener: That is excellent. You should come to some of my branch meetings, Helen. We need volunteers but we never get them.

Multiple Sclerosis (Respite Homes) (PE572)

The Convener: We move on to our consideration of petition PE572, which was submitted by Patrick and Jennifer Woods. They call on the Parliament to investigate whether there is adequate provision in Scotland of respite homes with no upper age limit for sufferers of multiple sclerosis and other disabling conditions.

I direct the committee's attention in particular to the last paragraph on page 1 of the clerk's paper. Members will see that a map and data have been provided. The details have been lifted from the Scottish care homes census. The material has not been sent to the petitioners yet, which is something that we could do.

Kate Maclean: In the second paragraph of the letter from Jacqui Roberts of the Scottish Commission for the Regulation of Care, she says that she should be able to supply us with the information that we have requested later on this year. Obviously, we will want to continue petition PE572 until we receive that information.

The Convener: I suggest that we send the maps and data that we have received to the petitioners, along with a copy of Jacqui Roberts's letter of 25 February. Given that we are awaiting more information, I also suggest that we continue the petition. Are members agreed?

Members *indicated agreement*.

Eating Disorders (Treatment) (PE609)

The Convener: If I can have the attention of the committee, we will move on to our consideration of petition PE609, which was submitted by North East Eating Disorders Support (Scotland) and the Scottish Eating Disorders Interest Group. I ask for comments on the petition, which is another continued current petition.

Mr Davidson: I declare again my interest, in that I have a daughter who suffers from the condition.

I draw members' attention to the hand-written letter in which Heather Cassie, who is the secretary of North East Eating Disorders Support (Scotland), highlights the continuing problems. At the previous committee meeting at which we considered the petition, I mentioned the Huntercombe hospital—it was recorded as Huntingdon hospital, but that could be because I mispronounced Huntercombe. I know that Dr Millar, who works for Grampian NHS Board, and his colleagues who work for Highland NHS Board are still lobbying the Scottish Executive to make an allocation for the creation of a specialist eating-disorder ward within the Royal Cornhill hospital.

Personally, I am not satisfied that the Minister for Health and Community Care has addressed the issue correctly. In the chamber, he has twice told me that the mental health framework document takes care of the issue. However, the nature of the condition requires co-operation across health boards, as the treatment cannot be provided by every health board. We are dealing with just the tip of the iceberg.

Perhaps we should take further evidence from the health service professionals so that they can explain at first hand what they seek to do. We could perhaps also take evidence—either written or verbal—from the director of the Priory hospital in Glasgow. He previously operated within the health service, but moved because of the lack of support that he was receiving. Taking evidence might help us to get a handle on what the professionals think.

The Convener: I apologise to David Davidson for being distracted while he was speaking.

We are in an odd position, in that the Public Petitions Committee, which previously said that it would initiate inquiries into petitions, has decided on a policy of not taking on inquiries. However, petition PE609 was referred to us prior to that decision and the Public Petitions Committee is awaiting further evidence on the petition. Therefore, I suggest that we should wait to see what the Public Petitions Committee decides. David Davidson's comments are now on record, and we share his concerns about the issue. However, I think that it might be more appropriate for us to wait until we hear from the Public Petitions Committee before we decide to continue with an inquiry into the issue.

Helen Eadie has inside information, so perhaps she will confirm what I have said.

Helen Eadie: I can confirm that the new policy of the Public Petitions Committee is not to take on board any inquiries.

I agree with David Davidson that the issue of eating disorders is of such concern across Scotland that we should put the petition into the pool that Duncan McNeil mentioned earlier. Depending on the Public Petitions Committee's decision, the petition would be a worthy candidate for further work at a later date.

Mike Rumbles: I agree that this is a worthy petition on a serious issue. I defer to David Davidson's first-hand knowledge of what is obviously a distressing issue. However, no petition that I have seen has been unworthy. I note that the Public Petitions Committee is considering petition PE609. If I may repeat what I said earlier, I do not want to give the petitioners the message that their petition is unworthy but we have a wider duty to tell people that we cannot keep saying yes to all the petitions. So far, we have not closed a single petition. We are in danger of sending people the wrong messages. The committee needs to be courageous and to say that, although the petition is on a worthy issue, another committee is considering it so we will not be able to take it further.

The Convener: With respect, we have specific reasons for not closing petitions, such as the fact that we are awaiting correspondence. The petitions may be closed next time round.

If the Public Petitions Committee decides not to take petition PE609 any further, the petition will come back to us and we will then have to take a substantive view one way or the other. At the year end, we may have to prioritise the many petitions that we have been sent. When that time comes, we can gather the important petitions together under our forward work programme and carry them forward.

I agree that we have a duty to respond not just to what the Executive or we want to put on the agenda but to what the public wants. It is a difficult balancing act. We will come back to several of the petitions at some point later in the year and say, "Here we are. Which ones are we going to prioritise, if we have a space to pick them up again?" That will be a matter for the committee to decide.

16:45

Helen Eadie: The Public Petitions Committee has stated clearly that it will not be undertaking inquiries.

The Convener: We know that.

Helen Eadie: However, in some instances it is asking for further information.

The Convener: I thought that I made it clear that that is the policy position, but the Public Petitions Committee might be able to undertake an inquiry into the matter because the change in policy post-dated the petition coming to us. That is a matter for you, as a member of the Public Petitions Committee, to resolve with that committee's convener. No doubt you will do so on our behalf and come back to us.

We have resolved that we will go back to the Public Petitions Committee to ask what it is going to do—it is awaiting evidence—and whether it will undertake an inquiry under its old rules.

Hospital Closures (Public Consultation) (PE643)

Consultant-led Maternity Services (PE689)

Health Service Configuration (Consultation) (PE707)

Maternity Services (Island and Rural Communities) (PE718)

The Convener: The next petition is PE643, which we will take together with PE689, PE707 and PE718, as they are all on the same topic of hospital closure consultation and consultant-led maternity services. These are all new petitions. We have a trio of MSPs here—how blessed we are at this late stage in the day—and our practice is to allow them to say a few words. I ask you to be brief and to indicate to which petition you are referring.

Is somebody here to talk to PE643, in the name of Dorothy-Grace Elder, on hospital closures?

Ms Sandra White (Glasgow) (SNP): I am here to talk to PE707 and PE643. It is important to emphasise that millions of pounds of public money have been provided to the Queen Mother's hospital. We should be aware of that if we are going to close it down. The equipment, and the money that is used to buy equipment, will be sucked straight into the health service. We should also flag up the prospect of more petitions being submitted, and the fact that there were thousands of names on the *Evening Times* petition, which led directly to petition PE707.

I thank the committee for inviting me along and allowing me to speak. As I am normally the one who sends petitions to you, I hope that you do not give me a hard time of it. I suggest that somebody on this committee should submit a petition to turn down the heating in this room—I admire members' fortitude in sitting through this heat.

Pauline McNeill and others will raise other aspects, but my point is on guidelines and

consultation, which are important. The Minister for Health and Community Care has said that he will consider them carefully when he makes his decision. In fact, I think that a guidelines working group has been set up.

Not only I, but other MSPs, the public and clinicians, feel that decisions were taken by Greater Glasgow NHS Board that did not go through formal consultation and did not follow proper guidelines. For example, regional planning, which is part of the report by the expert group on acute maternity services, has not been taken into consideration. The health board consultation document cites EGAMA, but there are two EGAMS reports, which are contradictory, and the document does not mention the differences between them. We should be looking at that.

I wrote to the minister about the report by the British Association of Paediatric Surgeons. Peter Raine, who wrote part of that report, told the health board that although it said that it had quoted from the 1999 BAPS report, it had actually quoted from the 2002 BAPS report. Mr Raine e-mailed the health board two weeks before 35,000 copies of the consultation document were circulated throughout hospitals and the health board—the consultation was also reported in a national newspaper—with that mistake in it.

Since then, I have written to the minister and the deputy minister, Tom McCabe, to point out what has happened. I received a reply from the deputy minister—thankfully—and I can certainly circulate copies. He says:

"If … a Health Board had either wilfully or accidentally made a false statement, my colleagues and I would wish to know"

so that they could

"determine what, if any, action would be appropriate".

In his reply to the Public Petitions Committee, which members have in front of them, Sir John Arbuthnott says that there was a "minor" error. I do not think that the error is minor, given that a warning was given two weeks before the consultation document was circulated; I think that it is a big error. The committee should take cognisance of that. As I have said, the error is still being quoted.

Clinicians have raised concerns. They wished to come along to the Public Petitions Committee to give evidence but were not able to because there were so many petitions.

Obviously, I cannot tell the committee what to do; you have to make up your own minds. However, considering the EGAMS report, the BAPS report, the lack of consultation and the mistakes that have been made, I would say that the consultation has been flawed. I would like the clinicians who lodged PE707 either to come to the committee or to submit a written report. Perhaps the minister could come along and clarify some of the points that I have raised.

The Convener: I think that we will leave it to the committee to decide on that.

Ms White: I acknowledged that, convener; I was only making some suggestions.

The Convener: Duncan McNeil and others have asked what is proper consultation and what is not. We are well aware of the difficulties.

I will work my way along the line of witnesses. Jamie Stone is next.

Mr Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): First of all, I thank members for allowing me to come to the committee today. I hope that I do not bore you by repeating myself.

The Convener: Heaven forfend, Jamie. You are never boring.

Mr Stone: Members have heard me on this subject before. Three and a half years ago, the NHS in the Highlands proposed downgrading the maternity unit in Caithness to a midwife-led unit. Indeed, the very last question that Donald Dewar ever answered was a supplementary question that I put to him during First Minister's question time on that very subject. The Executive backed off then but the issue is back on the agenda now.

What makes the situation so desperate and so singular is this: taking women and their unborn children well over 100 miles from Caithness down to Inverness and back again poses huge safety problems. What if the weather is inclement? What if the roads are blocked? What if the helicopter cannot fly? To put the situation in a central Scotland context, it is the equivalent of asking women in Glasgow to go to Carlisle to have their children. It is an absolutely huge issue in Caithness. Caithnessians will not take this lying down.

At a meeting of Highland NHS Board, I was very struck by a contribution that was made by the Church of Scotland parish minister from Wick, who said that it came down to a human rights issue. Marbled through EGAMS is mention of risk, risk assessment and the minimisation of danger. It is admitted in EGAMS that midwife-led services in very remote areas are untested.

Professor Andrew Calder, who was a party to the EGAMS report, was asked to carry out a review of maternity services in the Highlands. In his report, he outlined the transportation and inclement weather difficulties and the dangers associated with them. However, when he concluded that, inter alia, consideration should be given to having a midwife-led unit, he did not

attempt to answer the question of transportation. I put it to the committee that in areas as remote as Caithness, even with the finest ambulances in the world, and even with a fleet of helicopters, when the weather comes in, the weather comes in and you simply cannot move people. I talked to somebody the other day whose family had lost children who died with the mother in an ambulance on that journey in the bad old days.

I have put these points to ministers and Tom McCabe has been good enough to admit on the record in the press that distance is the big issue. As I say, it is the equivalent of Glasgow women having to go all the way to Carlisle.

Highland NHS Board has backed off somewhat, in as much as it has conceded that it will consider some sort of hub-and-spokes rotating service, incorporating consultants. However, the bottom line is that, in view of the unacceptability of increasing the risk, we must endeavour not to accept that.

Finally, I reiterate to the committee that surely women who live in really remote areas, such as John o' Groats, Canisbay or Bettyhill, have just as much right to a decent—indeed, the best—maternity service as women who live in Fife, Lothian or wherever. The issue is about weather and distance and will not go away. Indeed, I believe that it is so fundamental that it transcends the responsibility of NHS Highland; it involves ministers and the Parliament.

Pauline McNeill (Glasgow Kelvin) (Lab): I want to speak to petition PE707, in the name of Professor Dan Young, on maternity services. The petition has been signed and submitted to the Public Petitions Committee by five eminent retired professors who worked at Yorkhill in the Royal hospital for sick children and the Queen Mother's hospital.

Three issues arise from the petition, the first of which is the quality of the consultation process. In that respect, I urge the committee to include some of the aspects of this petition in the work that it has already been carrying out. The issue is not about the process itself but about the quality of expert opinion. Although these professors, who are eminent in their own field and have run the service, gave evidence in the consultation process, they cannot see where that evidence appears in the paperwork that was given to board members. The important distinction to make is that that evidence was expert, not public, opinion. The professors want the committee to address that aspect of the quality of the consultation process. After all, if an expert opinion has been given, it should be easy to find out where it has ended up and the extent to which it was taken into account.

Secondly, the petition asks the committee to examine the model of care at Yorkhill with the Royal hospital for sick children and the Queen Mother's hospital, particularly in relation to the delivery of a national service. There is work to be done on the delivery of children's services in Scotland. Although national services are delivered not by NHS Greater Glasgow but under the direct auspices of the Scottish Executive, the health board appears to have taken a decision on the future of children's services on behalf of every MSP around this table and beyond. As a result, the professors are asking the Parliament to examine whether all of us—not just me as a Glasgow constituency MSP with an interest in the matter—have a stake if we lose that model of care.

I will not talk about the conclusion that the board reached, because that is not the issue in question. However, there is a feeling that the decision was based on inaccurate information, which again highlights the very question of the quality of the process. An example of the inaccurate information that was released in the name of NHS Greater Glasgow was its claim that there are two foetal medicine departments in the city. There is only one such department, which is based at the Queen Mother's hospital. It has delivered training not only for the whole UK but worldwide and is the only referral centre for foetal medicine.

Moreover, the day before the decision was taken, board members received a minority report that was signed by almost 30 doctors and which stated that the plan following the closure of the hospital would be impossible to implement. Again, that report should have been made available to decision makers well before any decision was taken. Such incidents highlight the serious problem at the heart of this matter: the quality of the consultation process. Finally, the expert evidence of paediatricians such as Charles Skeoch contains a warning that transporting neonates to the extent allowed in the implementation plan raises serious issues with regard to the morbidity of children.

I have tried to steer away from expressing my feelings about the closure and ask the committee to add some of the issues that have been raised to its on-going work. I know that committee members are concerned about the quality of the consultation process and that the minister has still to respond. I do not want to add to the committee's work load; however, I would be very grateful if it could consider the distinct and important points about the quality of the process; the accuracy of the information on which decisions were based; the work that needs to be done on the model of care for children's services; and how we deal with expert rather than public opinion.

The Convener: I thank members for the very clear exposition of their cases.

Kate Maclean: As far as the minister's response is concerned, petition PE707 calls on the Scottish Parliament to

"consider a new legal framework for consultation".

Malcolm Chisholm notes in his letter that that is part of the petition. He says:

"It would not be appropriate for me to make any comment … at the current time",

but that he is

"taking careful note of all representations made."

He says that he

"will need to be satisfied that Greater Glasgow NHS Board has fully engaged with stakeholders"

before he approves any proposals. That takes care of one bit of petition PE707.

Another part of the petition concerns expert advice. Later in his letter, the minister says that he

"will … ensure that the guidance provides advice on the selection of expert advice",

in particular when

"the provision of a national service is affected".

Without going into the decision that is to be made locally, the minister's response covers the points in that petition.

17:00

Janis Hughes: After listening to what has been said today and reading the copious paperwork that accompanied the petitions, I think that the petitions could be split into two groups of two petitions. Petitions PE689 and PE718 are about the availability of consultant-led maternity services and petitions PE643 and PE707 are about consultation. I do not know whether we could take on board the petitions about consultant-led maternity services during our work-force planning deliberations. We could question people on that in the areas that we visit for our inquiry. We must understand that such decisions are consultant led. That is one driver of our work and of the inquiry that we are about to undertake.

Petitions PE643 and PE707 deal with consultation in the NHS, on which the committee's predecessor laboured long and hard in the previous session. The previous committee took the strong view that it would be inappropriate to involve itself in local decisions by health boards. However, we took a view on consultation in general and investigated it further. At that time, we obtained from the minister a commitment to guidelines, which I understand that we are about to see. Those guidelines are likely to say that end-process consultation is unacceptable and that boards must give their reasons for not choosing a particular option.

I am not saying that that means that consultation will be good, because the problem that we have always had is not so much with the consultation process, which has become more comprehensive, as with the cognisance that is taken of comments that are made during a consultation and how all the comments are evaluated, whether they be from expert witnesses or from the public. The issue is more how the outcome of a consultation process is evaluated. I am interested to hear other members' views on that.

Shona Robison: The petitions are timely, given the committee's work on work-force planning. I agree with Janis Hughes that we need to separate issues that relate to work-force planning and fit them in with our inquiry. That will include talking to the petitioners in more depth about the issues that they have raised when we go to our respective areas.

The Convener: I do not know whether members are aware that when the committee undertakes that inquiry, we will divide into three groups of three to make informal visits from 25 to 27 May. We have not set a structure for that, but we could take informal soundings that will inform the structure of our formal evidence-taking sessions, which our work plan says will commence on 7 September. That is in train. It is difficult to track what other committees are doing.

Shona Robison: It would be useful if the clerks pulled out what can fit in with our inquiry into work-force planning. However, there are clearly remaining issues that do not fit in with that inquiry, which we cannot just leave hanging. I was struck by what Pauline McNeill said about the quality of the consultation process. There are issues on which we need to go back to the ministers. There are clear concerns about the weighting that is being given to some bits of evidence and not to others—if they materialise. I do not think that we can allow that just to pass.

As we are in the difficult position of waiting for a decision from Malcolm Chisholm, there is a limit to how far we can go. However, I draw members' attention to something that the minister announced today—the expert group to plan for NHS service change, which will establish a national framework for the reconfiguration and redesign of services. Some might say—as I would—that that should have been in place before health boards around the country started to embark on the rationalisation and centralisation of services. The press release states:

"The group will not decide on current or imminent major service reviews by Health Boards. However, its work will complement future planning by Boards by giving a strategic national focus for the reconfiguration and redesign of services."

We need to take that specific issue up with the minister. Surely he cannot be saying that, from a

point in the future, things will be done differently, with a strategic national focus, but that everything that is done until then will be done on an ad hoc basis and in a piecemeal manner. We should either write to the minister or ask him to give evidence to the committee, as he has taken the initiative on this. It could be argued—to be controversial—that what is going on and the decisions that are being taken around the country fly in the face of what the expert group may come up with. We do not know, as we have not heard what the expert group is going to say—it will reveal its deliberations in the next few months. There is a strong argument that there should be a pause until the expert group reports.

Those are all issues that we could put to the Minister for Health and Community Care. He has put the cat among the pigeons with his announcement today, and we should, as a minimum, have him before the committee to discuss how the expert group will impact on what is going on around the country at the moment.

The Convener: Can you give us the number of that Scottish Executive press release?

Shona Robison: It is on the Executive's website.

The Convener: I am told that the minister wrote to me today, but I have not seen the letter yet.

Shona Robison: There is a letter.

Mr Davidson: On the point that Shona Robison has raised, I think that it is urgent that the committee call for a moratorium on any closure until the matter has been properly debated. It is fairly obvious that the piecemeal approach is hitting a national issue—access to services throughout Scotland. It is not a matter just for individual health boards, because when the National Health Service Reform (Scotland) Bill is passed, there will be a duty on health boards to look after patients from other health board areas. In other words, it is vital that the left hand and the right hand start working together.

I agree with the minister's letter that the subject of petition PE643 is not necessarily an issue of note for the committee to take any further. Many hospitals have acquired pieces of kit through public donation, and so on. The real issue is access to services and whether those services can be manned. That brings us back to our work-force planning exercise. However, there is an issue in the letter on which we could ask the minister to respond further. He takes a simplistic approach on page 1 of the letter, on which he cites

"declining birth-rate, changes in practice and impending changes to clinicians' working patterns".

This is to do with access and getting hold of clinicians. In fact, more and more people are having their first child later in life, which is far more complex. That complexity is a factor in the requirement to be able to access consultant care.

I received a very moving letter from a lady who lives to the north of Wick but who, until recently, lived on the outskirts of Aberdeen. She and her husband were going to start a family but discovered that there were going to be no consultant services there. She was advised that she would have to live in Inverness for the eight to 10 weeks—if not 12 weeks—before the scheduled birth, because of the risks of her age, which was 35. She has been very public about that. The issue is far more complex than the minister seems to acknowledge, and much of it is to do with work-force planning. Pauline McNeill made a comment about a centre of excellence; that is a national issue and not just one for Greater Glasgow NHS Board.

Mr McNeil: We all have a great deal of sympathy for those who experience the frustrations of the consultation process. That is reflected in Professor Young's petition and in the petition in the name of Dorothy-Grace Elder.

The National Health Service Reform (Scotland) Bill gives us the opportunity to raise those issues with the minister and I expect members to take advantage of that opportunity during the stage 3 debate. As well as that, when he is making his final decision on Glasgow, the minister has to take into consideration the quality of the consultation. There is a statutory requirement for that, so the committee might be being a wee bit previous on the Glasgow issue. It is certainly something that we have discussed and been aware of for some time.

Of course consultation is important and we have made some progress in the National Health Service Reform (Scotland) Bill. However, it is not enough progress and, as I suggested to the minister when he gave evidence to the committee, it does not deal adequately with issues such as the redesign of maternity services. On such issues we almost have to go outside the standard consultation. I believe that, although others might not support me.

However, consultation being the way it is, the minister has announced another review group today. As I understand it, consultant-led facilities at Caithness general hospital, Vale of Leven hospital and the Rankin memorial hospital in my constituency are being taken away irrespective of consultation. It is a dangerous game when politicians start to call for moratoriums or standstills. We face a difficult issue. It is easy to say that we should stop something, but the challenge is to ensure that we can get proper cover for mothers in those hospitals. The three areas that we are talking about are operating

under a contingency plan and do not have sufficient skills to enable them to carry on delivering safe procedures. That is the reality of the situation. I do not know how we can create a moratorium in those three areas. I just pose the question.

Thankfully, the work-force planning inquiry gives us an opportunity to roll the issue up. We could consider several areas when we are out and about and touching base with people who have concerns. We could also consider case studies and the impact of the issues in areas such as Argyll and Clyde and Caithness. We could focus on maternity services. That is what drove me to call for a work-force planning inquiry, so I hope that we can bring others into the inquiry.

The Convener: Before I bring other members in, I point out that the minister is before the committee next week. We could certainly slot in an item to deal with the quality of consultation and the issues raised by the minister's letter about the setting up of the expert advisory group. If the committee agrees, I could put that on the agenda rather than write to the minister. He will be here anyway, so we could just extend the session.

Mr McNeil: We should put the general issues on the agenda. With all due respect to the members from Glasgow, this is not just an issue for Glasgow. There is an issue with the quality of consultation and how we engage the public and redesign consultation. I do not think that the committee is in a position to evaluate the evidence that was given, but we have to remind the minister that we are aware of what petition PE707 says about expert opinion and doubt about the quality of evidence.

The Convener: I am trying to be helpful by separating the issue of the withdrawal of certain services, which is a staffing issue, from the consultation issues and the letter of April 2004 about the national framework for service change and the expert advisory group. As the minister is to appear before the committee, the sharpest way to deal with the matter is to question him then. We can extend the session and move on to the matter after addressing the budget process. Do members agree?

Members *indicated agreement*.

The Convener: Do Mike Rumbles, Jean Turner and Helen Eadie want to come back in, or can we come to a view?

Mike Rumbles: No. I have a contribution to make to the debate.

The Convener: That is fine—I have no problem with that. I was just thinking about the time, as usual, and about whether there is anything additional to say.

17:15

Mike Rumbles: Petition PE707 calls on the Scottish Parliament

"to urge the Scottish Executive to consider a new legal frame w ork for consultation"

and Dorothy-Grace Elder's petition PE643 calls on the Parliament

"to take the necessary steps to improve public consultation".

I agree that that is exactly what we are doing at stage 3 of the National Health Service Reform (Scotland) Bill. As the minister says,

"The guidance w ill be underpinned by a new duty upon NHS Boards to involve the public w hich w ill be established by the NHS Reform (Scotland) Bill."

As MSPs, we are doing that as we go through the process; the petitions are addressed by the work that we are doing collectively at stage 3. To put it crudely, I think that those two petitions are ticked. They should be noted, we should thank the petitioners for raising the issue, and the petitions should be concluded—that is the best way to proceed.

The other petitions that are before us, PE689 and PE718, are similar. PE718 calls on the Parliament

"to urge the Scottish Executive to urgently review the provision of maternity services for Scotland's island and rural communities."

Jamie Stone's petition PE689 calls on the Parliament

"to ensure the availability of consultant-led maternity services throughout Scotland."

The key word is availability. It is a national petition, and it hits the nail on the head in relation to what we are trying to do in our consultation. I am conscious that the committee has sat formally—I am not talking about going out on fact-finding missions—only in Edinburgh. If we are serious about the consultation and if we are to consider the effect of the availability of services throughout Scotland, we should leave Edinburgh. To take the two new petitions as examples, we could go to Rothesay or north of Inverness, perhaps to Wick. We should get out there and take evidence in the September sessions to which the convener referred rather than be focused here in Edinburgh.

The Convener: If we decide to subsume the petitions in whole or in part into our work-force planning inquiry, they will be closed down, because the inquiry will end the petitions.

I am quite happy to hear from other members, but I am trying to move things along.

Dr Turner: I will try to be as quick as possible because I know that you are dying to close the meeting.

The Convener: No, not at all.

Dr Turner: What really concerns me about the consultation process, which is important, is that although we are frequently told that doctors hold such-and-such an opinion, we know that many doctors have other opinions. The latter seem to be secret and are lost to the public. I do not know how we as a committee can bring out the information that is given in the consultation process so that we can see all the evidence. I wonder whether that information is also withheld from the minister, who has to make a decision about a national institution. Is he privy to that information? Perhaps Pauline McNeill and Sandra White know the answer to that.

Helen Eadie: Malcolm Chisholm states in the final paragraph of his letter that it is vital that there will be a

"duty and the guidance will expect Boards to inform, engage and consult with the public in the relevant area(s)".

The Convener: To clarify matters for the *Official Report*, Malcolm Chisholm states that in his letter to Michael McMahon.

Helen Eadie: The important bit of what he says is that boards will be expected to

"feed back the results of the consultation, including reasons for the eventual decision and explanations of how the public's views were taken into account."

It is important for us all to remember that.

I very much agree with what Duncan McNeil said. It would be inappropriate for us to engage in a moratorium and it is right that such matters should be embraced in our inquiry.

In answer to what David Davidson said, section 3 of the letter from Greater Glasgow NHS Board clearly brings out how vital expert consultant-led assistance is in the event of a difficult child birth and that it would want to be sure that any delivery takes place in a maternity hospital with an on–site intensive treatment unit. David Davidson made an important point, but it has been covered in the response from Greater Glasgow NHS Board.

The Convener: I want to draw the discussion to a conclusion. Petitions PE643 and PE707 are on consultation. In respect of those petitions and the letter of April 2004, with the announcement by the minister, do members agree that we will question the minister with regard to consultation processes after we have asked him about the budget process?

Members *indicated agreement*.

The Convener: Petitions PE689 and PE718 relate to work-force planning and so on. Do members agree that we should let the petitioners know what our plans are for our first informal foray and for informal evidence-taking sessions, at which they are welcome to give evidence? We will take on the petitions as part of our inquiry. The two petitions will be closed down at that stage, as we will have taken them on board as part of the inquiry. Are members content with that proposal?

Members *indicated agreement*.

The Convener: That deals with those four petitions. I thank members for waiting and for speaking to them.

Terrestrial Trunked Radio Communication Masts (PE650)

The Convener: The final petition is PE650. I welcome Mark Ruskell, who has been patient.

The petition was referred by the Public Petitions Committee to the Communities Committee, which agreed to consult this committee. The Communities Committee is still considering the petition. Members should bear with me—we are nearly finished. The petition was forwarded to us to allow us to consider its health implications. Members may give their views once Mark Ruskell has spoken. This is the first time that we have considered the petition.

Mr Mark Ruskell (Mid Scotland and Fife) (Green): I will take no more than a minute or two, as the committee has had a mammoth session.

I should emphasise that a degree of urgency surrounds many issues with which the petition is concerned. The public is concerned by the issue, which first came to my attention in April last year, before I was elected, when I attended a public meeting in Cupar in Fife. That meeting was about TETRA, which is a new type of mobile communication system. In the 12 months since that meeting, seven community-based campaign groups that are concerned about TETRA technology have been set up in Mid Scotland and Fife alone. Many of those groups have organised public meetings, which have sometimes been attended by more than 200 people. There is a lot of public concern.

While that concern has mounted, the TETRA communications system has been rolled out throughout Scotland and local authorities have approved new TETRA masts. In fact, the briefing material that members have received from the Communities Committee is now out of date. I think that, apart from two applications, all the 14 applications in Fife, which Fife Council was holding back on, have now been approved. The system will be operational in Dumfries and Galloway in the summer.

The petition was lodged last autumn. The Executive, the Public Petitions Committee and the company have corresponded, but I do not believe that the correspondence has addressed many

issues that the petitioners are concerned about and it might be time to take oral evidence and to consider the issues that are involved.

The petitioners' concerns are not about mobile phones as a whole. I am aware that an inquiry into mobile telecommunications masts took place in the first session of Parliament. The specific concern of the petitioners and of many communities throughout Scotland is that the TETRA system pulses using very low frequency radiation. The companies that are involved and members of the scientific community disagree about whether the masts pulse.

Another concern is about the potential health effects of the masts and handsets that will be used by the emergency services, starting with the police this summer. Further, the standards that have been devised for mobile communications systems predate the new technology—they deal with the mobile phones that we are used to using, not mobile telecommunications systems that use the very low frequency. The Stewart committee said that we should use the precautionary principle in relation to the new technology. We should not roll out a system that uses low frequency radiation until we are sure about the health effects.

The committee could examine those issues. The petitioners have not yet given oral evidence to a committee, although they have been working with scientists who are concerned about the contradictions in the standards and in the evidence on whether the system pulses, which is the petitioners' primary concern.

Mr Davidson: It is fairly common knowledge that, in the past three to five years, the science community has not agreed about the safety of new systems, as a result of which certain areas in other parts of the UK have declined to use them, either because of the potential risk or because of inefficiencies in the process. Frankly, I do not think that the committee is qualified to deal with the science aspects, although we are concerned about the public concern. We need to collate information on various aspects of the science from both sides of the argument. Perhaps a body such as the Royal Society ought to consider the issue on a UK basis.

When systems are rolled out, the planning authorities often have no positive evidence to argue against them. If an application does not breach the local plan or the strategic plan, the planning authority cannot do much about it. If we do not get the science right and do not have the knowledge, none of the committees of the Parliament can reach a firm conclusion and give the system a clean bill of health. I agree with Mr Ruskell that we should adopt the precautionary principle, but if we are to take evidence on the matter, we must do so in conjunction with Westminster.

Janis Hughes: I was a member of the Transport and the Environment Committee in the first session of Parliament when it carried out an inquiry into telecommunications masts, which concluded that no conclusive evidence existed and encouraged the use of the precautionary principle. The Transport and the Environment Committee took evidence from a huge number of people, which included evidence on the health aspects. I make that point because I think that the matter is best taken in the round, as part of a Communities Committee inquiry on the issue, if it intends to carry out such an inquiry. I do not know what can be gained from our input, except if it is asked for.

The Convener: For clarification, was a report issued as part of the Transport and the Environment Committee inquiry to which you refer?

Janis Hughes: Yes.

The Convener: Mr Ruskell, were you aware of that?

Mr Ruskell: I am aware of the good work that was done in session 1, but it did not relate to the TETRA system. Perhaps the heading for PE650 in the agenda is misleading. We are talking not about mobile phone communication masts but about terrestrial trunked radio masts, which are a different technology that was not considered in session 1 because it did not exist then.

Janis Hughes: I was simply suggesting that the petition could be dealt with by the Communities Committee. We have been asked to comment; my comment is that if the Communities Committee is to carry out an inquiry, it should take evidence on the potential health aspects in the round, rather than have a two-committee discussion.

17:30

Helen Eadie: Like Janis Hughes, I was a member of the committee that examined the issue. We found that a scientific committee has been set up at European level to investigate the issues. David Davidson's point that we must have regard to the science is well made. If the petition is to go anywhere, it should go to the Communities Committee and be considered in conjunction with work at European level.

Shona Robison: We must recognise the huge concern about the issue. I was contacted by constituents this morning about proposals. Has the Communities Committee offered to carry out an inquiry?

The Convener: The Communities Committee is in the same position with this petition as it is with the petition that we discussed earlier.

Shona Robison: We should suggest to the Communities Committee that there are unanswered questions, that more work needs to be done on the matter and that we hope that that committee will be able to do that work. If required, we will have input through a reporter.

The Convener: We do not need to agree on a reporter today. We will defer the matter until we see what the Communities Committee decides to do.

Before members leave, I have an issue to raise. I am sure that members have read in the newspapers that the former chief executive of NHS Scotland, Geoff Scaife, was killed in a dreadful car crash on Tuesday 20 April. He leaves a wife and four children. Do members agree that we should write with condolences to his family and his former team members?

Members *indicated agreement*.

The Convener: That concludes the meeting. I thank members for their forbearance in a sauna. We will try to meet in the chamber next time, where it is cold.

Meeting closed at 17:32.

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