HEALTH COMMITTEE

Tuesday 4 May 2004
(*Afternoon*)

Session 2

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by The Stationery Office Ltd.

Her Majesty's Stationery Office is independent of and separate from the company now trading as The Stationery Office Ltd, which is responsible for printing and publishing Scottish Parliamentary Corporate Body publications.

CONTENTS

Tuesday 4 May 2004

HEALTH COMMITTEE
12th 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:

Andrew Walker (Adviser)
Ms Sandra White (Glasgow) (SNP)

THE FOLLOWING GAVE EVIDENCE:

Malcolm Chisholm (Minister for Health and Community Care)
Dr Peter Collings (Scottish Executive Health Department)
Sandra Falconer (Scottish Executive Health Department)
Andrew Macleod (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 1

Scottish Parliament

Health Committee

Tuesday 4 May 2004

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:03*]

Items in Private

The Convener (Christine Grahame): I open the 12th meeting in 2004 of the Health Committee. I ask those present to switch off mobile phones and pagers. We have received apologies from Mike Rumbles.

Item 1 on the agenda is consideration of whether to take in private item 6, on work-force planning, and item 7, on possible witnesses for stage 1 of the Prohibition of Smoking in Regulated Areas (Scotland) Bill. It is suggested that we take item 6 in private because arrangements are still being negotiated and are at a provisional stage—this is work in progress. It is suggested that we take item 7 in private because usually when we have discussed the selection of witnesses, we have taken the view that it is not appropriate to go through lists of prospective witnesses in public. Do members agree to take items 6 and 7 in private?

Members *indicated agreement*.

Subordinate Legislation

General Medical Services (Transitional and Other Ancillary Provisions) (Scotland) Order 2004 (SSI 2004/142)

Tobacco Advertising and Promotion (Point of Sale) (Scotland) Regulations 2004 (SSI 2004/144)

Mental Health Tribunal for Scotland (Disqualification) Regulations 2004 (SSI 2004/154)

Mental Health Tribunal for Scotland (Appointment of President) Regulations 2004 (SSI 2004/155)

Primary Medical Services (Sale of Goodwill and Restrictions on Sub-contracting) (Scotland) Regulations 2004 (SSI 2004/162)

National Health Service (Optical Charges and Payments) (Scotland) Amendment (No 2) Regulations 2004 (SSI 2004/168)

National Health Service (General Ophthalmic Services) (Scotland) Amendment (No 3) Regulations 2004 (SSI 2004/169)

14:04

The Convener: Item 2 on the agenda is consideration of subordinate legislation. I refer members to paper HC/S2/04/12/1, which has been circulated. There are seven negative instruments on the agenda: SSI 2004/142, SSI 2004/144, SSI 2004/154, SSI 2004/155, SSI 2004/162, SSI 2004/168 and SSI 2004/169. The Subordinate Legislation Committee has no comment to make on SSI 2004/144, SSI 2004/154, SSI 2004/155, SSI 2004/162, SSI 2004/168 and SSI 2004/169 but has commented on SSI 2004/142. Members have seen its comments. No comments have been received from members and no motions to annul have been lodged in relation to the instruments. Is it the committee's view that we do not wish to make any recommendation in relation to any of the instruments?

Members *indicated agreement*.

Budget Process 2005-06

14:05

The Convener: Item 3 on the agenda is the budget process. I welcome our adviser, Andrew Walker, who will assist us during this evidence-taking session. I refer members to the letter from the minister that has been circulated, which updates the committee on progress on implementation of its earlier recommendations. I welcome the minister to the meeting, together with Peter Collings, the director of performance management and finance in the Scottish Executive Health Department, and Julie Wilson from analytical services in the same department—hello again.

I thank you for your prompt responses to all my recent letters. It is useful to have them for the next meeting. I appreciate the fact that you have come for a session of nearly two hours this morning. I ask you to brace yourselves, although there will be a break after questions on the budget.

The Minister for Health and Community Care (Malcolm Chisholm): Last time I was here for two and a half hours without a break, so this will be an improvement.

The Convener: If we have you for two and a half hours, we will keep you for two and a half hours. For the convenience of members and the minister, there will be a break between items.

We move straight to questions.

Helen Eadie (Dunfermline East) (Lab): The annual evaluation report states that 12 of the 14 health targets are on course to be met. There is good evidence to support that claim for the targets to reduce premature mortality, but the evidence is much less compelling for the other targets. What is the basis for the claim that targets are on course?

Malcolm Chisholm: It would be good for us to be challenged on the targets that are not on course. As the member points out, the health improvement targets are very much on course. At the weekend, there was considerable coverage of issues relating to coronary heart disease and stroke, but there is no doubt that the trend is that we are making significant reductions in mortality in people under 75. That is a legitimate issue to target. Obviously, we want fewer people overall to die from the big killer diseases, but the older people are, the more likely that is to happen. The particular tragedy of health in Scotland is that so many people have died prematurely from those illnesses.

Some of the waiting targets are on a longer time frame, but we believe that we are on track to meet the target for in-patient treatment. The fact that we met the target for a nine-month maximum wait by the end of December was an important signpost on the way. On cancer, the latest information is that 84 per cent of people are getting treatment within two months of urgent referral, so we think that we are on track to meet that target. We know that there have been particular problems with out-patient waiting in Scotland, but we are dealing with those in a radical way through the centre for change and innovation's out-patient programmes. We think that we are on course to meet that target, too.

In many cases, we are exceeding the target for access to health professionals. Recently I spoke to the Scottish primary care collaborative, which aims to offer people an appointment on the same day. Many practices in Scotland are already achieving that. It would be helpful if the member could flag up the targets that she thinks are particularly problematic.

The Convener: I will assist Helen Eadie by passing her a copy of the AER.

Helen Eadie: I refer the minister to the following target:

"All hospitals to have made significant progress towards the Clinical Standards Board for Scotland standards on infection control and clean hospitals by April 2003 and to make further progress each year thereafter."

The report states:

"The first part of this target has been met. The Clinical Standards Board for Scotland/NHS Quality Improvement Scotland (QIS) and Audit Scotland reports on NHS boards' performance against infection control and cleaning services standards were published in January 2003. These showed that performance had improved but that some boards were still falling short in some areas. Local improvement plans have been agreed between Audit Scotland and each board in terms of cleaning services, and boards are being supported to further improve their infection control performance through the work of the Healthcare Associated Infection (HAI) Taskforce set up in January 2003."

The question is whether NHS Quality Improvement Scotland will be able to deliver on all those targets to ensure that all the necessary progress is being made.

Malcolm Chisholm: We certainly think that we are on track. Problems were flagged up in the Audit Scotland report of January 2003, which showed that more than 20 per cent of hospitals had a clear need for improvement. In each case, the hospitals have agreed action plans with external auditors and the latest indications are that progress is being made. I am not in any way complacent about the situation, but all the indications are that improvement is being made in that area.

The Convener: I did not understand the answer. How do you measure that? Many people are very concerned about hospital-acquired infections. You

say that progress is being made, but how do you know where you are starting from or where you ought to be to show that progress has been made? How do you measure progress?

Malcolm Chisholm: We are highly dependent on NHS QIS, which is the body that is incorporating the Clinical Standards Board for Scotland. It goes round hospitals and makes reports. In relation to clean hospitals, Audit Scotland has a role as well. We set the target against the reports of those bodies. We are not making the judgment; the external bodies that produce the reports and carry out the assessments do that.

The Convener: They are doing the reports and the assessments, but you are the minister, so you have to set some kind of target. Am I correct? You need to say, "That is not good enough; the target has to be such-and-such." I am trying to establish how you measure progress. How do you know that it is being made?

Malcolm Chisholm: If one is making steady progress towards a final standard that has been set by those external bodies, that is an acceptable way in which to proceed. The idea of having continuous improvement is good, as long as one measures it and can demonstrate progress. In this case, the ultimate yardstick is the standards that have been set by those external bodies. We are measuring progress towards those standards.

The Convener: Has a time limit been set for meeting those standards?

Malcolm Chisholm: We are talking about significant progress. We have not set a timescale for the achievement of absolute perfection; we are saying that we want there to be steady progress towards meeting those standards.

Shona Robison (Dundee East) (SNP): You started off by talking about the comment in the media at the weekend about coronary heart disease. I want to ask you a general question about that. It was highlighted that there has been a rise in the number of men who suffer from coronary heart disease and a rise in the number of women who are dying of strokes. Target 1 in the AER is on coronary heart disease and target 3 is on stroke. If those trends continue for the next year or two, where does that leave your key targets—targets 1 and 3?

Malcolm Chisholm: The first thing to say is that, genuinely, we must consider trends rather than figures for one year. The figures to which you refer were not to do with under-75s, although that is not to say that we should not consider them carefully. The reality is that, although the increase that you have flagged up related to the incidence of CHD among all men in one year, the trend is still very much downwards. I think that there has been a 23 per cent reduction in the incidence of CHD over 10 years and a 30 per cent reduction in mortality. The position is similar for stroke—the trends are still downwards, notwithstanding the upwards move in one year.

The trends are what matter, but that does not mean that I am in any way complacent about the situation. More detailed analysis is required. Some people are saying that stroke mortality among women is very much to do with the aging population and so on. I will not give a final view on that, as further analysis is required. Even those trends are strongly downwards but, among under-75s, the trend is even stronger. That is where we have had significant reductions over the past few years. We are definitely on track to meet the target on that. Even the latest figures show a continued reduction. The two figures that Shona Robison mentioned do not affect the trend or the target for under-75s.

Mr David Davidson (North East Scotland) (Con): The British Medical Association gave us some written evidence that casts doubt on one or two of the minister's targets. There are three examples that I would like to run past him, and he hinted at one of them earlier on. The BMA says that, under the general medical services contract for general practice, offering 48-hour access is optional for general practitioners. It asks why the Executive has a national target and why it is committed to meeting it when the scheme is voluntary.

14:15

Malcolm Chisholm: The BMA has been making that point about that target for a long time, but I have met a large number of GPs—most recently, two weeks ago at the primary care collaborative—who are seriously engaged not only in meeting the target but in surpassing it. The evidence that I am getting, not just from GPs but from the whole primary health care team, is that that is not only good for patients but is incredibly good and motivating for the staff who work in general practice. By changing the booking systems and taking a team-based approach to care, they are finding that the stress and difficulty of their job are considerably lessened. Doctors and other primary health care professionals on the ground are enthusiastic about that. I know that the BMA is still officially against the target, but I merely make the distinction.

David Davidson went on to make a further point. We have incentivised the target through the quality and outcomes framework of the new GMS contracts, so there is an incentive for practices to meet the target. Perhaps he is suggesting that there should be a stick rather than a carrot. Let us see how it works out in practice. As I indicated at

question time last week, we are making enormous progress in reducing waiting times, and not just for seeing a GP, because the target is for seeing the appropriate primary health care professional. In practices involved in the primary care collaborative, we are getting beyond the 48-hour target and the target is to offer same-day appointments.

Massive strides have been made. Let us acknowledge the work that has been done in primary care. If problems are shown to exist that we had not anticipated, we can always look at other ways of doing things, but incentivising the target and acknowledging the fact that doctors and others in primary care realise the benefits for themselves will enable them to deliver.

Mr Davidson: My point is that many of them are trying to deliver anyway, regardless of whether the Executive has a target. If you put an incentive in place, it is for them to take it up or not to take it up. That is what an incentive is; it is not a stick. Perhaps what they are worried about is that a target may be seen more as a stick than as anything else.

I would like to take you up on another point. There is a target for cancer patients to be treated within two months, but I have a constituent who could not even get her breasts screened within two months. The big claim is that that is what will happen, but how can you be sure that it will be delivered? There has been a problem in England with that very target. Is there the capacity in the health service system to guarantee that it will be delivered? That seems to be where the Executive is going, but the BMA takes issue with that point.

Malcolm Chisholm: The target is for 2005, but I suppose that one of the functions of targets is to focus people's efforts and priorities. In the case of cancer treatment, the target is very much directed at ourselves. As you know, there is a massive programme on cancer, involving the cancer strategy and building up staff and equipment capacity for diagnosis and treatment. We are in the middle of a big cancer strategy implementation, so we believe that we can meet the target. As I indicated, we are making significant progress towards it.

Of course the BMA can flag up specific concerns, because there will still be areas of cancer treatment and care where there are problems, and it is perfectly legitimate that they should be flagged up. I am merely saying that I think that we can do it, but it will obviously require a big effort.

Mr Davidson: You mentioned 2005. Is that a hope or is it a prediction of when the target will be delivered?

Malcolm Chisholm: That is what we are aiming for and we believe that we can achieve it.

Mr Davidson: My final question is on smoking cessation. The BMA says that the target of a 2 per cent reduction is really not on. Why is the target not something like 10 per cent? Are you likely to stiffen your resolve and set a higher target?

Malcolm Chisholm: At the moment, we are doing better than that. I am open to your suggestion that we could set a stricter target, as I hope that we will achieve better than that. The target was set some time ago, and I accept that we want to do better than it. Current indications are that we are doing a bit better than that.

Mr Davidson: Are you likely to consider changing your targets at the end of the Executive's consultation on smoking cessation, which will take place over the summer? Are you waiting to get that through?

Malcolm Chisholm: There is on-going consideration of that target, as there is of other targets.

Kate Maclean (Dundee West) (Lab): I have a tiny follow up to that. How do you measure smoking reduction?

Malcolm Chisholm: I cannot answer that question in detail because I do not know.

The Convener: I have a small supplementary question, seeking clarification. The target that David Davidson mentioned was to wait for no longer than two months from urgent referral to treatment, so the referral would have to be urgent. Can you define that?

Malcolm Chisholm: That would be down to clinical judgment.

The Convener: So some people might wait considerably longer.

Malcolm Chisholm: Yes.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): Waiting times will always involve on-going discussions with health boards, as you said last week. Has the time not come to confirm patients' rights to minimum waiting-time guarantees?

Malcolm Chisholm: We have progressed significantly on the issue by giving guarantees beyond what applies in the rest of the United Kingdom, although I believe that similar guarantees apply in England for patients with heart disease. We have extended that to all in-patient treatment and to heart surgery and other heart procedures such as angioplasty and angiograms. That significant progress has taken place only this year. It is the correct way forward and it appears to be bearing fruit.

I know that you have lodged an amendment to the National Health Service Reform (Scotland) Bill to place the issue in primary legislation. I am against that and obviously there will be a fuller debate about that during the stage 3 debate on Thursday. If we give boards the legal duty to deliver treatment within a certain waiting time, we will be giving preference, in law, to elective surgery over emergency care and that is fundamentally wrong. At the end of the day, it would mean that, in an extreme situation, a health board or a clinician would be duty-bound to treat somebody who was waiting for elective surgery before an emergency, and that would be quite wrong. It would be wrong to give that status in law to elective treatment when it does not exist for emergency care.

Shona Robison: In its evidence, the Royal College of Nursing suggested that the target of 12,000 more nurses by 2007 will not be sufficient. One of its key arguments is that the target does not take account of those leaving the profession. If you believe that you are on course to meet the present target, is there not an argument for making it more ambitious, for example by taking into account those nurses who are leaving the profession, so that the 12,000 nurses are additional?

Malcolm Chisholm: No one is saying that we could get 12,000 additional nurses within that time. However, there is an unprecedented increase in the number of additional nurses entering the NHS. For example, last year a net increase of 1,000 extra trained nurses entered the NHS. We have figures on that and it is unprecedented in the Scottish NHS no matter how far back we look.

Recently, we had a constructive meeting with the RCN to discuss the issue. It is true that the 12,000 target is a recruitment target. Just because the other side of it is not embodied in the target does not mean that the work, which focuses on retaining the existing nursing work force, will not be done. It is crucial to ensure that as many as possible of the 12,000 extra nurses represent a net increase. We will also focus on student attrition. We have agreed to do further work with the RCN on that and I chaired the facing the future group on nurse recruitment and retention. The next meeting will focus on the retention of older nurses. I accept that the recruitment target does not tell the whole story; however, the fact of the matter is that it is still an important target.

Shona Robison: If the target was phrased in terms of a net increase, how many thousand additional nurses would be recruited by 2007?

Malcolm Chisholm: As I say, it is confusing when we are talking about nursing. Sometimes we talk about qualified nurses; sometimes we talk about the whole nursing work force, including health care assistants. If we focus on qualified nurses, 1,000 extra nurses was the highest number of extra nurses ever achieved in the history of the NHS in Scotland. Obviously, we want to improve on that, year on year, but, because 1,000 is the most extra qualified nurses that we have ever had, I think that a 12,000 net increase is unrealistic. We want to build on the position. I would not pluck a figure out of the air at this meeting, but we are continuing discussions with the RCN to try to establish agreement about the net increase that would be required.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): It is important that we keep nurses within the NHS. Our new nurses are learning and do not have the experience, so it is extremely important that we keep the ones who have knowledge within the system.

I am disturbed by the number of people in my constituency who have approached me because they are having great difficulty in getting grievances in the NHS sorted out. I can think of three extremely experienced nurses whose grievances have not been settled although they have gone on for two or three years. If such information on health boards is held centrally—it may not be—do you have figures for the number of nurses who are suspended or not in work because of stress-related illnesses arising from the fact that their problems are not being resolved?

Some very experienced nurses are leaving the service never to come back to it. It distresses me that there seems to be no system within the management set-up to deal with such things quickly so that they do not smoulder for two to three years, by which time the NHS will have lost those nurses. I would have thought that that is as important as getting new nurses into the system, because new nurses need experienced nurses to help them out.

Malcolm Chisholm: I agree that that is an important part of retention. I do not have figures for that in my head, but I can find out whether such figures exist. If they do, I will communicate them to you. Grievances are one area to address; health issues are another. Someone who attended one of my surgeries recently told me that, because of things that had happened to her, she needed occupational health support to go back to work. We need to consider all the issues relating to the retention of nurses—that is the correct way in which to proceed anyway if we are to value nurses. If we have the figures for which you have asked, I will certainly communicate them to you.

The Convener: That would be useful for the committee, as we are about to embark on an inquiry into recruitment and retention in the NHS.

Any information that we do not have to dig for will be gratefully received.

Mr McNeil: First, on the question of retention, you must have been disturbed by the reports over the weekend and the effect that they will be having on the morale of nurses and staff in the NHS. It has been suggested that the hard-working staff in the health service are about to lose substantial earnings. What is your comment on that?

Secondly, what moneys are available for work-force development and what barriers do you see in that area? We have a shortage of paediatricians, for example. I meet nurses who work in paediatrics who are not being allowed to develop as they should and could. How much money is available for work-force development and are we tackling it seriously to address the shortages that exist? What barriers are we coming up against in terms of interest groups that would prefer their control to continue and whose interest is served by the shortages?

14:30

Malcolm Chisholm: I hope that there is nobody in the latter category.

Mr McNeil: We will consider that in our work-force planning review, in which we will bring some vested interests into play.

Malcolm Chisholm: On your first point, I was slightly puzzled by the story in the Sunday newspaper. There are two main unions involved, but the reality is that the Royal College of Nursing has voted to support agenda for change by a 9:1 margin. The simple reason for that is that the vast majority of nurses stand to gain from agenda for change.

The issue that the newspaper article flagged up was that some staff will lose under agenda for change. However, at the end of the article, there was a reference to the fact that I had made it absolutely clear that nobody in Scotland would take a pay cut as a result of agenda for change—nobody will earn less cash next year than they did this year. Some people will gain more from agenda for change than others will and some people will be losers, but I have made it clear that there is an element of protection. I accept that ballots are still to be held by two of the main unions, so we will have to wait and see how that goes.

Your second question was about money for work-force development. There is a big budget line in the annual evaluation report for NHS Education for Scotland and most of that money is for the training of a variety of health care staff. There is also a specific budget line for nurse education and training. I remember that we had some discussion about those lines the last time that I was here, although that might have been for a previous year.

A lot of money is going into the area. In general, more money, focus and activity are going into work-force planning and development. All that takes time to bear fruit but, in the main staff groups, the numbers of staff are increasing—you will be aware of the partnership agreement targets for consultants, nurses and allied health professionals. We have a commitment to train more staff in each case, but there are also work-force development programmes for continuing professional development. Agenda for change recognises the professional developments that staff undertake in the rewards that they receive. Although there is a big agenda for work-force planning and development, that does not mean that more cannot be done or that problems will not remain. Such development takes a long time, particularly the training of doctors.

The Convener: We appreciate that, minister.

Mr McNeil: You said that money is available. When was the budget set? Given the drive and acceleration of the acute services review and the centralisation programme, does the budget reflect what we need to do now? Many of our communities will increasingly depend on specialist and consultant nurses to deliver local services, which are very much in demand. Do we need to review the budget? Do we need to accelerate the process if we are to meet—even halfway—the demands of the communities that we represent for delivery of local health services?

Malcolm Chisholm: We certainly need to keep reviewing and accelerating those programmes. I met the new chief executive of NHS Education for Scotland within the first week of his taking up his post in April. I thought that it was important to do that because NHS Education for Scotland is a key organisation. I spoke to him about specialist registrars, which is the level below consultants, to make sure that the expansion in that important area would take place during this year.

You mentioned specialist nurses. The expansion in the number of nurse consultants is a partnership agreement commitment and we are making progress on it. That is an important development not only for the delivery of care, but for the career opportunities that it provides for nurses. We are also expanding the numbers of allied health professionals and the opportunities that are available for them. We have programmes of work for each of the key staffing groups.

Money is obviously one factor in those programmes, but we also need to assess how many people it is possible to bring in within a given period. Shona Robison said that it would be nice to have a 12,000 net increase in the number of

nurses over the next three years, but I suspect that, no matter how much money I threw at the problem, it would be difficult to find that number of nurses within that timescale without going in for mass recruitment from overseas. There is an issue about supply as well as money. We are making progress, but I am sure that the committee will ask us to do things differently once it has completed its inquiry.

Mr McNeil: Can you provide more detail about the moneys that are being allocated and whether there are any plans to accelerate the provision of those moneys? What discussions are taking place with the various organisations to bring about that change in numbers and to effect a change in the duties that people can perform within the health service? How quickly will those changes take place?

The Convener: In addition to that, minister, do you have information—I appreciate that it may not be available or may not be able to be retrieved—on how many nurses leave the NHS to go into private commercial operations? Do you know how many NHS nurses become agency nurses? I would quite like to have that figure to see whether, instead of leaving the NHS entirely, people are coming back into the service at more costly rates.

Malcolm Chisholm: That is certainly a big issue and we will provide the committee with the figures that we have on it.

Last week, the facing the future group, which I chair, published an important report on nursing work load. One of the report's key recommendations was that we need to exert downward pressure on the numbers of agency nurses and to ensure that local health systems convert agency nurses to staff on more permanent contracts. That is an important part of the way forward.

Mr Davidson: One way of attracting people into the health care professions is to provide access to continuing professional development. Does the minister sympathise with the RCN's desire to have three days of CPD each working year? Is there money in the budget to cover that?

Malcolm Chisholm: We have not made a specific commitment on three days' CPD. At the moment, we have said that everyone is entitled to CPD. For nurses, in whom the RCN has an interest, we have dedicated annual funding to boost CPD by providing an extra £1.7 million a year over and above the existing CPD budget. Over the past couple of years in which that money has been provided, there has been a large expansion in CPD opportunities for nurses. However, we have not made the particular commitment that you mentioned.

Mr Davidson: I understand that specific moneys have been provided, but the nurses are seeking to be paid for those three days of CPD. In other words, the CPD should be done during working time. The health boards will require resources if they are to be able to provide that. Is there any money for that within the system?

Malcolm Chisholm: The extra money that has been provided allows people to be released from their work to attend CPD, so that should not be an issue in the nursing initiatives that we have supported.

Mr Davidson: Can we have a breakdown of those figures?

Malcolm Chisholm: If you want detailed information on how the £1.7 million has been spent, I can send it to the committee.

Mr Davidson: That would be helpful.

Shona Robison: For the record, it is important to clarify that the concern about the target was raised by the RCN, which had been led to believe that the target was to recruit an additional 12,000 nurses.

Minister, you mentioned the target for nurse consultants. Will you remind us where we are with that? What is the target and how far away are we from meeting it? How does our target compare to the levels of nurse consultants in England?

Malcolm Chisholm: I am perfectly willing to acknowledge that England is ahead of us in certain areas. I have been up front about that in relation to nurse consultants. It was a great frustration to me that so little progress on nurse consultants was made before the election. That is why I told the RCN conference a year ago that we would triple the numbers of nurse consultants from 18 to 54. I think that 27 are on the ground now, but I do not have the figure in front of me. More important is that a lot of other posts are being planned. Obviously, it takes some time to work up the details of the posts. We have made reasonable progress in the year since the election and we are on track to meet our objective.

Dr Turner: The RCN is worried that filling the nurse consultant posts would lead to a shortage of other nurses. We cannot keep replacing doctors with nurses, because that would lead to a deficit of nurses to do the rest of the work that nurses used to do. The RCN flagged up that point in some of the documents that I read and I understand why it has concerns.

There are still not enough nurses on duty, especially at night. I understand that sometimes there are not enough nurses covering the job and that health boards are reluctant to pay for staff. I hear about such problems in intensive care and coronary care units, in which people cannot have

operations because there are not enough nurses to do a lot of the background work that should be done. Such problems put stresses and strains on the nurse's professionalism. She may reach the point at which she must figure out whether she can continue to do the job to the standard to which she has been trained and, at that point, she may decide to leave.

The Convener: The minister has already undertaken to try to provide the committee with statistics on the number of nurses who leave due to stress.

Dr Turner: That is an issue, too, but the problem is also about employing enough nurses. I have spoken to nurses who have said that extra nurses are not allowed to be hired because of financial constraints on health boards.

Malcolm Chisholm: There are financial issues. I agree substantially with what Jean Turner has said. Nursing issues have been important to me throughout my time as Minister for Health and Community Care. We are making progress, but the RCN and others say that we need to make more progress. We had a constructive meeting with the RCN, which is—along with Unison—fully involved in the facing the future group. We are addressing the issue in partnership.

I flag up the report on work load that came out last week. It is an important piece of work that will help to address some of the issues that Jean Turner raises. One of the problems is establishing the number of nurses that there should be in a ward or in a hospital—that can vary across Scotland, as people might not use the same methods to calculate how many nurses there should be on a ward.

The steering group's work on the project and the report that has been produced have carried that agenda forward significantly, so the number of nurses on a ward is now likely to be calculated more objectively and with greater consistency throughout Scotland. I recognise that there are serious problems with work load in some wards in Scotland; that is one of the major issues that nurses have raised with me over the past two years. The project has carried the work on that issue forward.

Jean Turner is right to mention funding, because there are funding issues. I am clear that there has to be an expansion of the nursing work force. We should remember—the matter is part of the work-force planning agenda—that the skills mix is changing across the board. Just because nurses are doing things that they did not do in the past—a major piece of work is on-going on nurse role development—that does not mean that they are also doing all the things that they did in the past; health care assistants or other health care professionals might be doing some of the things that nurses used to do. That is why work-force planning must be done on a multidisciplinary basis to work out some of those skills-mix issues.

The Convener: This may be a very stupid question—it probably is and I probably should not ask it because it will make me look stupid—but is there any guidance on the number of patients per nurse? I understand that there are other intricacies. There may be guidance on the number of patients that a general practitioner can have, but is there guidance about that for nurses?

Malcolm Chisholm: That is precisely the kind of territory that the work-load report went into. Sometimes, different hospitals use different systems and the work-load group has tried to introduce more standardisation and greater consistency. However, it would not be possible to give an overall ratio of nurses to patients. Intensive care is an obvious example of the fact that different kinds of wards require different numbers of nurses.

14:45

The Convener: Is that being looked into?

Malcolm Chisholm: If we have not sent you a copy of the work-load report, we should send you one. That report is, if I may say so, relevant to your more general work on the work force.

The Convener: We do not have a copy, but one would be very useful.

Mr McNeil: Minister, we have heard what various organisations think of the national targets. Is this a good time to review those targets? Is there scope to change the emphasis? Last year, you suggested to the committee that two of your priorities would be service redesign and public involvement. I accept, as I think others do, that those issues affect existing targets. Do you agree that targets have to be realistic and flexible and that they have to be constantly assessed so that new priorities can be introduced? Targets that have been reached can be dropped. What kind of work is your department doing to evaluate targets and to change them?

Malcolm Chisholm: The targets are for this spending review period—which is three years officially, but tends to be two or three years. Obviously, we are now considering the next spending review period. You make some fair points; we are certainly considering how we can achieve what the committee, in its recommendations, correctly calls "SMART" targets for public involvement and patient focus. The agenda is not just about the wider public; it is specifically about patients and their involvement. Achieving specific, measurable, achievable,

relevant and time-limited targets for that is challenging, but I accept in principle that we should have such targets. We will certainly try to have them for the next spending review. I am not saying that the present targets are the final targets, because the situation is evolving. I do not disagree with the principle of what you say.

Mr McNeil: For the next spending review, will you be giving the committee information on how you intend to involve the public and the committee before targets are set or will we just hear about the targets when they have been set?

Malcolm Chisholm: That is an interesting process issue to do with the spending review, but it is not really one for me to answer. As you know, an announcement will be made in the autumn. The arrangements will be the same across the Executive. Peter Collings will know about that.

The Convener: Minister, did you say that the targets are not for you—

Malcolm Chisholm: No—the targets are for me. However, Duncan McNeil's question was on the process of how spending reviews are developed and how committees are involved.

The Convener: I thought that he was asking about input from the committee and the public in respect of those targets, rather than about processes. He was asking about substantial input.

Mr McNeil: Convener, I was picking up the minister on his point that there could be a role for the public and the committee in engaging in discussions on the targets that are to be set. The minister has certain priorities, but other priorities have been set by society in general, I suppose. How can we influence the process?

Malcolm Chisholm: I was just making a point about the process of the spending review, which we are obviously already well into. I do not know what the involvement of committees in that process will be. I have no doubt that I should know, but I do not know what the Minister for Finance and Public Services has said about the matter. Peter Collings may be able to help.

Dr Peter Collings (Scottish Executive Health Department): Thus far, the engagement has been between the Minister for Finance and Public Services and the Finance Committee, rather than between him and committees more generally. We expect an announcement in September. If committees have views, it would clearly be extremely helpful to hear them before the summer recess.

Janis Hughes (Glasgow Rutherglen) (Lab): Our budget adviser has been working to obtain financial plans from health boards for the current financial year. It is unfortunate that, although we are more than a month into the current financial year, we have been able to obtain only three such plans. That seems to be a recurring problem—at the beginning of previous financial years we have been unable to see the financial plans for all health boards. What are your views on that? Do you have any mechanisms in place to ensure that the situation does nor recur year on year?

Malcolm Chisholm: We discussed that issue the last time I was before the committee, when we talked about the fact that things are out of synch. We are looking at the budget for 2005-06 and the plans that you have or have not received are presumably for 2004-05. However, no doubt you are saying that you would have liked to have had more plans from health boards for this year. I know that there has been at least one meeting with some committee members, if not all committee members, and Andrew Walker on getting more information from health boards. Peter Collings and Julie Wilson may wish to comment on those issues.

The Convener: The meeting was with the deputy convener and me.

Dr Collings: The reason why the committee has not received more plans is that a number of boards are still working on their budgets for this year. They do a first cut of the figures early on, but they are still evaluating how much pressure there will be, what developments they can afford and what savings they need to look for—there is a moving target.

We have said that we will provide the committee with a summary of the local health plans once they are all in. Some of them are finalised, but most are in draft and awaiting approval by boards. We will also provide some summary financial information on the forward plans of boards once we have a complete set. Julie Wilson can expand on that point.

Julie Wilson (Scottish Executive Health Department): Following the meeting at the beginning of March, we provided Dr Walker with all the information that we currently hold on the breakdown of the money into care programmes. It would be beneficial for the committee to examine what is spent on that basis. Once we have all the financial plans, we can link them together, to give the committee the past trend and the projection. On finances, the local health plans have a tie-up element at a very aggregate level.

We also supplied Dr Walker with information that he wanted to examine on high and low-value treatments. We should agree on a basket of that information before we get fully under way, but I thought that it would be helpful to look out the four or five items that he flagged up in the first instance. It might be useful if we have a follow-up session, because the type of information that the

committee wants to build on for the next budget discussion may need quite a bit of work and we should not lose too much of this year if we want to be in a position where the committee has everything that it wants for next spring.

Janis Hughes: I welcome that helpful offer. Dr Collings, when will you be able to give us the information that you mentioned?

Dr Collings: I hope to have it in June, but where boards are in the process varies. We are pressing them to provide us with the information but, as you will be aware from reports of health board meetings and the papers, some of them are still reshaping the budgets for this year. It is hard to judge, but I hope that we will have the information in June.

Janis Hughes: We have seen only three financial plans, but they predict financial shortfalls that will be covered by non-recurring money or cost-recovery programmes that will affect front-line services. People are concerned that front-line services may be affected by recovery plans to address deficits that have built up over a period of time. Does that give you cause for concern? How do you plan to address that issue when you see the recovery plans of the boards that are in deficit? Indeed, some boards face a substantial deficit.

Malcolm Chisholm: Peter Collings can provide more detail, but I think that three boards are in deficit.

Obviously, boards face particular challenges this year, because all the new contracts will kick in simultaneously: agenda for change, which was mentioned in passing; the consultants contract; and the GMS contract, although the funding for that will not flow through the mainstream allocation to NHS boards, but will be provided separately through ring-fenced money. The fact that those contracts will come on stream together will present difficulties, but we will do all that we can to help boards in that difficult situation. I managed to distribute an extra £30 million just before the end of the financial year—boards obviously welcomed that money, but it will not address all their difficulties. I will see what else I can do during the year through any further distribution of money—for example, if we save money from central budgets, as we did last year with the £30 million.

The reality is that the new contracts will bear fruit, although it might take time for some of them to bear their full fruits. The new contracts present great opportunities to employ the work force differently by providing more team-based care and direct clinical care and by offering more flexible working. I certainly think that the contracts are worth while—they are very much about money for change in terms of service development and improvement—although they will present challenges in the year in which they start to operate.

Janis Hughes: It appears that some of the larger boards are hoping to recover moneys from the smaller, neighbouring boards to which they provide services. The recouping of such money appears to be part of the larger boards' recovery plans, but it places more financial pressure on smaller boards. Will you comment on that?

Malcolm Chisholm: I presume that you are talking about money for cross-border flows of patients. There have been issues about that and I think that we are making progress, but perhaps we need to make more progress. Peter Collings will talk about that in more detail.

Dr Collings: There is a range of issues in relation to that matter, one of which is whether the major teaching boards are adequately compensated for the complexity of the cases that they deal with when they take patients from other board areas. A lot of work has been done on that in the east of Scotland, where arrangements are fairly stable. In the west of Scotland, there remains a debate about whether compensation is adequate.

The minister mentioned pressures such as the consultants contract. Boards that provide services to other boards will expect that increase in their costs to be reflected in the payments that they receive from those other boards. The discussion about what would be a fair adjustment to payments to reflect the increasing costs must take place between the boards concerned.

Mr Davidson: Minister, you appoint health board chairmen and you meet them regularly—I think that you meet them monthly. What guidance or instructions did you give chairmen in advance of their preparation of financial plans for this year?

Malcolm Chisholm: Again, Peter Collings can respond to that, because a lot of that work happens at chief executive level, as well as at chair level. Obviously, all boards must live within the resources that they are given; that is a key issue in health management and a primary duty of the chief executives—who are the accountable officers—even more than it is of the chairs. Within that context, boards have to take account of the priorities and targets that need to be met, which must be uppermost in their minds when they plan for forthcoming years. Obviously, we give them as much information and intelligence as we can about the various pressures that build up in the system.

15:00

Dr Collings: The other point that we made, with which the boards completely agree, is that it is important to try to find savings on non-clinical

costs. For example, there are savings on overhead costs from the move to single-system working and we are working with boards to see whether we can achieve substantial cost reductions in NHS Scotland by aggregating procurement. We have said that those areas are the first places in which they should look for savings.

Mr Davidson: So that guidance has been given by Dr Collings's department to—

Dr Collings: Those points were made at meetings with the chief executives. As well as meetings with chairs, the department has monthly meetings with the chief executives, which are chaired by Trevor Jones as chief executive of NHS Scotland.

Mr Davidson: Does the minister's response mean that, in the main, he leaves it to the civil servants to deal with the mechanics, or has he given any specific details on the outcomes that he is looking for next year?

Malcolm Chisholm: Obviously, the priorities and targets are set by ministers, so at that level there is full involvement. I take a great deal of interest in the state of the finances because, at the end of the day, money is required for all that we want to deliver. I am conscious of the issues and we talk about them at the meetings with chairs. A greater level of detail is gone into at the meetings with chief executives, but that is consistent both with what is said at the meetings with chairs and with the ministerial priorities and targets.

Shona Robison: You said that three health boards are in some financial difficulties, but there could be more; Peter Collings said in his evidence that there are seven others that could go either way. You said that you do all that you can to help boards, but surely the matter comes down to one of two things. If you are fully funding the new responsibilities and boards are unable to manage with the money that you give them, there must be gross financial mismanagement at the local level. If that is not the case, the opposite must be true, namely that you are not fully funding the new responsibilities and boards therefore have to make cuts elsewhere—those cuts form the basis of the recovery plans—to meet the responsibilities. It has to be one or the other and, from the evidence of the health boards, I think that many elements of the new responsibilities are not fully funded. That must surely have an impact on the targets that you set, in that the health boards' ability to deliver on the national targets is compromised because they have to cut back on some of the service developments that would help them to meet those targets.

Malcolm Chisholm: I think that Peter Collings will want to comment further on the seven health boards. The general point that you make relates to the way in which money is distributed to boards. We do not add up all the responsibilities of a board, aggregate the figures then give out the funding—money is not distributed to boards in that way. In the Scottish Parliament, there is three-year budgeting and, in historical terms, generous health budgets have been set. There are a lot of pressures in the system, but that is the way in which budgets are set. Within that, people have to make local decisions about priorities.

I would not make the distinction that you make between the new costs and other targets, because many of the new costs are for staffing, and how else are we going to deliver most of what we want to achieve? I do not accept that investment in staff pay, additional staff and new ways of working contradicts the aims of shorter waiting times and higher-quality care. I have acknowledged that, because of the introduction of the new contracts, more of the new money may be going into staffing this year than has been the case in the past, but I do not regard that as a bad investment for local health systems.

Dr Collings: On the numbers that the seven health boards have sent us so far, I cannot say at the moment whether those boards will end up a little bit over or a little bit under budget, because they are sufficiently close to spending exactly to budget. As at the end of last year, they are not at risk of the numbers suddenly changing so that they are badly in deficit.

Shona Robison: I would like to check one more thing. Is it your assertion, minister, that the new responsibilities that are now on health boards vis-à-vis the contracts and so forth are fully funded by the Health Department?

Malcolm Chisholm: As I say, money is not distributed in the way that you suppose is the case. It goes out as a block to boards, from which they have to meet their various responsibilities. The money is not worked out by adding up all the different responsibilities of the health boards. As you know, we have three-year budgeting in health and the decision on funding was made at the time of the spending review, just as in September we will make an announcement about health funding over the next few years. That is the basis of health funding.

If there are particular pressures from the new contracts, as there are in this case, I will obviously try to help boards by redistributing money within the overall health budget. Indeed, I did so in March with the £30 million that I distributed and I will try to do a bit more of that this year. I do not accept that the situation that you describe is the way in which health resources are distributed.

The Convener: If I may, I will give an example of something that has been brought to my attention. In Glasgow, for example, the £77 million of new money has been used for pay and price inflation, including for the new contracts. There is nothing left for anything else—nothing for your targets. The money has simply been put into staffing—there is a direct correlation. If it is possible to say how much is going to cover pay increases, inflation and the required staffing levels in Glasgow, it must be possible to do that in other health boards.

Malcolm Chisholm: I am not quite sure how many other pressures are included in that figure. It is reasonable for the committee, in seeking information from boards, to ask exactly how much of the new money has been spent in a particular way. I do not know whether we have that information from all boards at the moment.

The Convener: My adviser tells me that we have that information from three health boards. What we are trying to get at is the simple question whether boards are getting into greater deficit because they did not get enough money to cover inflation, staffing and everything else that arose as a consequence of the new contracts. The examples from Glasgow and two other health boards show that there is a direct link.

Dr Collings: In the case of Greater Glasgow NHS Board, one of the issues is its decision last year to fund some costs out of non-recurring money. To that extent, the situation in Glasgow is not the same as that of the other health boards.

The Convener: We might return to the issue as soon as my adviser stops frowning and comes back with a supplementary.

Malcolm Chisholm: The other thing that I noticed about Glasgow is that although it had a lot of publicity for the things that it was not able to do, it was some of the service development that it wanted to build into its plans that resulted in the consequential reductions in other areas.

The Convener: That is right. That is the point that is being made. After it had dealt with inflation and staffing costs and so forth, Glasgow did not have the money for anything else.

Malcolm Chisholm: That is not quite the point that I made.

The Convener: We will leave it at that. We can look at the *Official Report* and see what was said. No doubt I will be given further advice on the subject.

Kate Maclean: I have to say that I am not very happy with the answers that the minister has given, particularly to the last set of questions about the additional pressures on NHS boards. As the issue is one that I have raised with the minister before, I suspect that he will not be surprised that I am doing so again.

I think that your answer is a bit glib and does not acknowledge how serious the additional pressures are. Anybody listening to you would get the impression that, although there is a little bit of extra difficulty and things are a bit challenging, it is all going to work out and the situation is actually good. In fact, the consultant contracts involve more than £50 million of additional resources that health boards have to find. The consultants will be getting higher wages and better training and will be able to perform better, but that does not mean that there will be any more of them. In terms of meeting targets, there will be the same number of consultants but they will cost a lot more. Obviously, something will have to give if health boards are to pay for that. I do not think that the additional pressures have been properly taken on board. Further, I do not think that we know the full effect of other changes. For example, we do not know whether the new GP contracts will put additional pressure on boards.

I do not think that any of us or any business or organisation would like to operate our finances on the basis of hoping that a benevolent minister will rearrange elements of his budget and find a few extra million pounds. That is not a good way in which to ask health boards to operate. Do you accept how serious the difficulties are for health boards?

Is the £30 million that you said that you have already distributed to try to help out a one-off payment or will it be included in the health boards' baseline budgets for next year? If it is included next year, will it be counted as being additional money? Members of the public might think that health boards get tremendous amounts of additional money every year but, in fact, there is such a great amount of committed expenditure and money that has already been accounted for in another way that the amount of extra money that health boards have to spend on new developments is quite minimal.

Do you accept that health boards are facing significant and unusual pressures this year? Is that £30 million going to be counted as part of health boards' base budgets in years to come?

Malcolm Chisholm: I am sorry that I have given the impression that you describe. I did not intend to and I think that I have said on several occasions this afternoon that there are particular pressures this year because of the introduction of the new contracts and that I will do everything that I can to deal with those pressures within the budgets for which I am responsible.

I assure you not only that the investment of £30 million will be repeated but that I am confident

that, before too long, I will be able to find more than £30 million to distribute to help boards to deal with the additional pressures. I am not being glib in any way. I acknowledge that there are particular pressures on boards this year and I am determined to do everything that I can to support boards. I am not fundamentally disagreeing with you.

Kate Maclean: We are asking for financial plans from health boards, but they do not know what their finances are going to look like. They do not know whether they are going to be given extra money to meet the additional pressures. Do you think that that is an acceptable way to have to run major organisations that are trying to deliver key policies of the Government?

Malcolm Chisholm: That is precisely why I hope to find some extra money for them in the near future. I want the boards to be able to take that into account throughout the year. Equally, however, they have to examine their budgets seriously. Obviously, we do not want patient care to be affected in any way as we want to improve and develop it but, as Peter Collings said, boards need to examine seriously the money that they are spending on services in other, non-clinical areas. We have a big agenda in the Health Department involving shared services and saving money through the way in which we deliver non-clinical services.

At both national and board level we must continue to seek ways of saving money in non-clinical areas. Boards should do that, but they know that we will distribute some extra money. That is not something that I am announcing out of the blue today—boards have been told that some more money will come. However, they know that the situation will still be challenging. I acknowledge that that is the nature of this year. I am doing everything that I can to make the changes as deliverable as possible by boards. I assure the committee that I will pull out all the stops to do that.

15:15

The Convener: How was the £30 million distributed? Who got it for what?

Malcolm Chisholm: The Arbuthnott formula was used.

The Convener: Can you provide the committee with an estimate of what the new contracts will cost each board? As we have said, the boards are just meeting policy requirements. I ask Kate Maclean to develop that point. I would like the minister to clarify the situation.

Kate Maclean: That is interesting. Obviously, money has to be distributed using a certain formula, but in other Executive policy areas distribution of money has not been equal in all local authorities, despite the fact that a formula was used. I refer to the McCrone settlement for teachers and the concessionary travel arrangements. Does the same apply to this money, which has been distributed specifically to fund consultants' new contracts? Would it not be better to distribute the money based on how many consultants there are in each health board area, rather than on the Arbuthnott formula? I know that there have been complaints in the past.

Malcolm Chisholm: The money has not been distributed specifically to fund the consultant contract. You make an interesting suggestion. Given that the consultant contract is subject to individual job plans with every consultant in Scotland, the issue is not just the number of consultants but how many sessions they negotiate with boards. Distributing the money on the basis that you suggest would be a very complex procedure. I know that you have questions about the Arbuthnott formula, which you may ask later, but I still think that it is the fairest means of distributing the money.

Kate Maclean: It would be interesting for us to know how many consultant sessions will be provided per health board, rather than how many consultants each board employs, and how much of the additional £30 million each board has received. We could then see which boards have benefited more than others.

The Convener: Because we have to produce our report next week, we will draft a letter and circulate it to members later today or tomorrow, so that they can have input to the minister and, hopefully, get a response before the report is finalised.

Mr McNeil: I am sorry to labour the issue of the consultant contract, but I want to pursue the point made by Janis Hughes. We welcome the additional money, which will relieve pressure on boards. Over recent months, boards have lobbied us concertedly about the shortfall and the disagreement about what should be paid. More important, what is in this for the patient? Although we welcome the money, it will have little impact on the patient. Today you said that the contract was worth while. When he was asked about the patient benefits last week, Peter Collings said that we must pay the going rate to retain people and that if we do not, we will not fill vacancies. He also said:

"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."—[*Official Report*, *Health Committee*, 27 April 2004; c 740.]

How much have the contracts cost us up till now? When will patients see the benefits from that? Who is pulling out all the stops to get the contracts in place as soon as possible so that we start to get value for the money that we have invested?

Malcolm Chisholm: The contracts will be in place soon, but job planning is not a one-off process. The job plans will be continually revised and developed. That is why some of the advantages will take longer to come on stream. Redesigning how care is provided cannot be done in the short period of time that is required for the initial job plan.

In that sense, the contract provides opportunities that must be grasped by the managers on the ground. We have put a lot of effort into communicating to the service the need to take the opportunities that are provided by the new contract. Although the contract is a good pay award, it is primarily about getting more guaranteed clinical care from every consultant in Scotland. Consultants will have to provide seven and a half sessions as a minimum. We know that a large number of consultants have been doing that anyway, but some have not. The contract provides us with guaranteed minimal delivery of clinical care.

The contract provides wider opportunities for managers to have more control over how the consultant's working week is organised so that the consultant can fit into the whole health care team rather than operate as an autonomous individual, as has traditionally been the case. The contract presents a big change for consultants, but Peter Collings is right that it will not suddenly show up in a one-off change in a few weeks' time when all the initial job plans have been agreed. However, we will have made a start that we can build on and develop.

The GMS contract, which has been thoroughly discussed in the Parliament, presents similar opportunities for the delivery of higher-quality primary care for patients. The third contract is agenda for change. As I have already highlighted, agenda for change rewards people for the skills that they use and the roles that they perform by providing a greater connection between pay and the job that a person does. All the contracts will help to improve the quality of care, but it will take some time for those benefits to show up.

Mr McNeil: We do not expect a big bang, but we want some confidence that we will see additional service sessions. When can we expect to see those? 2005? 2006? 2007?

Malcolm Chisholm: We will see some benefits right away, in the sense that all consultants will be required to do seven and a half sessions of clinical care. That will start very soon, once the initial job plans have been signed up to. However, some of the other redesigning of services and roles will take a bit longer.

Mr McNeil: Why do you not just say that you do not know?

Malcolm Chisholm: That is not the correct answer, so why should I say it? I cannot say what things will look like in 2008 and it would be completely wrong of me to do so. David Davidson and others would jump on me if I sat here and said exactly what every consultant in Scotland would be doing in 2007, 2008 or 2009. That will be subject to the job planning between local managers and local consultants. My job is to ensure that they do that job properly and that they seize the opportunities that are provided by the consultant contract. My job is not to fill out the job plan details for every consultant in Scotland.

Dr Turner: The consultants are catching up with the junior hospital doctors, so they will certainly be paid better for what they do. Do you expect the bill for the waiting times initiatives to go down as a result? Will consultants do that additional work within NHS time or will they still get paid £500 a session to reduce waiting lists?

Malcolm Chisholm: Waiting times initiatives will still exist, but they will be standardised across Scotland. Up till now, the way in which the rate that is paid could be inflated has been a problem in certain parts of Scotland, so there will be more standardisation on that. However, given the job planning and the new contracts, we expect that there will be less need for specific waiting times initiatives in the traditional sense.

Dr Turner: A lot of money has gone into such initiatives, but we were surprised that the figure for Greater Glasgow NHS Board was—I think—only £2 million.

I am almost feeling sorry for health boards, because at one point I thought that you said that you had ring fenced the money for consultants' salaries—

Malcolm Chisholm: I said that the money for the GMS contract is separate from health boards' money.

Dr Turner: If Greater Glasgow NHS Board, which is nearly £60 million in debt, has to claw back about £37 million in the first year and the rest in the second year by cutting a lot of services, patients will suffer greatly as a result of the new contract.

I would not like to manage a health board if I could not plan ahead because I did not know how much money I would receive to pay for all the salaries that I had to meet. If the Executive is saying, "We have decided that everyone will have a new contract and be paid more and it will cost

this much money", that money should come out of the central coffers, so that health boards can continue doing what they do without cutting any services. Efficiencies in relation to waiting times should not come out of the extra money; that is divisive in the work force and makes people angry because they think that money is unnecessarily being spent to meet waiting times targets.

I feel sorry for health boards. The money should come from central Government and boards should not have to meet those bills.

Malcolm Chisholm: The money is coming from central Government—I do not think that I can add to what I said about that earlier. I recognise the pressures on health boards, but boards have known for a long time how much money they will receive. In March we supplemented that to some extent and we will seek to do so again in the near future.

Mr Davidson: I note that you said that the money for the GMS contract is ring fenced, but we must consider what boards will be expected to pay out in future. Three boards are currently in deficit and seven are hovering around break-even. What do you anticipate that the situation will be this time next year and what will you do if the budget down south does not bring the routine increases to Scotland?

Malcolm Chisholm: We are not looking "down south", as you put it, in that timescale, because such matters are considered in terms of spending review periods, as I said, so in that sense there is no annual allocation. We know how much money we will have in 2005-06 and obviously we are trying to get the best intelligence from boards about the pressures that their systems are under. Obviously, we also have our own information and we want to take early action. It is precisely because we recognise the pressures in the system that we seek to find more money centrally to send to boards in the near future.

I am repeating myself when I say that boards face particular pressures this year. We are taking a series of actions to deal with those. At the Audit Committee last week, Peter Collings was asked about capital-to-revenue transfers. We hope to help boards by resolving some of the issues around such transfers and I think that we can make progress on that, which is good news for boards. That is one way in which we can help and, as I said, a second way would be to find extra money to distribute in the near future.

Mr Davidson: It might save time if you could send the committee a note to inform us how you set criteria for recovery plans and how you judge such plans. You said that everything goes out on the Arbuthnott formula, whether or not there is a problem, but different boards will have distinctly different problems.

Malcolm Chisholm: I am sure that Peter Collings can provide that information. He could speak at great length on the subject, too, but you have not asked him to do that.

I think that you were making the point that some people might say, "If one board has a big deficit, why don't you just give all the money to that board?" Perhaps that is not what you were saying. We think that, on the whole, Arbuthnott is fair, because we do not want to appear to reward a particular board. Other boards might say, "We have been managing our finances for a long time and now we are being punished, in effect." It is a difficult argument, but in general we think that it is best to distribute money on the basis of Arbuthnott, because that is the fairest way to do so, although it is not perfect.

15:30

Mr Davidson: It is nice to hear you admit that. I was not giving a view; I just wanted to find out what your view was.

Last week, the Scottish medicines consortium ran a seminar for MSPs, which was very informative. One point that came out of the seminar was that when new medicines are cleared for use many health boards do not have the money to take the medicines on board, because many of the medicines are quite expensive, although they might improve health. How does the Health Department ensure that the recommendations of the SMC are carried out on the ground?

Malcolm Chisholm: You raise a series of issues. We have a new system and we have made significant progress in expanding the role of the SMC so that new drugs can be considered well in advance. Chief executives and others are involved in the SMC, so boards have quite a long lead-in time if a new unique drug is recommended for use throughout Scotland. Planning has improved in the past year and we have tried to address postcode prescribing, which has been a big issue for the Health Committee and the Health and Community Care Committee over the years. We think that we have made significant progress.

You asked how we ensure that boards implement the recommendations. We certainly want to establish that they do. If anyone had evidence that a board was not implementing the recommendations, I think that that would quickly be drawn to our attention. I do not think that the SMC's recommendations would be ignored on the sly; it would be perfectly obvious if a drug that had been recommended was not being prescribed in a

particular board and we would take appropriate action if that were to happen.

Mr Davidson: Are you saying that clinicians have the right to prescribe in the best interests of their patients, as long as a drug has been approved, so boards must live with that?

Malcolm Chisholm: That is absolutely the case, yes.

The Convener: Thank you. We will have a short break.

Malcolm Chisholm: Is that the end of questions on the budget?

The Convener: Yes. The next item will be consideration of your letter of April 2004 on the appointment of an expert group to develop a national framework for service change in the NHS and the final item will be hepatitis C.

15:32

Meeting suspended.

15:43

On resuming—

National Health Service (Framework for Service Change)

The Convener: I reconvene the meeting and thank the minister for his prompt return to the table.

I draw members' attention to the letter from the minister, dated April 2004, on the national framework for service change in NHS Scotland. The issue was referred to at the committee meeting last week in relation to two of the petitions that we discussed. I welcome Sandra White, who will sit in with the committee on this item.

We agreed to question the minister on the issues raised in petitions PE643 and PE707, in the context of the announcement. Do members have any questions?

Shona Robison: I will quote from your letter, minister, in order to put my question in context. The letter states that you are establishing an expert group and that its work

"will provide strategic direction to the service as it reconciles the various pressures on sustainable healthcare arising over the coming years."

The group will

"develop a national framework for service change. My intention is that we should provide a strategic framework as well as guidance to NHS Boards to assist them in developing new configurations of service."

The letter also states:

"I envisage an exercise lasting no more than a year, in order to limit uncertainty or delays for local change plans."

Would it not have been good to have had a national framework in place some time ago—perhaps when the Parliament was established—in order to give a context to the centralisation of services that has taken place throughout Scotland? It has struck a number of people on the committee and throughout Scotland that many decisions are being made in isolation and that there is a lack of communication between boards and a lack of public consultation. It seems strange that in 2004 a national framework is suddenly being developed when in some cases the horse has already bolted. Although I welcome the initiative, is it not too little, too late?

15:45

Malcolm Chisholm: I do not think that it is too little. It can always be argued that things are too late. People can always say, "That is a good initiative—why did you not introduce it last year or

the year before?" Shona Robison could probably pick out a large number of things that we are doing and put them in that category, but I do not know how useful it is to go down that route. People can say that the work should have started last year or the year before, or in the first year of the Parliament, but at that time the focus was on other health issues. This issue has certainly become increasingly prominent. People who were members in the previous session of Parliament will recognise that the matter has become the number 1 issue in this session in a way that it never was in the previous one. I am not saying that Shona Robison is wrong—no doubt an argument can be made that we should have started the work sooner—but the important point is to do the work rather than argue about the precise date when it should have started.

I am keen to get on with the work and to involve a large number of people in it. I believe that I have brought together some of the most progressive and enlightened health-care thinkers available. I have great confidence that the group will make a very helpful contribution.

Shona Robison: We are where we are, but as I said, your letter states:

"I envisage an exercise lasting no more than a year, in order to limit uncertainty or delays for local change plans."

That seems to acknowledge or imply that the expert group's recommendations could certainly impact on some of the service changes that are happening locally. You acknowledge that point in your letter and in the terms of reference and scope for the expert group's work. One of the terms of reference that is outlined is:

"providing services in a consistent and equitable manner across the whole of Scotland".

You will be aware that a number of decisions are pending about local services—whether it is maternity services in Caithness or at the Queen Mother's hospital in Glasgow—where a national framework could be of crucial importance. Would it not be better to acknowledge that the framework should be established before further decisions are made? Otherwise, some of the decisions that are taken at a local level could run counter to what is recommended by the expert group in a few months' time.

Malcolm Chisholm: There are a few things to say on that. It is interesting that the examples that you give are about maternity services. Many of the issues and current controversies that are in the forefront of people's minds happen to relate to maternity services. We already have a framework for maternity services and the expert group on acute maternity services—EGAMS—has produced its report. I should probably also have made this point in response to your previous question: it is not as if we are starting this piece of work cold. Work has been done on maternity services and the white paper on health, published last year, dealt with some of the issues, albeit in a more general way. Other pieces of work, such as the acute services review, were done before the Parliament took over.

Obviously, the group will carry on from where its predecessors left off. I do not envisage that its comments on maternity services will be dramatically different from those of EGAMS. When all is said and done, EGAMS consisted specifically of experts on maternity services. The piece of work that we are discussing will not change fundamentally the framework for maternity services that already exists. That is one reason for not freezing decisions about maternity services.

Some issues—for example, those relating to staffing—are very urgent. It may not be possible to delay making some decisions, whether or not one thinks that that is desirable. The group was not set up as a way of freezing decision making and creating planning blight for a year in the NHS. Rather, the aim is to create a synergy between local work and the national framework. A national blueprint will not be imposed. There will be a partnership between the centre and local systems. No one wants us to go down the road of planning the whole Scottish NHS from Edinburgh. However, we think that it is important for us to have a framework. It is consistent to have that framework developed while local systems go ahead with producing proposals for service development.

The Convener: It would have helped if your letter had made it plain that maternity services had already been dealt with elsewhere. It does not do that and refers merely to "configurations of service", which implies all kinds of service.

Kate Maclean: No one would disagree that it is a good thing to have an expert group develop a national framework for service change. The group includes members from Tayside NHS Board for whom I have a great deal of respect and in whom I have considerable confidence. However, I agree with the point made by Shona Robison. We have already had the Primary Medical Services (Scotland) Act 2004 and the National Health Service Reform (Scotland) Bill, which are intended to modernise the delivery of service and to increase patient involvement in the planning of services. There have also been a maternity services review and an acute services review, to which you referred. One would have thought that those measures would have been predicated on the work of the sort of group that you are now establishing.

It confuses me when you say that maternity services have been dealt with because there has been a maternity services review, the result of

which will be pinned on to the findings of the framework expert group. Does the same apply to the acute services review that you mentioned? If that is the case, and given that other issues have already been decided by the legislation to which I referred and will not be affected by the national framework, what will the expert group recommend? In most areas everything is already cut and dried.

Malcolm Chisholm: I was not aware that I was saying that. Shona Robison raised the specific issue of maternity services. I did not say that that issue was excluded from the remit of the group, but that a major framework for maternity services was produced just over a year ago and is available to be used by boards now. Boards do not need to wait for the new expert group to complete its work before they make decisions on maternity services. I do not envisage that maternity services will be central to the group's work, but should the group wish to examine those services further, they will not be excluded from the group's remit.

I am not sure about the other issues to which Kate Maclean referred, but the group's work is not pre-empted. Obviously, it must work within the context of health policy in Scotland. The group knows the parameters within which it will work and will not recommend that we throw out the National Health Service Reform (Scotland) Bill, for example. However, we want bold and innovative thinking. I agree with Kate Maclean's comments about the two representatives from NHS Tayside, whom she knows. The same is true of the group's other members.

One of the issues around service change that challenges me is that, although we need service change—which is, perhaps, better described as service development and improvement—we have to make absolutely sure that we have considered all the options and are coming up with the best possible configuration of services. That is partly what makes me think that we need to do this piece of work. I am not saying that I do not have confidence in boards or that I do not want them to get on with their work; I am saying that I want them to be able to draw on the best available models of care and to be able to work in the best available framework. The work of the expert group is important and is not pre-empted by previous pieces of work except to the extent that it is being done within the general parameters of health policy in Scotland.

Kate Maclean: If the expert group finds that the provisions in the National Health Service Reform (Scotland) Bill are not the best way to manage services, allow public involvement and consultation and deliver joint-agency working, or finds that the results of the maternity services review or the acute services review are just mince and do not represent the best way to deliver those services, will it be able to announce those findings or has it been told that it must work within certain parameters? If it does come to those findings, where do we go from there?

Malcolm Chisholm: We should distinguish between differing issues. Most of the National Health Service Reform (Scotland) Bill, which we will debate on Thursday, is not about the configuration of services as we understand that in terms of the on-going controversies about the hospitals in which certain services should be located and about whether services should be local or centralised. Obviously, the National Health Service Reform (Scotland) Bill is relevant to that in so far as it sets up community health partnerships and ensures that single-system working is enshrined in legislation through the abolition of trusts. All of that is a given for the expert group, which means that it is not going to say that trusts should be reinstated or that community health partnerships are a bad idea. Those areas are not within the group's remit.

From the controversies that are going on around Scotland at the moment, most of us know what we mean by service reconfiguration and that is the remit of the group. The public involvement parts of the National Health Service Reform (Scotland) Bill are relevant to that, but that will not be central to the remit of the expert group. However, we have policies on public involvement that we want to develop and we want the group to have a major involvement with the public and this committee.

Janis Hughes: My question is in a similar vein. We have been talking about this for a long time. About two years ago, as a result of a petition about acute service change and proposals relating to a medium secure care unit in Glasgow, the Health and Community Care Committee conducted a similar exercise about consultation. I am sure that I remember you telling the committee at that time that new guidance would be brought forward. We now have a national framework with terms of reference and a distinguished group of people who will consider the situation and report back in a year but I wonder what on earth will be left to be changed in a year's time. Over the past four or five years, the NHS has gone through some of the most dynamic and far-reaching changes that it has experienced since it was established. It strikes me that, by the time the group reports, there will be nothing major left to change. I accept that change is an on-going process and that the group will do good work to help that process, but the major changes will have taken place.

In the terms of reference that are attached to the letter before us, you mention "partnership" a couple of times: once in relation to the themes

contained in "Partnership for Care"; and once in relation to working in partnership with patients, staff and other stakeholders. That has been the problem all along. In the context of the petitions that we want to talk about today, one of the problems is that the nature of the partnership is such that the views of staff have not been taken on board at an early enough stage. In particular, the views of some clinical staff are different from those of the board. I know that you will never get everybody to agree, but it is important to try to take as many people with you as possible, and in the situation that we are talking about, that has not happened. What are your views on that type of partnership? I do not think that we have got it right, and I am not sure how the terms of reference will deal with that. You talk about working in partnership, but how will you ensure that people's views are taken on board before consultation starts?

16:00

Malcolm Chisholm: There are two issues. We have talked on many occasions about public involvement and consultation, and I understand that the petitions are basically flagging up those issues. The process issue about how we involve people in service change is part of the National Health Service Reform (Scotland) Bill. The expert group, which is made up substantially of staff along with some members of the public, is considering that; more substantively, it is concerned with models of care. I have no direct control over the group whatsoever, and who knows what it will come up with. I am not saying that the two issues are not closely related, but there is the public involvement agenda, which needs to develop and which we will discuss further on Thursday, and then there is the substantive issue of what the best models of care are, in terms of quality of care, clinical safety, local access and so on. The two subjects are related but separate.

I will pick up on your last point, because I did not answer the earlier question on it. As you know, we set up the expert group, which is like the other expert groups that have been set up under the Scottish Parliament—we will, no doubt, touch on a previous expert group under the next agenda item. The group may well come up with things that are challenging or different from what I, you or whoever has been saying. That is part of how we do policy in the Scottish Parliament; we try to draw on the expertise that exists in the field rather than to control and direct everything from the Scottish Executive. The expert group is a bold attempt to capture and tap into the expertise that is out there to benefit the whole of the NHS in Scotland—that is a substantive issue. The public involvement issues are proceeding separately, and I have not asked the group for its views on them because that is not its remit. We have a substantial body of policy on public involvement, which will be further developed by the National Health Service Reform (Scotland) Bill, which we will discuss at stage 3 on Thursday. I am asking the group for its views on how services should be configured in Scotland.

Janis Hughes: I accept that, but one of the most important groups of stakeholders in the argument consists of people who work in the NHS. The difficulty in the situations that the petitions address is that groups of clinical staff have different views and are at odds with each other. We can understand how that upsets the public, who look to clinical staff for their expert knowledge and advice. How do you quantify that?

Malcolm Chisholm: My difficulty is that it seems that I am being asked about two distinct issues. The agenda item is on the national framework for service change in the NHS, but I know—by chance, as it happens, not because it is on the agenda—that there is an issue about the petitions that the committee discussed last week. As I understand it, the issue is public involvement and, no doubt, staff involvement in service change—I think that it is particularly about maternity services in Glasgow, but I am not sure. All that I am saying is that the two issues are separate. We can disagree about the details, but I agree entirely that we need to get better at public involvement—that is what we will discuss on Thursday during stage 3 of the National Health Service Reform (Scotland) Bill. I agree that staff should be involved in that too, but the present agenda item is about something different. I am not saying that it is not related, but it is a different issue from that of the petitions that you flagged up. However, you have made an important point—

The Convener: Minister, if I may interrupt, I have checked the position. Your department was informed that we would refer to the petitions as well as to the letter.

Malcolm Chisholm: Sorry. I followed the agenda rather than anything else, but I accept what you say. I suppose that I was confused when I saw the agenda because I did not know where the petitions would come up. That is the point that I was trying to make.

I agree entirely with Janis Hughes that the particular problem in Glasgow is that different staff groups have had conflicting views on maternity services. In part, that is because different specialists have taken different views of the situation. However, that does not mean that we should not involve staff fully and at an early stage in proposals for service change. It is probably regrettable that more agreement could not be found at an earlier stage among the obstetricians and different specialisms in Glasgow, because it is confusing for the public when one group of

clinicians sends out a message that is completely contrary to that of another group of clinicians. It is not surprising that people are confused when clinicians come out with different messages on maternity services in Glasgow.

Mr Davidson: I echo the respect that others have shown for the people that the minister has managed to get as members of the expert group.

Paragraph 4 of the terms of reference and scoping paper that the minister has provided for us mentions that the national planning exercise

"will draw on a set of values underpinning the modernisation of health services".

The values that are listed contain nothing that one could disagree with. However, in theory the NHS has been run on those values for years.

In paragraph 7 of the paper, the 14 bullet points are written up as if they were new activities. As far as I am aware, the Health Department already takes demographic changes into account. I presume that it also examines trends in epidemiology—although I have raised several questions on those over the past two or three years without receiving a clear answer. One would assume that many of the activities listed in paragraph 7 are going on already. Is your department simply beginning to realise that there is a need to pull together all the bits and pieces of work that are currently being conducted by universities, by the Health Department and so on? If that is part of the exercise, it strikes me that it is a wee bit late.

I will stop at that point to let the minister respond.

Malcolm Chisholm: The fact that work is already taking place in those areas does not contradict the need for the expert group to consider it. In fact, if the work was not taking place, it would be difficult for the expert group to take the work into account.

Paragraph 7 fills out some of the factors that the expert group will want to consider. The first two bullet points provide good examples, because we cannot plan for the future without having some view of demographic and epidemiological trends. Work has been done on those issues, but that does not mean that further work is not required. You may remember that, during the cancer debate that we had before Christmas, I said that we wanted to do more work on cancer scenarios, such as making projections about the future incidence of cancer and the morbidity associated with that. We are simply saying that, in the conclusions that it comes to, the expert group needs to consider and take account of the many on-going bits of work. I do not think that those things are contradictory.

Mr Davidson: In other words, the expert group will pull together the state of knowledge—

Malcolm Chisholm: They will do more than just pull that knowledge together; they will need to take account of it. They will use that work to come to conclusions about service reconfiguration and redesign.

Mr Davidson: The group will report to you in a year's time. For the record, will you confirm that you will consider openly any proposals from the group, even if it proposes that some changes that have been made during your stewardship of the health portfolio should be undone?

Malcolm Chisholm: As you will know, I have great confidence in the group—although that is not surprising when one considers that I have appointed it.

The Convener: The minister may be giving a hostage to fortune by saying that. "Hand-picked" is the phrase that comes to mind.

Malcolm Chisholm: I am not sure. Who do you think appoints groups?

As the next agenda item might illustrate, previous reports have been challenging for the Executive. For the report on hepatitis C, "challenging" is without doubt a fitting word. We cannot say that we will necessarily accept every single word that an external group says before it has reported. That would be foolish. However, I have great confidence in the expert group, and I will set great store by whatever it comes up with. We have to set things in the framework of how service change is carried out by NHS boards in Scotland. If you are suggesting that all the service changes that have recently taken place will have to be revisited, I would say that that is not necessarily the case.

Mr Davidson: In the first parliamentary session, the Audit Committee and the Auditor General for Scotland started examining carefully the outcomes from health delivery. Is the report a one-off, or does it mark the start of a rolling review? Is that an option for the future that you might have up your sleeve? If a rolling review is being undertaken, what are the terms of reference?

Malcolm Chisholm: In a way, it is both. The expert group has been asked to come up with a report within a year, but the work will continue for the Health Department. Obviously, we are not just going to say, "Well, that is done—we'll forget about it for the next few years." It involves both a piece of work to be done within the year and on-going work thereafter.

Mr Davidson: As a matter of interest, what budget has been allocated for the group to do its work?

Malcolm Chisholm: I do not know the answer to that question, but we can find out for you.

Dr Turner: I was encouraged when I read the minister's letter. I go along with what other members have said—that the horse has bolted—but I would like to think that this horse, despite having bolted, might somehow be retrieved and brought back to the stable. It is commendable to accept that things have to be reviewed. I am glad to hear that a report will be produced within a year, and that the Executive will be considering the on-going review of the changes that are taking place. There have never been so many changes within the health service, and they have put a tremendous strain on every part of it. The consultant contracts, the European Community regulations and so on have put enormous strains on the delivery of services throughout Scotland.

We must take stock of the situation. We will not be able to sustain communities throughout Scotland if we cannot provide them with NHS services. I am glad that maternity services have not been excluded from the review. When acute maternity services are taken away from an area, say in Thurso, that changes what anaesthetists are able to do for maternity and other services. It is not just maternity services that are under threat throughout Scotland; it is also general medical and general surgical services.

Returning to the subject of services in Thurso, I met some friends two weeks ago, whose niece was going up to stay in the Thurso area. That young girl and her husband were thinking about starting a family there. They were extremely worried when they realised that consultant maternity services were going to be based 100 miles away, and they are rethinking whether they should in fact stay there and set up a family there. I would not like to be a young woman in that situation, knowing that consultant services were located 100 miles down the road.

I did anaesthetics, and I saw the worst side of maternity services when anaesthetists were called in for emergencies. I have seen the acute side of obstetrics. Once we have taken stock, we should perhaps revise how we provide such services. We might wish to consider rotational consultant contracts, to allow doctors to rethink how they work and to provide services outwith the big towns. At present, I see everything moving east and south. We certainly do not have enough capacity in Glasgow to cover the work that we are supposed to be able to do now.

16:15

I commend the Executive for what it is doing. The first paragraph of the Executive's paper on the terms of reference for the national planning exercise says:

"These include a commitment to safe, high quality, sustainable patient-centred care delivered close to the patient wherever possible and in appropriate, modern specialist facilities when necessary. These themes are supported by increased public investment".

That will be difficult to achieve, but I give you 10 out of 10 for coming up with the idea.

There was a section on public involvement in "Partnership for Care: Scotland's Health White Paper"—I think that it was on page 43. You wanted to ensure that you knew what the public required before you took decisions. However, public involvement, no matter what form it takes, seems to be ignored. Janis Hughes mentioned the secure unit at Stobhill hospital and others mentioned the Queen Mother's maternity hospital. If Greater Glasgow NHS Board's blinkered remit was that only two maternity hospitals could exist in Glasgow, it had to close a hospital, although surely the point about the maternity unit in Yorkhill is that it is a specialist unit. No one has difficulty with centralised specialist units, but everyone in Scotland has difficulty in accessing general services. I support a national framework and I look forward to hearing the expert group's recommendations.

The Executive's paper says that one intention is to remove

"barriers from the patient's pathway of care".

The expert group has just been appointed so it might not yet know how that can be done, but will you give us more information about that?

Paragraph 7 gives a long list. I mentioned line management earlier and it is extremely important that management listens to staff. That would remove a lot of stress from their lives. A good manager would not allow the grievance procedure to continue for longer than was necessary to deal with it: a month is too long and three years is ridiculous. Perhaps that should also be considered.

Malcolm Chisholm: You raise many issues, but you got to the heart of the matter: all those controversies in Scotland centre on the tension between local delivery and centralisation. My approach has always been that we must do both; some services must flow into localities and others into a more centralised location. That is a key tension that the expert group must resolve.

I entirely agree that staff should be involved, but in reality, staff and clinicians disagree about maternity services in Glasgow—and about other matters. You are a clinician and you take one view, but it is fair to say that a large number of

your clinical colleagues take a different view. The group will have to address those issues.

The removal of

"barriers from the patient's pathway of care"

is a general objective. The phrase refers to the development of single-system working in Scotland, which we hope will get rid of the acute sector, primary care and social care silos and try to join up those different sectors. Obviously we want to make that pathway as smooth and as quick as possible, with no big delays at any stage.

The phrase "pathway of care" is a bit jargonish—when we talk about the patient's journey people sometimes think we are talking about the journey from the bus stop to the hospital, rather than through the different parts of the health system.

The Convener: Jean Turner raised an important point. I have a supplementary question, which might seem frivolous.

Will anyone in the expert group consider the socioeconomic impact of changes in services, rather than the narrow—in the most polite sense of the word—clinical provision? That might be useful.

Malcolm Chisholm: That is an interesting dimension, which I do not say is unimportant. As I said in the recent debate on maternity services in Caithness, I recognise the big issues around the service in Wick and I certainly do not want to pre-judge that situation. However, when I responded to the question on maternity services in Oban during question time last Thursday, I was thinking about population centres in Scotland that do not have consultant-led maternity services.

With regard to the area north of the Clyde, I asked myself when, in the history of Scotland, any of those major population centres, such as Oban, had a consultant-led maternity unit. The answer is that they never have had one—I am not saying whether that is a good or a bad thing.

The Convener: I was not narrowing the issue down to maternity services, although they are important. It simply seems that a Government that prides itself on addressing issues in a cross-cutting way should address the issue that I was talking about.

Malcolm Chisholm: I will reflect on what you are saying, but I am merely reflecting the context in which the matter has been raised. I am not saying that the analysis that you mention should not be undertaken, but it would be quite difficult to do so; that is my point. Oban is a major centre of population, but is its maternity care provision stopping people living there? Perhaps that is the issue that we should be considering—I am not saying that it should not be considered—but my thoughts about the population centres north of the Clyde gave me a bit of perspective on the idea of how catastrophic it would be if a certain centre of population did not have a consultant-led maternity unit. Everywhere on the west coast of Scotland has been in that situation forever.

Helen Eadie: The kingdom of Fife has been through the process of the acute services review and as a result has experienced changes that are reflected across Scotland. Above all, people want to feel safe. Whether you are a patient or someone who works in the NHS, you want to know that you have a future. That is the loud and clear message that has been given. That is why I like the point that you make in paragraph 5 in the terms of reference that are attached to your letter, which covers an area that was missing from the work that took place in Fife. There was no big picture or vision of the various models that might support sustainable healthcare provision in Scotland. As Jean Turner said, it would be extremely welcome if that were to be set out. Everyone has seen the process as one that brings threats rather than opportunities. However, in talking to medical people—as we have the privilege of doing from time to time—we learn that they would like some changes to be made in the interests of bringing patient care much closer to the patient. For historical reasons and for reasons of custom and practice, they have been prevented from making those changes. It is important that we get across to the public the message that the process presents opportunities and not just threats.

On the theme of communicating with the public and the staff, it is concerning when we turn on the news—whether it is on the BBC or another broadcaster—and hear someone such as Dr Rosemary Leonard saying that the contracts have been imposed on GPs. Often, no counterbalancing voice is raised when such suggestions are made. The Scottish Executive must be alert to such issues and strive to add balance when misrepresentations have taken place.

Developments in new technology are interesting. I e-mailed the clerk and one or two of my colleagues with information relating to the massive new developments at the Robert Gordon University in Aberdeen, in which Scottish Enterprise is involved. New machinery, such as digital x-ray machines, is being brought in and new practice is being adopted. We are not communicating to the public the ways in which those advances, which will help to bring treatment much closer to home, will impact on service delivery. How are you going to tackle that?

I hope that, for best practice, you will look to the ophthalmology unit in the Queen Margaret hospital in Dunfermline. That is an example of the Executive's targets being delivered way ahead of

schedule in the treatment of cataracts and other conditions. The redesign of the service there has been driven by the consultants, the clinicians and the patients together in a team-based approach. The one concern that I have about the paper that we have in front of us is that, although I appreciate the fact that expert groups have to be made up of individuals who are chosen from your expert team, I do not see any representation from the kingdom of Fife.

Malcolm Chisholm: That last point is a fair one, but I am not sure that we can construct groups by taking one person from each health board. Kate Maclean was kind enough to point out that there are two representatives from Tayside on the expert group. I am happy to say on the record that NHS Tayside has been one of the most successful health boards in engaging with the public and in dealing with the difficult issues of service change, whether at Stracathro or in Perth. Notwithstanding the controversies around maternity services, the board has managed to put a lot of services into Perth in its plans. It is correct that we have two outstanding people from Tayside on the expert group. I apologise that there is no one from Fife on the group, but I do not think that it would be possible to construct the group on that basis.

I thank Helen Eadie for all her other comments. She started by talking about the models. That is the heart of the matter. We want to have the best models that we can possibly get, and we want to learn from the best practice that is available. The trick in health care improvement is to find out fast what the best models are and what the best design of services is and to find ways of disseminating that information as rapidly as possible. I hope that this exercise will be part of that process.

Mr McNeil: It is back to basics with me, Malcolm, as usual—the big, bad wolf.

The paper makes a classic mistake in raising expectations that will not be met. It states that one of the objectives of the exercise is

"to promote opportunities for local access to services and balance local delivery with the need to have centres of excellence providing high quality, modern, specialist care".

That will not happen with the type of panel that has been appointed. I do not believe that the panel will challenge the status quo or the dominant thinking, which is to concentrate and centralise consultant-led in-patient services. That will be the conclusion of the group, just as it was the conclusion of the EGAMS group and others, and that will put a professional seal on the process. I am not saying whether such an approach is necessary or unnecessary in the wider debate, but we must get people out there arguing. However, if that is the way in which we will deliver our health services in the future, we need to be more honest about it. I am sorry. It is not like me to be negative, but—

The Convener: We love it when you are negative.

Mr McNeil: I do not expect the expert group's deliberations to have any dramatic consequences; I expect only that the group will confirm the centralisation of our services. In rural communities that feel disadvantaged or in communities such as those in my constituency, which have a poor health record and a low level of car ownership—Paisley is just as far away for some of my constituents who have to travel to visit relatives—that disengagement cannot help. Such issues are worrying to constituents up and down the country, and we need to be honest about them.

The Executive's paper states that guidance is going to be developed "in tandem". Does that equate to support now for the reviews that are under way in Argyll and Clyde, Glasgow and various other places? Does "in tandem" mean that we can consider those reviews as they unfold? Will these experts, with their blue-sky thinking, consider measures to support health boards in dealing with the issues that they are struggling with now?

We hear that people throughout Europe and the rest of the world would not consider the problems that we are dealing with as significant. They have overcome them, or they work differently or whatever. They would certainly not get as excited about those problems as I do. However, where is that European or worldwide context? Where is that new thinking, or is it just that establishment people will come together and do what they have got to do? Where is the thinking about how other countries overcome geography to deliver effective services in a way that is acceptable to their citizens?

16:30

Malcolm Chisholm: Well, we certainly want to draw on international experience. We have close relations with Norway, for example, on rural health care. Without going into all the details, you will find that the solutions are not fundamentally different from the kind of approach that we have taken. For example, community maternity units, which are used extensively in Norway, are proving quite controversial in some parts of Scotland. We want to make those international connections, and we do not want to be parochial. The phrase "in tandem" means, at one level, that the solutions will be developed simultaneously, but I have used the word "synergy", and I would expect that there will be some kind of relationship between the solutions.

Argyll and Clyde NHS Board is doing some major work this year—it will be aware, as I am, of the work that is being done by the expert group. At the end of the day, Argyll and Clyde's plans, and anybody else's plans, will come to me.

I consider the expert group to be important. I am not a member of the group, but I have adopted a certain position in it; I attend its meetings but, because its members are the experts, I speak only if they ask me a question. If they want, they can ask me questions, drawing on my knowledge and my awareness of what is going on in the world. I am basically there as an observer. I listen to the group and I am influenced by what it is saying. That will feed into the on-going discussions with boards and the approval of boards' plans. The phrase "in tandem" suggests that there will be a creative relationship between what is going on at the centre and what goes on locally. The Executive is not saying that local systems can opt out of what is going on, or that that is not their responsibility any more. We just want to help and support them. In fact, local systems have been asking for some more national work around these difficult issues, so that they can be confident that they are thinking of all the best models that are available.

Ms Sandra White (Glasgow) (SNP): Malcolm Chisholm mentioned the fact that maternity services, which are the subject of petition PE707, are not covered by this agenda item. He talked about the strategic framework and the remit of the expert group, and mentioned regional planning, which used to come up all the time in the Public Petitions Committee. He also mentioned that he is asking the boards to get the best services possible, and to consider the best models of care. How to get the best model of care will come through the strategic framework and guidelines, which the minister says will come along in a year's time. Those issues were mentioned by the petitioners—not just those involved in PE707, which concerns the Queen Mother's hospital, but those involved in the three petitions on maternity services and hospital closures—when they submitted their petitions; the petitioners also highlighted their concerns about how they had been handled in the consultation process.

Like Janis Hughes and others, I went along to meetings on the consultation process for nearly two and half years. The Executive has received so many complaints from around Scotland—not least Glasgow—about the way that consultation processes have been handled that it has felt that it has had to have a strategic framework. That is both a knee-jerk reaction and—I agree with Duncan McNeil on this—a rubber-stamping exercise. I would like to ask the minister—and I think that other members would like to ask this as well—why there is a strategic framework all of a sudden, when there will be no services to have guidelines or a framework about. Why is it that, despite the fact that the Queen Mother's hospital at Yorkhill gives the best services to the public and represents the best possible model, the board's recommendation is to close it down?

I want to turn to the two petitions on the closure of the Queen Mum's, which I am concerned about. The EGAMS report has been mentioned, but we know that EGAMS produced two separate reports, which were contradictory. People have also cited the report from the British Association of Paediatric Surgeons, but we know that the BAPS report included misinformation because it used the wrong year. Despite what the EGAMS report says, the Queen Mother's has operated for more than 40 years without any mother fatalities, yet all of a sudden, we are told in one part of the EGAMS report that the hospital cannot possibly be allowed to continue.

On the new consultants contract, which Jean Turner touched on, we know all about the new framework. However, if the minister shuts the Queen Mother's, he will still have to provide paediatric care and he will still have to service the Royal hospital for sick children in Yorkhill, the Southern general and the Royal infirmary, which are three different hospitals. Basically, closing the Queen Mother's will make no savings on staff costs.

Last, but not least, will the minister tell us when he will come to a conclusion on the future of the Queen Mother's hospital? Will it be before or after the strategic framework is produced?

The Convener: In fairness to the minister, that question is not within the remit of what we are asking him about today. However, the main question that Sandra White and others have asked is reasonable. Given the closure of maternity units and the huge fights that are taking place throughout Scotland about the closure of various other services—which I am sure all committee members have come across—why is the minister only now setting up an expert group that will report a year down the road, when all the battles with the public, such as the ones in Sandra White's area and in other areas of Scotland, are taking place now? That is what mystifies me.

Malcolm Chisholm: As I pointed out at the beginning, we already have a framework for maternity services. That is not to say that the new expert group will not consider maternity services, but maternity services are unlikely to be the main part of the group's work, given that we have a recent framework by another expert group on that subject. That was the balance that I wanted to establish.

Sandra White's question highlights the fact that, as I said earlier, we are dealing here with two closely connected but separate issues. In the case of the Glasgow proposals, one issue that I must consider is the substance of those proposals. The new expert group will consider substance but, in a sense, the way in which the board has handled the proposals is a separate issue. It would be possible to come to the conclusion—I am talking only hypothetically here—that the Glasgow proposals are right but that they have been handled terribly. That is not what I am saying, but one could say that. The reality is that those are two separate issues—

The Convener: But there could be an issue about both the process and the substance—

Malcolm Chisholm: Or, vice versa, one might conclude that the board had handled the proposals brilliantly but that the proposals were wrong. The reality is that those are two issues that I will need to take into consideration. Throughout this whole discussion, we need to consider both these issues: how we involve the public and engage with them effectively, and what the best model of care is that will give the best quality of service.

I do not know that I can say much more than that. I could talk endlessly about Glasgow maternity services, but it is right that I and others take time to consider the matter. The issue is complex. The proposal is probably the most controversial one that has arisen in the five years since the Parliament was established, so it would be a bit strange if it was rubber stamped. I have already said that the decision will not simply be rubber stamped.

The issue is very complicated. The convener may need to hold me back from making a speech about this, but part of the problem is that senior clinicians are sending out completely different messages. That is difficult for anybody to deal with. Some members have homed in on the arguments from the people at the Queen Mum's, but I have met the different groups. I have sat in a room with a large number of obstetricians and anaesthetists who have told me that it is not safe to provide maternity services without co-located adult services. It is very difficult when senior clinicians tell you different things. That is another reason why it should take quite a long time for me to consider the issue.

The Convener: I know that some members have further questions, but I am afraid that I need to close down this discussion. We might return to the subject, or individual members might do so, once we have had an opportunity to read the minister's comments in the *Official Report* of this meeting.

Hepatitis C

16:40

The Convener: For agenda item 5, which is on hepatitis C, the minister will be joined by officials. Andrew Macleod and Sandra Falconer are from the health planning and quality division of the Scottish Executive Health Department.

I refer the minister to the correspondence—my letter to him and his response of 29 April. Paragraph 3 of the response states:

"I have read this article and should like to point out that it does not in fact quote me as saying the payments made in the Irish Republic were 'without legal liability on the part of the state'—although I have no argument with that view."

I apologise for that, minister. The quotation was from Miss Ann McGrane, who is the assistant principal officer in the Irish Government's blood policy division. You are right that the quote was erroneously attributed to you, although I note that you share the view.

I came late to the issue and have tried to follow it. The Health and Community Care Committee in the previous session of Parliament spent a considerable amount of time on the matter and considered it thoroughly. I want to clear up two issues in my mind about the inquiry. I am trying to work out whether I am comparing apples with apples or with pears when I compare the Irish and Scottish situations. Paragraph 12 of the Health and Community Care Committee's 17th report of 2001 states that the Scottish inquiry

"was conducted by officials from within the health department."

You may not be able to answer this question, but was the inquiry in Ireland also carried out by officials from the health department there? The inquiry here led to the view that you and the Health and Community Care Committee took about ex gratia payments. Did the two inquiries have similar compositions?

Malcolm Chisholm: The officials may correct me, but I understand that the Irish inquiry was a judicial one. I do not think that I said anything incorrect during the previous Health Committee meeting in which the issue was discussed. I am happy to preface my remarks by saying that I am not an expert on the Irish situation. It is interesting to compare what happened here with what happened in Ireland, but we have to make decisions that are based on what we think is right for Scotland. However, as the matter has been raised, I point out that I believe that what I said was true. The judicial inquiry in Ireland used the words "wrongful acts", which is what I referred to in the previous committee meeting. That does not contradict what somebody else said subsequently.

The Convener: So the Irish had a judicial inquiry.

Malcolm Chisholm: Yes, as far as I know. My officials might want to give a little more detail.

The Convener: We had an internal inquiry, which is obviously different from a judicial inquiry in which witnesses are heard and other issues are developed. The Irish did not have an internal, in-house inquiry.

I want to clarify another issue to see whether I am comparing apples with apples. I understand from the Health and Community Care Committee's report that the main aim

"of the inquiry was to re-examine the allegation that the SNBTS was negligent during the 1980s in allowing hepatitis C-infected blood to enter into circulation. This seems to us to have been dealt with fairly exhaustively in the report, and after surveying the main arguments for ourselves, we found ourselves provisionally in agreement that the SNBTS did not appear to have been negligent in its actions."

The report continues:

"It is regrettable, however, that a number of important matters were not addressed in the report."

It goes on to say:

"Events before and after the mid-1980s were not examined."

The committee added a rider to its comments. Was the remit of the Irish inquiry the same?

Malcolm Chisholm: I am sorry; I do not have that information.

The Convener: That is fine.

Malcolm Chisholm: One of my officials may have it. Andrew Macleod can say something on the matter.

The Convener: I simply want to make clear the basis of the comparison of one arrangement with the other. There may be a perfectly legitimate reason for the differences, but I do not know what the remits of the two inquiries were.

Andrew Macleod (Scottish Executive Health Department): The circumstances in Ireland and Scotland were different. In the incidents that took place in Ireland, it was clear that the blood service had followed practices that should not have been followed and which allowed the hepatitis C virus to spread into the blood supply. Those incidents led to the establishment in Ireland of a judicial inquiry.

In Scotland, an official investigation was undertaken by Scottish Executive Health Department officials. It focused largely on whether the Scottish National Blood Transfusion Service had taken up as quickly as it should have done the developments and practices that were available to take precautions against the spread of hepatitis C. In effect, the inquiry examined whether, as knowledge and understanding of the hepatitis C virus developed, the steps that could have been taken against it were taken and whether they were taken quickly enough. An entirely different set of factors and circumstances was investigated in Scotland, because there was not the degree of initial prima facie evidence of wrongful practice in Scotland.

16:45

The Convener: I see. People might wonder why I am getting tendentious about the issue, but it is because of the difference between the two inquiries. The inquiry in Ireland was based on a statement that there was legal liability, whereas the inquiry in Scotland was based on a statement that there was not. I wonder how those two statements came to be. You are telling me that there was no prima facie evidence of wrongdoing in Scotland, but am I not correct in deducing that the remit of the inquiry in Scotland did not go down that road in any detail? I may be wrong about that; I simply ask the question.

Andrew Macleod: The remit of the inquiry in Scotland was different because the circumstances in Scotland were different.

The Convener: The Scottish inquiry did not go down that route because of the circumstances.

Andrew Macleod: In Ireland, there was an incident, as it were, around anti-D, blood transfusions and plasma. In that case, it was fairly clear that the Irish National Blood Transfusion Service had been following practices that it should not have followed. I think that there has not been that kind of prima facie evidence in Scotland. Clearly, there is controversy and debate around the practices that the SNBTS followed. However, a different set of issues and a different debate applied in Scotland.

I would like to make one further comment regarding legal liability. The point was raised at the beginning of our discussion this afternoon. My understanding is that the Irish Government does not accept legal liability. In its view, there is no legal liability on behalf of the state in Ireland. The judicial inquiry found that wrongful acts had been committed by the Irish National Blood Transfusion Service. Such a finding has not been replicated in Scotland.

The Convener: Okay. I am not sure where I have got with that one. Does another member want to come in?

Shona Robison: I understand what you are saying about the different focus that was taken in the two inquiries. My question is for the minister. With hindsight, do you now appreciate that, to those who are affected, the Health Department inquiry looked very much like the police policing the police? Would it not have been better for the

initial inquiry to have been far more open and transparent? The other criticism of the initial inquiry was that its focus was far too narrow. Would it not have been better if the inquiry had looked at a wider range of issues? If the issues had been examined in an open and transparent manner, would that not have avoided or eliminated some of the concerns that are still around today?

Malcolm Chisholm: The inquiry was held before my time, so I was not directly involved in how it was set up. The evidence that is presented in the report is open for all to see. People can read the report and question it, as they feel appropriate. From reading the report and from the other evidence that I have looked at, I would say that it does not appear that blame attaches to the Scottish National Blood Transfusion Service. When the Health and Community Care Committee undertook its report, it did not raise that issue specifically. I am not saying that the committee looked into the matter in detail, but it did not say that that was the route that we wanted to go down in Scotland.

As I have said throughout, we would need some new evidence, over and above the evidence that is presented in the report. I have always said that I will be open-minded if people present new evidence, but there is no point in setting up an inquiry unless it appears that there is new evidence to be considered. That is my general approach—I am open-minded about considering new evidence, but I am not persuaded that it exists.

The Convener: Was the medical evidence made public during the in-house inquiry? I do not think that it was.

Sandra Falconer (Scottish Executive Health Department): It was; all the references that were mentioned in the report were made available.

Mr Davidson: Why were representatives of those who contracted the disease omitted from the inquiry?

Malcolm Chisholm: As I said, I was not involved in the inquiry, so I do not think that I am in a position to answer that question.

Sandra Falconer: The remit of the initial investigation was set by an approach from the Haemophilia Society about an area that it wanted to be investigated.

Mr Davidson: Who attends the management meetings of the Skipton fund, and is there a reason for the minutes of those meetings not being in the public domain?

The Convener: You are pre-empting a whole string of written questions that I have lodged.

Mr Davidson: I am sorry for beating you to it.

Malcolm Chisholm: One of my officials will answer the question in more detail. The reality about the Skipton fund is that there has been engagement with patients groups on the issues. The fundamental reason for delay is that, at one of the meetings, patients raised points about the forms; they wanted those points to be addressed, and another meeting is coming up soon to deal with that. Officials from the Health Department are involved in the meetings; in fact, one of the officials who usually comes to the Health Committee is not here today because he is in London at a meeting with officials from the Department of Health. There is UK collaboration on the matter.

Andrew Macleod: The scheme that is being established is a joint scheme of the UK Government and the devolved Administrations. The meetings that are taking place to establish the terms and framework for the Skipton fund involve the four Administrations and, at least at some meetings, patients' representatives and the Skipton fund itself. In effect, the policy parameters and frameworks for the operation of the fund are being set, along with the specific application processes.

You asked about the publication of minutes. We consider the meetings to be working group meetings at official level. If questions were asked about whether the minutes would be made available to the public, we would look into that with our colleagues in the other Administrations, but it is not a matter that the Executive alone can control.

Mr Davidson: You said that you are setting the parameters for how the fund will work. When will that work be brought back and shown to the committee? The previous committee did a lot of work on the issue, and Parliament has debated the issue. Parliament has a right to compare the terms that seem to be evolving from the working group with what it agreed to.

Malcolm Chisholm: At the meetings, aspects such as the forms are being considered at a high level of detail. I repeat that the people who are involved have taken on board the comments that have been made by patients groups—that seems to be a correct and admirable thing to do.

We have to accept that the scheme is a UK scheme, so we do not have unilateral control over some of the issues. I am not sure what level of detail you refer to when you express your wish for further involvement.

Mr Davidson: It would be helpful if the committee knew the details of the parameters that are being agreed, so that we could compare them with what was discussed in Scotland and agreed by the Parliament.

Where might the process go next? For example, are there proposals for a review, in relation to dependants who are left behind? The public ask

us such questions and they think that we should be able to answer them.

Andrew Macleod: The terms of the scheme, the payments and the criteria are those that the Minister for Health and Community Care announced last year. The UK Department of Health announced in August last year that it would extend a similar scheme to England; the other devolved Administrations also made that decision.

The discussions are about implementing the scheme, which is an announced scheme with clear payments and criteria attached to it. They are about how the scheme will be applied, what form of application process there will be and what people will need to do to apply for payments. There are two levels of payment, so certain tests will be needed to ensure that the higher payment goes to people who are more seriously affected by the disease. Clinical issues have to be determined with regard to exactly what tests will need to be used, and how those issues are determined will affect the questions that need to be asked and the design of the application form. Those are the sorts of issues that are being discussed.

A framework is being set for the scheme and important issues are being discussed, but they are concerned with the operational application of the scheme that was announced last year.

Mr Davidson: If there is a commonality of view and the four Administrations are working on a uniform basis, should there be—for the sake of argument—a successful legal challenge in England, would that apply automatically in Scotland?

Malcolm Chisholm: We are talking hypothetically. Since it is a UK scheme, you can presume that we would want to keep together on it. I am not currently aware of any legal challenges.

The Convener: Heaven forfend that we should give legal advice, but is it not the case that if a decision is taken in England it is very persuasive, but not binding, in Scotland?

Malcolm Chisholm: Obviously a decision would not be binding, but since it is a UK scheme I am suggesting that we would probably want to stick together on it. That is my point; I am not making a legal point. I would not presume to make a legal point in front of the convener.

Mr McNeil: This is all very interesting. If there had been a legal solution to the matter, the committee would not have had to do as much work as it did to ensure that people would get some compensation. The report in the *Sunday Herald* about a statement by an Irish civil servant has prompted a half-hour debate in the committee with the minister and goodness knows what. That is all very well and some people may be particularly interested in that issue for their own purposes, but the constituents whom I meet are concerned about the time that it is taking for some compensation to be handed out. I hope that all the diversions about what has been reported in the *Sunday Herald* and what has been said in Ireland or wherever have not reduced the minister's focus on the issue.

The real issue is that people are ill and the money could make a big difference to their quality of life. Some of those people know that they do not have long before them and they feel a driving need to put their house in order. That is the type of person that we are dealing with. We need to get the payments processed and delivered to people as soon as possible.

Malcolm Chisholm: I agree entirely, but I do not see evidence that anybody is deliberately trying to delay the process; people are genuinely trying to get the detail of the scheme right.

As Andrew Macleod said, the parameters have been set out clearly and they have been adopted by all the Administrations. The discussions are very much on the detail—the forms are the best example of that. If patients groups have asked us to look again at what is on the forms, it is perfectly reasonable for us to take that request on board. Like Duncan McNeil, I want the details to be finalised as soon as possible. The First Minister said in Parliament on Thursday that there will be an announcement this month—I hope that the announcement will indicate clearly that the matter will all be sorted very soon.

The Convener: I remind my colleague that I asked the question at First Minister's question time. I am sure that the minister can handle queries about the niceties, which are still relevant, in relation to the basis upon which decisions will be made and address issues on the substantive procedures and processes. I am glad to hear that the work on the forms is accelerating after all this time.

You may or may not be able to tell us at this stage whether legal aid or advocacy assistance will be available to applicants who go to an appeals tribunal when all or part of their claim is refused—either for the first £20,000 or the additional £25,000. Do you have information about that yet? If you do not, when shall we have it?

Malcolm Chisholm: Sorry—I do not have that level of knowledge about legal aid, but we will write to you on the matter.

The Convener: That concludes the evidence session. Thank you very much, minister.

17:01

Meeting continued in private until 17:36.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, 375 High Street, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

Friday 14 May 2004

Members who want reprints of their speeches (within one month of the date of publication) may obtain request forms and further details from the Central Distribution Office, the Document Supply Centre or the Official Report.

PRICES AND SUBSCRIPTION RATES

DAILY EDITIONS

Single copies: £5
Meetings of the Parliament annual subscriptions: £350.00

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committees will be published on CD-ROM.

WHAT'S HAPPENING IN THE SCOTTISH PARLIAMENT, compiled by the Scottish Parliament Information Centre, contains details of past and forthcoming business and of the work of committees and gives general information on legislation and other parliamentary activity.

Single copies: £3.75
Special issue price: £5
Annual subscriptions: £150.00

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Standing orders will be accepted at the Document Supply Centre.

Published in Edinburgh by The Stationery Office Limited and available from:

The Stationery Office Bookshop
71 Lothian Road
Edinburgh EH3 9AZ
0870 606 5566 Fax 0870 606 5588

The Stationery Office Bookshops at:
123 Kingsway, London WC2B 6PQ
Tel 020 7242 6393 Fax 020 7242 6394
68-69 Bull Street, Birmingham B4 6AD
Tel 0121 236 9696 Fax 0121 236 9699
33 Wine Street, Bristol BS1 2BQ
Tel 01179 264306 Fax 01179 294515
9-21 Princess Street, Manchester M60 8AS
Tel 0161 834 7201 Fax 0161 833 0634
16 Arthur Street, Belfast BT1 4GD
Tel 028 9023 8451 Fax 028 9023 5401
The Stationery Office Oriel Bookshop,
18-19 High Street, Cardiff CF12BZ
Tel 029 2039 5548 Fax 029 2038 4347

The Stationery Office Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0870 606 5566

Fax orders
0870 606 5588

The Scottish Parliament Shop
George IV Bridge
EH99 1SP
Telephone orders 0131 348 5412

RNID Typetalk calls welcome on
18001 0131 348 5412
Textphone 0845 270 0152

sp.info@scottish.parliament.uk

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178