HEALTH COMMITTEE

Tuesday 20 September 2005

Session 2

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HEALTH COMMITTEE
22nd Meeting 2005, Session 2

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

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

COMMITTEE SUBSTITUTES

Paul Martin (Glasgow Springburn) (Lab)
Mr Kenneth Macintosh (Eastwood) (Lab)
Mary Scanlon (Highlands and Islands) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Lewis Macdonald (Deputy Minister for Health and Community Care)

THE FOLLOWING GAVE EVIDENCE:

Scott Haldane (NHS National Services Scotland)
Professor David Kerr (National Framework for Service Change Advisory Group)
Adam Rennie (Scottish Executive Health Department)
Professor Bill Scott (Scottish Executive Health Department)
Dr Kevin Woods (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION
Committee Room 2

Scottish Parliament

Health Committee

Tuesday 20 September 2005

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

Items in Private

The Convener (Roseanna Cunningham): Welcome to this meeting of the Health Committee. Agenda item 1 is consideration of items in private. The committee is asked to consider whether to take agenda items 6 and 7 in private. Item 6 is to review the evidence on the budget process that we will hear from Executive officials. We have adopted the practice of reviewing oral evidence immediately. Item 7 is to consider the timetable and other arrangements for the Abolition of NHS Prescription Charges (Scotland) Bill. Are members content to take those items in private?

Members *indicated agreement*.

Subordinate Legislation

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 9) (Scotland) Order 2005 (SSI 2005/421)

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 10) (Scotland) Order 2005 (SSI 2005/431)

14:01

The Convener: Item 2 is subordinate legislation. We are asked to consider under the affirmative procedure two orders that relate to amnesic shellfish poisoning. I welcome the Deputy Minister for Health and Community Care, Lewis Macdonald, who is accompanied by Chester Wood from the Food Standards Agency. The Subordinate Legislation Committee considered the orders and had no comments to make. As members have no comments or questions on the orders, I assume that we do not wish to debate motions S2M-3237 or S2M-3238. Do members object to a single question being put on the motions?

Members: No.

The Convener: In that case, I invite the minister to move the motions.

Motions moved,

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No. 9) (Scotland) Order 2005 (SSI 2005/421) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No. 10) (Scotland) Order 2005 (SSI 2005/431) be approved.—[*Lewis Macdonald*.]

Motions agreed to.

The Convener: I thank the minister and Ms Wood for their attendance.

Mental Health (Specified Persons' Correspondence) (Scotland) Regulations 2005 (SSI 2005/408)

Mental Health Tribunal for Scotland (Practice and Procedure) Rules 2005 (SSI 2005/420)

Regulation of Care (Prescribed Registers) (Scotland) Order 2005 (SSI 2005/432)

Food Safety (General Food Hygiene) Amendment (Scotland) Regulations 2005 (SSI 2005/435)

The Convener: Agenda item 3 is consideration of four instruments under the negative procedure. The Subordinate Legislation Committee has considered the instruments and commented only on SSI 2005/408—the comments are reproduced in the extract from the Subordinate Legislation Committee report. No comments have been received from members and no motions to annul have been lodged. Do members agree to make no recommendation in relation to SSI 2005/408, SSI 2005/420, SSI 2005/432 or SSI 2005/435?

Members *indicated agreement*.

National Health Service (Framework for Service Change)

14:03

The Convener: Agenda item 4 is a discussion of the national framework for service change in the national health service in Scotland. Following the publication of the "Building a Health Service Fit for the Future" report, which was produced by Professor David Kerr's national framework advisory group, the committee agreed to invite Professor Kerr to give evidence on the report. I welcome Professor Kerr to the meeting.

The committee agreed to give those who participated in the public debate earlier this year an opportunity to submit questions from which committee members could draw during the session with Professor Kerr. We have had a big response to that request. Members will pursue a number of issues with Professor Kerr, but we will not be able to cover all the issues that members of the public raised. Several people who attended the public debate are here today to listen with interest to Professor Kerr's evidence—I welcome them, too. If they submitted questions, they may hear questions from members that relate to their concerns.

Professor Kerr, I ask you to make a brief introduction, after which we will go straight to questions.

Professor David Kerr (National Framework for Service Change Advisory Group): I will be brief. I would just like to thank the advisory group, which supported me through the year when we pulled the framework for service change together. I also thank the citizens of Scotland who came to our public events to make their contributions, thus strengthening the report significantly. Finally, I thank the front-line forum: the health care professionals, nurses, doctors and others who raised their voices in concert and strengthened our report. The report came out well, but it was definitely improved by the fact that we listened to people, which engendered a broad spectrum of support.

The Convener: Thank you, Professor Kerr. We will move straight to questions. Several members have already told me what areas they would like to cover. I will go straight to Mike Rumbles, who has questions about neurosurgery.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Professor Kerr, your report has been welcomed across the piece. Its message of a new way of delivering care and of planning centrally but delivering locally has been warmly welcomed. However, I know that the detail of

some of the recommendations has caused alarm—I do not think that that is too strong a word—in the north-east of Scotland. For example, you say in paragraph 2 under the "Key issues" heading:

"For neurosurgery the recommendation is to move, over time to a networked approach from a single hub."

You also remark later in the "Key issues" section that some highly specialised services should be delivered

"on one or two sites in Scotland."

I was at a meeting yesterday with the Grampian NHS Board in preparation for this meeting. The board thought that your proposal would be a huge mistake for neurosurgery. In almost every other area, you are delivering locally, but in neurosurgery you are focusing on central sites. People in the north-east feel that those recommendations would have a dramatic effect on patients for neurology and orthopaedic surgery and on recruitment and retention at Aberdeen medical school. The report's recommendation for patient pathways focuses on the patient, so would it not be a major error to focus on one site many miles from where patients are?

Professor Kerr: Let me respond in two ways. One is to set out some broad principles that underpin the philosophy of centralisation, which I have a sense you have reservations about. Let me also be specific about why we adopted the recommendations that we did on neurosurgery.

One of the great areas of debate among the public and this committee has been the fear of an overcentralisation of services that is not driven by any obvious or compelling logic. Throughout the report, we have said as often and as rationally as possible that we would prefer to treat patients as close to home as possible. However, we also say—and we asked about this at our public meetings—that there are some clinical conditions and some types of treatment that are better ordered and better delivered from a smaller number of centres. Scotland's population is relatively small, although we understood that we had to find a solution to the problems of geography and of Scotland's remote rural communities.

There was a great deal of debate with some of my clinical colleagues about whether there was evidence that, if people were treated in a single centre—I use that model as an example—they would live longer and better. There are compelling hard data suggesting that that is the case in complex neurosurgical, cardiac and some cancer procedures. The evidence is strong and I am quite a difficult person to convince, as, no doubt, are you.

We felt that we could marshal strong, compelling data on neurosurgery that would allow me to go into the lions' den—the medical school in Aberdeen or wherever—to argue our case. The evidence would strike a chord with the senior medics and health care professionals involved. We thought long and hard about the matter.

Professor Graham Teasdale, the president of the Royal College of Physicians and Surgeons of Glasgow, chairs the intercollegiate group in which the different colleges come together. By chance, he also happens to be a world-famous neurosurgeon. He carried out the work on volume and outcome. If we have good evidence that suggests that we should focus on centralising the services for some of the conditions that have been mentioned and if we can make sense of that evidence for the citizens of Scotland, I believe that people will be prepared to travel to receive those services. Indeed, they have told us as much and we have responded to their comments in the report.

Why did we model neurosciences and neurosurgery? When I first took on this job, the secretariat had strong representations from the chief medical officer. I asked him to give me examples of decisions regarding service redesign and reorganisation that have been almost impossible to take in Scotland. I said, "You probably have a shelf full of such things. Why don't we take down a couple, blow the dust off them and see whether we can work up a process or framework that will allow us almost to reach a decision on them?" The chief medical officer chose neuroscience and neurosurgery and paediatric services, and we modelled those aspects.

Each member of our advisory group took on a different work stream. The neurosurgery work stream was chaired by the director of the Royal College of Nursing, who worked with professionals from each of the major medical schools and centres in Scotland and brought in external experts to work on the evidence base and filter the evidence that was being received. However, because all the ducks were not quite in a row, he could not be precise and say that the centre should be established in Glasgow, Edinburgh, Aberdeen or wherever. Basically, although I was twisting the group's arm to put a pin in a map and validate its decision to me, it did not get quite as far as being able to do that.

Until we had this discussion, I thought that there was broad consensus among professional bodies and centres, including Aberdeen medical school, that are interested in delivering neurosurgical, neurological and neuroscientific care to the people of Scotland. We are not proposing that everyone who requires a neurological or neurosurgical opinion should go to Glasgow, Edinburgh, Dumfries or wherever it is decided that the centre

should be set up. Instead, in keeping with the first premise that I outlined, I believe that we should have tiered care that would allow patients to receive as much care as close to home as can safely be delivered. Of course, Aberdeen is a dead important component in those different tiers of care.

If we have a hub-and-spoke model instead of what might be better described as a partnered network, the hub will have special characteristics and needs in order to deliver care for all the folk of Scotland. I think that I can produce evidence that would convince the committee and the folk of Scotland that they would get a better deal if such care were delivered from a single site.

Mike Rumbles: Thank you for your response. I have to say that I entirely agree with the general thrust of your remarks. Your report suggests that care should be provided locally where it is safe to do so and that, if detailed procedures such as neurosurgery are provided more centrally, people will benefit. However, I did not take from your response that we should go further and provide care from a single, central hub. We have some fantastic hospitals in Scotland and all the information that I have received suggests that there is absolutely no reason why we should not have hubs in Aberdeen, Glasgow and Edinburgh.

Although I am sure that we all agree with your general philosophical approach to this matter, I am worried that implementing your recommendations in practice will just pull things apart. For example, there is a real danger that care provided locally in X, Y or Z might get sucked into a single centre. Surely that cannot be your intention.

14:15

Professor Kerr: What we need is tiered care. You are right—not every neurosurgical patient, neurosurgical operation and neurological opinion can be dealt with at a single site in Scotland. I agree with that entirely. However, there is a certain portfolio of operations, investigations and tests that it would be sensible to do in one place. As is always the case, the majority of treatments can be delivered in Edinburgh, Aberdeen, Glasgow and Dundee, but we need referral pathways and guidelines with certain conditions that can only be dealt with in one type of centre. I would not want to abandon those conditions for which there is a clear relationship between volume workload and outcome. However, the data were compelling enough to show a well-described basket of investigations and treatment that are better delivered from a single site.

What you said was very interesting in that, when push comes to shove, it is fine for us to sit around and talk in theoretical terms about how we are going to have graded neurosurgical care and how everything will work together, but when someone says, "Well, that means that you will be doing this and he will be doing that, but this centre here will be doing a bit more of the other," that is when things start to disintegrate. There is a need to balance narrow self-interest—I am not saying that that is true of the specific case that you mentioned—with the national good if we can provide the evidence that supports the proposal. It should not become a case of "Yours is bigger than mine" or "Mine is shinier than yours". If we can provide hard facts—and I believe that we can—that should be compelling in a wider decision-making process.

Mike Rumbles: I would like to pursue that point. When we took evidence from Professor Teasdale and the royal colleges, the question was asked when it is completely safe to do something at a central location. The logic is that, if things are centralised, they become safer, because the surgeons have more practice. However, you are not saying that.

Professor Kerr: No.

Mike Rumbles: We have good hospitals in Dundee, Aberdeen, Glasgow and Edinburgh that could cope with being centres of excellence. My worry is that, if you are now pursuing the idea of a centre of excellence for the greater good in Scotland, so that people go to one place to get the best care, we will go back to the position that we were in before. If we concentrate investigations and treatment in one place, we might get the best possible care, but that will not help the patients in Dundee or Aberdeen—or, indeed, in Glasgow or Edinburgh if the centre is up in Aberdeen.

Professor Kerr: Forgive me, but you are oversimplifying and polarising the issue. I think that you and I are broadly agreeing with each other. Tiered care can be safely and well delivered from each of those impressive hospitals that you mention. I have visited those worthwhile places, many of which have national and international standing. We have no problem in agreeing on that.

However, there is strong evidence that if some—not all—neurological procedures are delivered from a single centre, the people who are treated there will live better and longer. Without going into a lot of detail or using many statistics, we are talking about toleration of risk. For many of the things that we do, the evidence mandating a central drive is pretty slight.

I think that sometimes there is a tendency to do a bit of shroud waving and to say, "If we do not centralise, the wheels will fall off and people will be dying." We sometimes hear such amplified and hyperbolic stories. I agree that that is not the case. The majority of common treatments can be done equally well in Fort William, Dundee or wherever.

The citizens of Scotland have posed the same question. They want to know what treatments can be delivered safely close to home and what they might need to travel for. They say that, if there is good evidence that they will live longer and better, they will travel. We have looked at the evidence as closely as we can. I would not stick up for something unless I had the figures to back it up. There is a lot that I would not try to defend. We have said, "No, let's keep that network model there."

Mike Rumbles: I agree with you 100 per cent that people want local care but that for major issues they are prepared to travel. However, I thought that you were saying that not in relation to our community hospitals in Aberdeenshire or Fort William or wherever, but in relation to the major hospitals in Scotland—in Aberdeen, Dundee, Glasgow and Edinburgh. I did not think that there was an option of cutting back on our major hospitals and going to one centre. That is the nub of what I am trying to get across.

Professor Kerr: That is an important point. Perhaps neurosurgery is a bad example. We are talking about a narrow portfolio of work that undoubtedly would be best delivered in a single, well-equipped centre with paediatric and other support. That does not take away other neurosurgical procedures that will be done in Aberdeen and Dundee, for example. However, given Scotland's size and population, undoubtedly we would have better outcomes if we focused a significant but narrow amount of neurosurgical work in one centre.

Yes, I expect the people of Scotland to trust my report and to travel for that particular portfolio of work. Other neurosurgical procedures can be performed well, safely and effectively in the other places to which you referred. It is a question of degree. We agree with each other, but for some rare cancer operations, transplants and other such procedures, we probably need just one centre in Scotland. I firmly believe that, if we said that and had evidence to back it up, the citizens who are sitting behind us would buy into it. We are in agreement.

The Convener: Can I turn that on its head and cut away from all this agreeing with each other?

Mike Rumbles: I was not agreeing.

The Convener: I noticed that you were not.

I will turn the argument on its head, in relation not just to neurosurgery but to all the other things to which you might apply it. The other side of what you are saying is that, right now, procedures are being carried out in our hospitals that are either unsafe or are not going to deliver the outcomes that they should deliver. Right now, in a variety of hospitals around Scotland, things are happening that, according to your advisory group and all the doctors, are detrimental to patients. Is that what you are saying? I do not want a 15-minute answer, Professor Kerr.

Professor Kerr: I will give you a very precise answer. The relationship between workload and outcome is narrow and exists for a relatively small number of clinical procedures. The evidence supporting the centralisation of a host of common procedures is not sufficiently strong for me to be able to say that those procedures should be centralised.

The Convener: Currently, four centres carry out neurosurgery. Are you telling us that some of those centres are not performing in a way that is in the patient's best interests?

Professor Kerr: I am saying that they could perform better if some of the work that they do were to be centralised at a single site.

The Convener: Each of those four neurosurgical centres is attached to a medical school. Has any consideration been given to the impact on the medical schools of removing the services?

Professor Kerr: We have not had that discussion, so I could not reasonably comment on the impact.

Shona Robison (Dundee East) (SNP): To be fair, and if we are to move forward, we should acknowledge that the report is about give and take. However, my concern lies with the point that you ended on. I hear your argument and I do not doubt that the statistics exist to back it up. However, many of us are concerned about the consequences for remaining services if you siphon off some services—not just neurosurgery—to a central point. The issue is not as simple as saying that only a basket of procedures will be taken from existing centres and the rest will be left. My appeal is for further work to be done to reassure the centres that are not centres of excellence that there will not be a knock-on consequence on their other services. The last thing that any of us wants is a cascading situation in which other services are under threat. I am sure that you do not want that, either. That work has to be done and the reassurance must be given that the neurosurgery proposal will not have unintended consequences.

Professor Kerr: I fully support the general principle of what you say—that many if not all disciplines in modern medicine are interrelated and that, if one kicks one pillar away, the temple will come down.

I am not a neurosurgeon and I was not on the neurosurgical committee. However, as far as I can tell from the general buy-in to planning and movement towards the proposal, the representatives from each of the medical schools

and clinical centres believed that the negative impact on existing centres would be minimal. They saw the proposal as a strengthening—

The Convener: No.

Professor Kerr: I can only report what came back from the working group. Clearly, concerns have arisen since the report went to press, but, until that point, it looked as though there had been remarkable consensus building to sort out a thorny problem that has been sitting on the shelves of the Health Department for years without anybody making a big effort to tackle it. I can only tell members what the situation is. I agree with the general principle of what you say, but I think that the neurosurgical proposal would have a pretty small impact.

Shona Robison: I suggest that we need to take further evidence on that point.

The Convener: That is possible. In response to Professor Kerr's point, I should say that, when I met members of the Ninewells team before the recommendations were made, they expressed a great deal of concern and alarm about what they saw as an inexorable process that was just grinding on to get the result that had not come out of the past three reviews but that they believed was always wanted from the start. I do not know whether that is the view in Grampian.

Mike Rumbles: Nanette Milne and I were at Grampian NHS Board yesterday where it was put to us forcefully that the proposal is a major concern. I agree with Shona Robison that the committee needs to take more evidence on the issue.

The Convener: We will take evidence under advisement.

Professor Kerr: There really was a sense of important consensus building among the group. What has not existed in Scotland until now is a national planning framework or means of deciding on such issues. As has been said, these problems have been hovering over us for some years without resolution. We, the citizens of Scotland, need that resolution and we have come close to it. Not to accept that feels like a step back and not the step forward that we are hoping to make with our recommendations.

The Convener: I am conscious that we have spent nearly 25 minutes on one issue, so I will jump to Duncan McNeil, who has questions about health inequality. I will come back to other members about related points.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): The report raises issues about effective health care, narrowing health inequalities and decades of underfunding. Perhaps it is because the people who are dying in my constituency are 50 and 52 years of age and there is a general life expectancy of 64 that they do not form campaigns. They do not march on Parliament because they are grieving privately. The report is significant in what it says about what we can do to improve the situation in communities such as mine.

Health inequalities give rise to issues such as access to general practitioners. The most affluent and healthy people in Scotland are looked after by the same number of GPs as our poorest people, who are in greatest need. Also, effective health care interventions are more likely to be delivered in healthier areas, which widens the gap between the healthy and the unhealthy.

I will go over my questions. First, what can be done to increase GP numbers in frontline areas where there is a clear need? Secondly, what action will be taken to ensure that future initiatives in primary care do not follow the precedent of being taken up twice as often in affluent areas as in poorer areas? Finally, how will your report help to address the relative failure of the distribution formula to provide for primary care services to address unmet need in deprived areas?

14:30

Professor Kerr: Those are important issues. I know your constituency and the questions are entirely relevant. When we wrote the report, we were thinking about the 15 or 16 lost years of life. If my son were born in Oxford tomorrow, he would have a median life expectancy of 82, but if he was born where I was, in Maryhill, he would have a median life expectancy of 64 or 65, as you said. That is neither tolerable nor sustainable. We are lucky that Harry Burns, who is Scotland's chief medical officer, has studied health inequalities and what underpins them. He supported us and helped us devise a means of reaching out, which is what is required. We cannot passively wait for those who are disadvantaged or less well off to access the health care system, because we know that they do not. There is an argument about mountains and Mohammed. What is required is what our report calls anticipatory care, which means going out to find cases and bringing people in to the system. In my field, which is cancer, patients from less well-off backgrounds come with cancer that is more advanced, which means that it is more difficult to treat. When they do come, they do not get access to the same treatment as people who are better off. At every point in the system, they get another kicking.

We want to employ a new type of primary care professional who case finds; they will go out and encourage people to come in for health screening—to have their cholesterol level and blood pressure measured. We have done some calculations, of which Dr Turner will be aware, that

suggest that if everybody who needed one of the drugs that prevent heart attacks got it, we would save hundreds, if not thousands of lives in Scotland every year. However, the folk who need those drugs are out in the schemes, they may be on their own and they think that screening is not for them, whereas those who are better educated and who understand the system access everything that is going. That is partly by virtue of their knowledge and drive, but also because of the density of general practices in their areas.

Your original question was underpinned by the question whether we should skew the new measures in some way. It seems entirely logical that, if we bring in a new group of health workers for anticipatory care, we would load the funding towards the communities that are, to be blunt, designated the poorest. We have discussed and thought through such a measure. I am sure that Dr Harry Burns, as CMO, will be keen to model and make progress on that suggestion in some way. We need anticipatory care so that the right folk are encouraged to come in for the right treatment.

That feels like a short-term answer to me; the longer-term issue for all of us is about citizens starting to take responsibility for their health, while we educate and support that. I hope that one of the results of the community health partnerships—through which local authorities, social work and education will work together—will be that we start to inculcate a sense of reaching out in an educative way that incentivises people to look after themselves, to avoid the wrong sort of food, to stop smoking and all the rest of it. Everybody knows what is wrong, but we need to reach out and emphasise that in a way that really counts.

On your final point, I do not know enough about the details of the Arbuthnott formula. The formula delivers big chunks of money to the health boards. A component of it is supposed to take account of postcode and relative levels of poverty. You are suggesting that that is not working strongly enough; I am not able to deny that. It would be entirely legitimate for us to ask Sir John Arbuthnott to go back and study the formula to see how that is delivered. I truly do not know enough of the details to know how it does or does not work.

Mr McNeil: But you agree that the status quo is not an option.

Professor Kerr: I do.

Mr McNeil: To continue to provide for those who are healthy will not narrow our health inequalities, but make them worse.

Professor Kerr: Yes.

Mr McNeil: We can get a short-term hit though. We can quickly prevent people dying.

Professor Kerr: We will. I refer to some of Harry Burns's ideas on heart attack prevention. Heart attack is still the biggest killer in Scotland. We can do a lot to bring down high blood pressure and elevated levels of blood lipid, called cholesterol. Modern drugs can reduce hugely the risk of heart attack and save hundreds and thousands of lives. That will be at the forefront of anticipatory care.

Mr McNeil: I turn to the community health partnerships. The model is local, but in constituencies such as mine there are affluent areas as well as a number of deprived wards. Can we be assured that CHPs will be able to deliver for poor people in smaller, defined areas? How will we ensure that the partnerships will deliver for those in most need?

Professor Kerr: Why do we not ask them or tell them to? The community health partnerships hold great promise. We know roughly what they want to do, but we have a pretty empty page when it comes to exactly what their targets should be. We have suggested what they should be; why do we not ask or tell them to do exactly what you suggest? We could say that they have to reach out, distribute, reduce inequities and consider the anticipatory care model. Why do we not ask the Executive to make that a must-do?

The Convener: I know that other members want to ask specifically about community health partnerships and at least one of them wants to cover other issues. I ask Nanette Milne, then Helen Eadie, to address community health partnerships specifically at this stage. I will allow them to come back on workforce planning issues.

Mrs Nanette Milne (North East Scotland) (Con): How do you see the community health partnerships developing? Everyone in a community health partnership has to be committed to it if it is to come together and work properly. Do you see general practitioners, consultants and other professionals breaking down the professional barriers and coming together in the partnerships? That could be crucial to how they work.

My other question is about funding. Your report mentioned CHP fund holding, for want of a better expression, and collaborative contracting. Will you expand on that?

Professor Kerr: There are no community health partnerships in England, so I got to learn about them here. They hold great promise and, as with everything, they have strengths and weaknesses. The strength is that they will be embedded in the community; they will know what local needs are and will be able to work with other agencies, such as social work departments, the police, education authorities and so on. They will be strongly focused on geographical patches. The people in the CHPs will know their patch better than anyone

in St Andrew's House or some other central place ever could. There is enormous strength in that. Their flexibility and ability to adapt to local problems is another strength.

One of the worries that we had—although that word is perhaps an overstatement—was that we felt that there were key deliverables that were required of all CHPs. As Mr McNeil said, we felt that there were some must-dos, which are not about the imposition of a central menu of things that the CHPs have to do but around areas such as anticipatory care, looking after patients in the community and developing models for the long-term care of patients with chronic conditions.

We said with some clarity to the CHPs, "These are the must-dos that we expect you to take on. Within that, the next five things that you can do have to be flexible in response to what your community needs and how things move forward in that way." We were trying to strike a balance between saying, "Centrally, these things are awfully important for the country as a whole, but you must also have enough laterality to be able to engage with whatever your local community needs." We tried to strike that balance and to move it forward.

The point about breaking down barriers is incredibly important. We need clinical engagement on these issues. When we were on our travels, one of the things that we came back with was a nascent sense of anxiety about what the CHPs would be and whether they would dilute the voice of the local clinical leaders.

We heard that the existing local health care co-operatives were working and that there were good relationships between secondary and primary care. Although folk could see the potential advantages of the CHPs, the clinical fraternity and sorority are a bit nervous of them. Therefore we—the CHPs—need to work exactly as Mrs Milne suggests in order to ensure that the barriers do not go up again.

If we are serious about trying to manage patients with long-term chronic illnesses, the only way to do that is by developing care pathways that go all the way from somebody's home to some very fancy hospital wherever it might be—as locally as possible, but it might be somewhere distant. The only way to get the pathway to work is by breaking down barriers between primary care—looking after folk at home and in the community—and secondary care. That is the big prize of the whole report—challenging the culture of the rather segmented way in which we look after folk at the moment. Folk just do not go seamlessly through anywhere at all. The CHPs have got to be absolutely fundamental to dissolving barriers, keeping an eye out and keeping all that stuff happening.

In terms of Mrs Milne's second question, about funding, I was talking around how we incentivise and drive forward change. It is all very well for me and the team to write a report that is motherhood and apple pie to everybody, but unless there are levers that we feel we can operate to make it happen, the report will go back on the shelf again and nothing else will happen. The report does not deserve to ebb away; it does not deserve that in terms of the effort that we and others put in to get this sorted and in terms of the buy-in that we have seen for it.

I was talking about whether we could borrow examples from elsewhere. The debate is about a significant redistribution of what I will call the balance of power—and I probably mean that—away from secondary care. I work in a hospital in an ivory tower. I suck huge amounts of resource and energy into the hospital because it is my kingdom, but only 10 per cent of all care goes on in that way. I was talking about trying to find ways in which we could legitimately balance and say, "There's got to be more of an equal partnership in how patients are looked after." That is why we looked at collaborative contracting.

Take the example of a diabetes consultant who has some sessions in a hospital and others in community hospitals or general practice. I am thinking of somebody who is involved in training diabetic patients to look after themselves, helping their families to help them and so on. It should be regarded as a failure if a diabetic patient ends up being admitted to hospital. It should be that the system has let the patient down rather than, as sometimes happens at the moment, we suck patients into hospital. If somebody had that sort of a contract, they might feel, "Oh, I am owned by the hospital and by primary care." That might be one way of doing it.

In terms of how money moves through the system, I was just putting some small ideas up about how we might introduce grit into the oyster—to use a slightly odd English term—or contestability. That is all the buzz down south just now. However, a model that is based completely on contestability in the market is not right for Scotland. I have said that before and I mean it. We have a more collective approach to health, which fits in with how we are as a society, with our history and with the way in which we can get our hospitals, GPs and so on working together. I was just flagging up some general ideas to see how the Executive responds. I have no idea how it will respond.

14:45

Mrs Milne: Is there a risk that the CHPs will be too big to allow the collaboration that we are talking about?

Professor Kerr: Some clinicians are worried that they will be diluted in a large organisation in which their voice carries less weight. I keep saying that clinical engagement in the widest sense is dead important to the cultural change that we need to get this forward.

The answer is "maybe", but the CHPs were chosen pretty carefully to try to represent joined-up government. Again, I do not know enough about the geography of the CHPs. The issue needs to be resolved, but my sense is that the geography of the CHPs is about right. I do not think that I would want more CHPs or smaller ones.

The Convener: I have to say that I am still reeling at the idea that we are going to get consultants out of their ivory towers to work in medical centres. At the moment, we do not appear to be able to persuade them to travel from one hospital to another, much less into the community. If that is the plan, there are some massive hurdles.

Helen Eadie (Dunfermline East) (Lab): I come from Fife, which is, outside Glasgow, one of the biggest areas of deprivation in Scotland. It was formerly Scotland's biggest coalfield community. We had what the Scottish Executive regarded as a model LHCC. Since the inception of community health partnerships, great suspicion has grown up among clinicians. I have engaged with GPs and consultants and they are concerned about the change. I am not persuaded; you have introduced something new, but there was already a good model in place. Given that the LHCCs worked, I cannot understand why you have thrown them out. There is an argument that if something is not broken it does not need to be fixed.

I represent a village called Lochore, which is 103 per cent above the Scottish average for disability and sickness. That might be hard to believe, but it is a fact. My concern is that there is not a single NHS dentist to be found in that area. Some 15,000 of my constituents received letters to say that they will no longer have an NHS dentist. The relationship between gum disease and heart disease is clear, but no thought is being given to that. How will the community health partnerships address such issues?

The Convener: Helen, there is a point that needs to be made. LHCCs were abolished under Executive legislation in an act that I think you must have voted for. It is not something for which Professor Kerr was responsible.

Helen Eadie: Primary care includes dentistry, chiropody, opticians and so on.

The Convener: Professor Kerr is not responsible for the decision to move away from the LHCC model. That was an Executive decision.

Mike Rumbles: We did that.

The Convener: Yes. In effect, the partnership or the Parliament did that.

Helen Eadie: The question is to what extent there is still a possibility of using the model that was in place. That brings us back to a point that was made by Dennett. The British Medical Association and others have written to us about their concern that clinicians will not be engaged in the way that they were with the LHCCs. That is the point. It is about getting clinicians and consultants engaged in a way that will deliver for communities.

Professor Kerr: I pick up on what the convener said. I understand the sensitivities and I detected them too. I inherited the community health partnerships, as did you. I just want to make them work. We detected the same doubts and worries as you. That is why we said that clinical engagement is critically important and that the community health partnerships must get on the front foot with that immediately because otherwise that engagement will be diluted and will waste away. I hope that we can use the community health partnerships—

Helen Eadie: May I interrupt you for a moment?

Professor Kerr: Of course.

Helen Eadie: I want to make a more refined point about GPs and how we know whether they have had the new contracts, which seem to be silent on a whole range of issues, such as the delivery of osteoporosis diagnosis and treatment centres. Skin disease is another such area—there are people in the public gallery who represent psoriasis and dermatology interests. People are not convinced that there will be diagnostic facilities for skin conditions, because the GPs contract does not allow for that.

Professor Kerr: I am not sure. Is your question about how GP contracts—

Helen Eadie: Your report says that community health partnerships will provide diagnosis and treatment in the centres, without people having to go to hospitals, but if you cannot get dermatology services delivered locally because the GP does not have that in his contract, or if GPs cannot diagnose osteoporosis because that is not in their contract either, how can the CHPs deliver those services? You are talking about services being delivered in the community, rather than in a big hospital building.

Professor Kerr: I understand your point. It may sound a little lame, but you have got to start somewhere. When I initiated the national cancer plan in England, that was because I was a cancerologist and because cancer was a huge big killer. It was really important to everybody and it was a number 1 priority. I have not been involved

in the way in which the GP contract was set up, but I think that you are right in saying that it has been biased towards developing points for the big killers, or the big-ticket items. If that has in some way disadvantaged those who suffer from a multitude of other diseases, that feels completely wrong. I guess that that was a start, or a first shot at the issue, but I would imagine that, when further contractual negotiations come in, people will have to pay attention to the broad spectrum of diseases. I guess that people had to make a start somewhere, but I understand your point, which is important.

The Convener: I want to move on to workforce planning issues now. Nanette Milne and Janis Hughes have questions on that.

Mrs Milne: If the local delivery of health care and anticipatory health care is to work, it will involve a huge amount of workforce planning. People will have to get used to going to see not just a GP, but teams of people, and there will be lots of involvement of allied health professionals. We already have difficulty in recruiting GPs in certain parts of Scotland, and we have significant difficulty in recruiting consultants to certain specialties, not only in Scotland but globally. The Royal College of Nursing says that we are training for replacement but not for expansion of the service, and we will presumably need more specialist nurses in future. Physiotherapists are saying that they do not have enough training posts for people coming out of college. Such concerns are being voiced by AHPs of various kinds. Could you comment on that? One or two specific points were raised with us, which I might ask you about afterwards.

Professor Kerr: That is a critical set of questions. I know that the committee has received reports from Sir John Temple and from Sir Kenneth Calman, who have looked at clinical workforce planning and at medical training, to give you some idea of what measures have been put in place to expand student numbers and how training places will be improved for clinicians coming through.

There are two elements to the issue. One of the things that we tried to bring out in the report—I am paraphrasing Don Berwick—is the need to work better, not harder. If we can improve working practices and redesign service delivery, we hope that we can improve the quality of service that we deliver and that those who deliver it will feel happier about what they are doing. The status quo cannot continue. People feel that they are constrained to deliver a second-rate service. We are asking clinical groups, in the widest sense, how they can use their intellect, power and energy to redesign services and make them better. We want to set people free to do that. That will play an important role in rewarding people, incentivising them in their own sectors and segments of care to do the very best that they can with the resources that they have just now. We want to do the best that we can with that which we have.

I found your question on multiskilling absolutely fascinating. I have gone round Scotland, as I am sure you have done, and seen many of the excellent and innovative ideas for the upskilling and retraining of a whole host of different health care professionals. My father was an ambulance driver, and when I was a medical student I would go out on the night shift with him on the south side of the city. We saw some extraordinary things. We would pick up people as quickly as we could and shoot off to wherever it was—I almost said the Victoria infirmary, but I am glad that I did not. Oops, I just did. My brother now manages a big bit of the ambulance service and I am terribly impressed by the skills of modern paramedics. Graduates are being attracted. In the old days there was a steady trickle of people; now there are waiting lists. By getting the right people doing the right thing, and by training them, giving them confidence and setting them free, a huge amount can be achieved.

I was impressed by the telemedicine centre in Aberdeen. They gave us a demonstration of a paramedic in someone's home, managing a heart attack much more effectively than I could. That was governed closely by a consultant working in the accident and emergency unit in Aberdeen. The electrocardiograms came through, and it was a perfect example of what we can do if we ask how we can use people who have a set of skills that we can amplify and that we can link in. It always comes back to linkage and collectivism, and getting things moving forward in that way.

There are some excellent people out there. Scotland has a vision of upskilling and uptraining, and of bringing other professionals to the game—in terms of first responders—and working closely with them. Retention is an issue, and I guess that we will discuss remote and rural communities. It is desperately important that we make those jobs attractive so that high-quality consultants and general practitioners want to work in remote and rural communities. I heard some good ideas about how we could do that, such as financial incentivisation, quality of work, training and simple things such as how we advertise for those sorts of posts. There are lots of good ideas out there about how to get new people in, how to get them where we need them and how to hang on to them.

Mrs Milne: Are the resources there to train all those extra people?

Professor Kerr: Yes.

Mrs Milne: The Royal College of General Practitioners has asked the following question:

"Your report acknowledges the increased importance of the medical generalist and general practitioners with a special interest as part of service redesign. How do you envisage this being achieved given the anticipated shortfall in the general practitioner workforce and the limitations on the number of training places available to train general practitioners?"

Professor Kerr: Thought needs to be given—and is being given—to career training structures. I do not know whether it is true, but I read in the papers a few days ago that the BMA says that thousands of doctors down south are unemployed; that is junior doctors who could not get on the career training grade. There is a big question mark over that, but if it is true we need to resolve it. There is no point in having GP and consultant jobs available, and in training lots of medical students, if the bit in the middle acts as a bottleneck rather than facilitating. I do not know enough about that, but it seems illogical.

Mrs Milne: I am told that it is a significant problem south of the border but not yet in Scotland.

Professor Kerr: I hope I am not being parochial about it, but if that is the case perhaps we can take advantage of that and make Scotland an attractive place, so that the brain drain comes from England up here rather than, as always, leaching our medical students down south and elsewhere. There may be a window of opportunity that we can use. It is daft if there is a bottleneck; we need to understand it and see what we can do to expand the number of training posts.

We met some wonderful GPs in remote and rural communities—GPs who wanted to go the extra mile, who wanted to be able to attend road traffic accidents and resuscitate and who are saying, "Train us. Give us new skills. How can we work more closely with our hospital colleagues?" There are excellent examples at the Vale of Leven hospital and in Fort William and so on. We encourage that. We want the colleges to get together and to come up with attractive training programmes that would facilitate and support training rural GPs.

15:00

The Convener: Janis Hughes wants to come in on nurse numbers, but Duncan McNeil had his hand up to ask a question on this.

Mr McNeil: I have a question on the equalities theme again. How do we tackle the fact that two thirds of the training capacity for general practice is based on the affluent half of Scotland? There is a major issue there about training people to work in areas of need. I am a supporter of upskilling. I am quite convinced that there are many workers, such as allied health professionals, who are desperate to take on some of those jobs. In such areas, where people often have more than one illness—they might have diabetes and heart disease, for example—can we be assured that the health professionals can cope with that level of challenge?

Professor Kerr: I was not aware of the statistic that you just gave and I hope that I can say this free of political connotation. Should it take affirmative action to get that balance right? We would be more likely to retain GPs in areas of need if they were trained there, understood the problems and realised how worth while it was to be embedded in the community and to play a significant part in improving health. Why do we not take affirmative action to get the ratio right?

Janis Hughes (Glasgow Rutherglen) (Lab): Your group gave close consideration to workforce issues, especially the external factors that are driving the need for change in the NHS today. You focused heavily on the medical profession, but I know that you also looked at the work of nurses, allied health professionals, admin and clerical personnel and other ancillary staff. It is worth noting that more than three quarters of the workforce in the NHS is female and that a large number of those females are employed on the nursing side of the profession. A moment ago, you said that thought needs to be given to career training structures. You were referring to medical staff. Does the same apply to nursing staff?

The Association of Scottish Colleges suggested that the NHS might be too preoccupied with degree-level entry qualifications at the expense of learn-as-you-go training. When I trained as a nurse, we did on-the-job training and received a salary for our work. My view is that we are disfranchising a large number of people who would make excellent nurses, but who might not want to follow an academic route into nursing. I feel that increasing the number of people who are available for training as nurses would help to address the shortages that we are experiencing. Perhaps we should consider bringing into the profession people who are not as young as those who would prefer to pursue the academic route into nursing. Did your group consider that?

Professor Kerr: That was a series of important points. James Kennedy, who is director of RCN Scotland and who co-chairs the Scottish partnership forum, was on our group. As you would expect, he gave a large voice to nursing. When I talk about clinicians, I really mean clinicians and the broad spectrum of allied health professionals.

I hate to sound antediluvian, but you and my wife share the same outlook. She trained in the Western infirmary. The expression "too posh to wash" that has emerged down south is resonating.

During my training, when I was a junior doctor, I worked with state-enrolled nurses. That highly skilled and knowledgeable group of nurses has been wiped away, but I do not know enough about nursing structures to comment on that. To bring in bright people with degrees has got to be good for us all, but I agree that having a more flexible approach might encourage people who would be put off by the rigours of taking a degree, but who would nonetheless have a great deal to offer. I do not know enough about the situation, but it would seem daft to marginalise or exclude people who could make a significant contribution. From my knowledge of the old days, I find myself agreeing with you, but I hope that I do not get into trouble for knocking nursing colleagues out of their position.

Janis Hughes: The group obviously did not discuss that issue specifically, but would you be able to explore it in your discussions with the minister?

Professor Kerr: Yes, I would. I am having similar discussions down south about how we can get people who made a real contribution to the health service, but who left for family reasons or whatever, to come back. The fact that time has moved on in the years that someone has been away is quite a big hurdle to overcome. You can imagine the discussions that we are having. We need to consider introducing some courses that would allow such people to come into the NHS at a certain level. We would then see how that went. Different promotional models could be used. Your suggestion is definitely worth exploring.

The Convener: Jean Turner had a question about the training of junior doctors.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): It was mentioned earlier that there have been difficulties in finding places for the new training of senior house officers. A doctor in my constituency is unable to get a job up here because of that. If we cannot train doctors, we cannot get them in place, which means that many of the procedures relating to getting people into hospital, where they can be well looked after, go by the board. We all know that, in general practice, we can see one patient at home for five in the surgery. The issue is all about trying to get people's competency up to a level at which they will be confident. We do not want people to have confidence without competence. What do you have to say about that?

Professor Kerr: If there is a bottleneck in relation to training posts, we need to consider that. I do not have enough detailed information to give a specific answer, but if that is an emerging picture that is backed up by evidence, we will need to carry out an exercise to match the number of kids coming through to substantive posts. Training enough health care professionals to do the right job in the right place when we need them to do it involves quite a complicated formulaic exercise.

Dr Turner: Another issue that was raised by allied health professionals is the feeling that, because there is a shortage of doctors, work will be dumped on other professionals. Some of them say, "Doctors don't do what we do because they are not trained to do it, but we have to be trained up to do our job and the jobs that doctors used to do."

We have to get a balance in getting more training places for professionals. You agreed with what Janis Hughes said about the need to open out how we train people; perhaps, having apprenticeship training is not a bad way of doing that and of encouraging people.

Professor Kerr: Yes. However, I did not get a sense that people were being dumped on. I felt that people were hungry for training and information because they felt that they could contribute more. Perhaps I was just lucky, but everyone I met said, "Train us, let us do more and let us work as part of a wider team." They were looking to be upskilled and did not feel that they were being dumped on.

Dr Turner: It might be worth reading the letters that the allied health professionals have written to our committee. A lot of people have passion for their job but, if there are too few people doing it—too few nurses in the hospital and in the community, for example—the job does not get done as well as it should. Whatever happens in relation to implementing the report must go side by side with the need to have sufficient trained professionals at all levels and in every area.

Professor Kerr: I agree.

The Convener: That leads neatly to Shona Robison's questions on implementation, but before she asks those, I think she might have a specific question on the workforce.

Shona Robison: Professor Kerr, your comments about nursing contained a bit of a dilemma. The delivery of your recommendations will require nurses to take on more and more of the work that doctors did in the past, so there could be an argument for the route becoming even more academic. How do you marry the two differing ideas that we have discussed in relation to nursing? I do not necessarily disagree that there has to be a route in that offers people such as health care assistants a qualification in the nursing profession but, in some ways, your report requires the opposite to happen.

Professor Kerr: I think that it is internally consistent and cohesive. We are saying that there may be a highly trained, interested and well-

educated stratum of nurses, from whatever group, who would want to take on additional roles and become nurse consultants, run community casualty units and so on—we have seen good examples of that—and that there are other nurses who will prefer a more traditional role. It will be horses for courses. Such groups are not two tribes that sit comfortably beside each other, but a seamless progression would take place. We require people who function at all levels.

A role has emerged for the upskilled nurse to do the tasks to which you referred and which we mentioned. Equally strongly, we need the basic primary care, which is important for sick folk. We must not neglect our drive for that. We will not suck every nurse up into being nurse consultants who work in community casualty units and so on. Some movement will take place, but it will not be huge. We will want to bring in other people to support the other role.

Shona Robison: The issue might be terminology, because I see that as the health care assistant's role.

Professor Kerr: It could be.

Shona Robison: I will move on to implementation, which will be a burning question for many people. It is interesting that the first line of your implementation section is:

"Of course, this will not be easy."

Perhaps the previous discussion of neurosurgery raises some of the difficulties. The last part of your report says that the NHS in Scotland can meet the challenge of change by

"Building a new relationship of partnership and trust with the public aligned around the direction set in this report."

That means that we must be careful with implementation. I would like to hear your views about how we do that.

I will give an example of dangers. If health boards get ahead of themselves as they move forward, does not the danger exist that trust will be broken before it is even established? I am thinking in particular about changes to accident and emergency services. On changes to unscheduled care, your report suggests that

"In order to facilitate access and ensure an appropriate distribution of care across Scotland, all NHS Boards through their Regional Planning Groups should review over the next 12 months the configuration of the unscheduled care networks on a regional basis".

That is not quite the same as consulting on proposals to close A and E services. How should implementation, particularly of changes to such emergency services, be handled so that health boards can draw back a bit? Much damage could be done in the meantime.

Professor Kerr: That will be the subject of great contention and it is completely relevant to highlight it. All committee members and I have been struck by the way in which health care has often been planned on the basis of a rather irrational, narrow, geographic bit of Scotland—the old health board boundaries and so on. That led to some health board decisions about how we ask patients to move that looked odd when put beside one another. That connects to your original discussion. If we ask patients to move, we should ensure that it is for good reason, is logical and possible and does not involve three trains, two buses and an expensive taxi ride to receive standard care. That was our thinking.

We have discussed the number of health boards, which I was not charged with interfering with. I hope that we have made a case on that. I felt that we needed the people who would undertake the large, difficult task of delivering change and the report—if we assume acceptance by the Executive—to work to break down barriers and to sort out CHPs and all the rest of it.

The regional point relates to tiers of unscheduled care. At the top tiers—the all-singing, all-dancing ones—regional decisions are required, so that we do not end up with two category 3 or 4 accident and emergency units beside each other across a health board boundary. That would not be right, which is why we imposed regional decision making. We will not step back from that recommendation.

Shona Robison: I understand that. However, despite the fact that, as you said, we still await the Executive's response on how the report should be taken forward, at least one health board has, on the back of the report, produced a series of proposals to reduce its accident and emergency services. In your view, is that the right way or the wrong way to proceed?

15:15

Professor Kerr: I do not see a problem if the proposals have been discussed regionally.

Shona Robison: Is not the problem that your report proposes a national plan or framework that must be agreed at national level? In particular, the Executive needs to say whether or not the plan is a good idea. Is there not a danger that health boards will be perceived to be taking the opportunity to proceed with the actions that they wanted to take anyway, whether or not those actions are taken for good reasons—as may well happen? The danger is that the public trust to which your report refers could be undermined. Surely it would be better to proceed more slowly so that we take the public with us.

Professor Kerr: Clearly, you have given both a general example and a specific one, but I do not

know anything about the specific example to which you refer. At the back of your mind, you clearly have a specific example of an action that has been taken or is being discussed. However, I honestly do not know enough about the issue to be able to say anything useful.

Shona Robison: I am thinking specifically of Ayrshire and Arran NHS Board's proposals.

Professor Kerr: I honestly do not know enough about that situation, as I have been back in England for a while since delivering the report. I would be interested to know how the board proposes to configure services to see whether its proposals make sense in terms of our recommendations. It would be unusual—I might also be a little disappointed—if the board had proceeded with a consultation on a configuration on which it had not had regional discussion with its nearest neighbours.

It is dead important that we maintain public trust, so we must never let that be lost. We got a lot of momentum behind our report, including serious clinical engagement, and I honestly think—and am prepared to be tested on it—that the mood of the folk of Scotland who attended our public events in town halls was behind us. Neither I nor you want that momentum to ebb away, so we agree on that. Therefore, if the proposals made the public feel in some way disfranchised or hoodwinked, that would be just barmy, plain wrong and doolally.

However, the board might be proposing a sensible and thought-through configuration of services that has been regionally discussed. If, having considered our national report, the board has decided in association with its regional partners that it should respond by proposing certain changes, on which it now wants to ask the public what they think, that seems fair enough. However, I do not know enough about the issue to know whether that has happened.

The Convener: I will allow a small question each from Mike Rumbles and Duncan McNeil.

Mike Rumbles: On implementation, the final paragraph on page 32 of the report states:

"It is true that a relatively small number of people who might have had emergency surgery in one hospital may in the future have to travel a bit further. But the numbers involved are relatively small".

No one would disagree with that language about people possibly having to travel a bit further were it not for the dangers that might arise, as Shona Robison pointed out, when the report is implemented.

The report says that

"the numbers involved are relatively small in comparison"

as if the issue does not matter, but it will matter to those who will need to travel further. My concern is that such a broad-brush approach assumes that, with central planning, we can have a hospital here and a hospital there, to which some individuals might need to travel further, but that will not matter because of the greater good.

The Convener: Great small question, Mike.

Professor Kerr: I will stick up for myself a wee bit. I am just not the sort of person who would ever write or say that it does not matter. You are paraphrasing a wee bit.

Mike Rumbles: The report says that the numbers of people affected will be relatively small.

Professor Kerr: That is a numerical statement. It means that those patients will be in a minority. We know that the majority of work—some 70 per cent—that is currently dealt with in A and E departments could be handled in what we have designated as community casualty units. Only a minority of patients—a third or less than that—need to be admitted for emergency surgery or physician-type care. Let me say out loud that I do not for a moment mean to imply that sick folk do not matter.

Mike Rumbles: I did not say that.

Professor Kerr: Okay. That is all right.

Mike Rumbles: I was referring to what you said about the number of people being relatively small.

Professor Kerr: Yes. The figure is small.

Mike Rumbles: There is an implication there.

Professor Kerr: The group that worked on the matter did the sums and the figure is relatively small, because 70 per cent of the work can be dealt with in community settings. It is a numerical statement.

Mike Rumbles: But it has implications.

Professor Kerr: I understand the point about travel, and it is really important. I said that it is unacceptable that it should be necessary to take two trains, three buses and an expensive taxi ride to access services. I agree that that issue must be factored into the configuration of services.

Mr McNeil: I could not have a better cue. I am delighted that Shona Robison raised the issue of accident and emergency services, unplanned care or whatever we describe it as. The issue has generated a lot of interest throughout Scotland.

You have said that it is not logical to have to make two train journeys and take a taxi or whatever. How can we engage people and be honest with people if they do not understand the rules of engagement of the consultation process? What factors will decide whether a community such as my own—I do not want to put you on the spot, but you can generalise—will have a certain

level of hospital service? What weighting decides whether a service is level 1, 2, 3 or 4? Is the decisive factor travel, the nature of the community, the population size or the type of people who present as admissions?

I know that the convener will come back to consultation. Unless people understand the rules of engagement, there will be mistrust. We want to know what the rules of engagement are.

Professor Kerr: That is a very interesting question. I do not have a list of rules that I could give you off pat, but we need them. In this first step of the process, what we did not do was to put pins in a map. We wanted to be broadly descriptive about the tiers of service and what they should be. We were not washing our hands of the matter or stepping back, but we did not state where the services should be situated. We did not, in the usual way, go to a bunker in the Scottish Executive—I had better watch what I say, but one model for conducting such an exercise would be to get a bunch of health professionals together and do the map exercise without taking account of the entirely legitimate and dead logical questions that you pose.

We should flag up the creation of such rules as a piece of work for the Executive to think through to ensure that the decision-making process is transparent and that folk do not feel that services are being moved for arbitrary reasons of shroud waving or however it has been perceived—probably wrongly—in the past. We could come up with a series of items that would allow us to respond to the question that Duncan McNeil has asked, but such a response would currently be off the top of my head. We need to do that piece of work. The point is very interesting.

The Convener: It is not like Duncan McNeil to be interesting, is it?

That leads on to the questions that I want to ask, and other members might want to come in.

First, I ask you bluntly why there was no mention anywhere in your work of the provision of maternity services, which has been one of the most controversial areas of provision of health care in Scotland in recent years.

Professor Kerr: When we asked the Executive what items or issues it would like to look at it suggested a few—the ones that I mentioned such as neurosurgery and child health. We did not pick up on maternity services. I thought that you were also going to ask about mental health services.

The Convener: I could ask about those but, in the context of implementation and consultation, maternity services—along with A and E—have easily been the single most controversial issue in Scottish health provision over the past five years. I find the omission unusual to say the least.

Professor Kerr: Remember that the report is a 20-year plan. We were charged with trying to find generic, widely applicable solutions. I would argue that the solutions—the ideation—in the report would fit maternity services.

The Convener: What level of maternity services: 1, 2, 3 or 4?

Professor Kerr: I said that they would fit, but I do not know enough about it to give a specific answer—I truly do not. We asked the Executive what areas it wanted to focus on, but maternity services was not one of the areas that it proposed.

The Convener: I bet it was not. The issue of consultation is central and the arguments about maternity services point up the enormous deficiencies in how we consult people.

I want you to address certain issues. In the section headed "Our Key Messages", on page 5 of your report, you make a bold statement about the need to

"Develop options for change with people, not for them, starting from the patient experience and engaging the public early on to develop solutions rather than have them respond to pre-determined plans conceived by the professionals.

If that is done for an area such as maternity services, the public's clear response is not what the health professionals want to hear. Therefore, they take out certain options and present what is left to the public. The public's preferred option is no longer in the refined list of options, so it becomes clear to them that they will not get what they want. That scenario probably applies to consultations on other services as well.

Given the statement in your report about public involvement, how will you turn that situation around, given that in many cases the public's response will not be what you or health professionals want to hear?

Professor Kerr: In a way, you have answered your own question, which allows me to speak generally about consultation. I agree with your point, but it refers to what happened before, when consultation on services such as maternity services, mental health services or cardiology was binary in form, in that the message was to take it or leave it. Such consultations provided carefully considered options that health professionals had bought into, which were presented in an arbitrary way. We agree with the criticism of that form of consultation and I have blown it away in my report. Consultation on maternity services, for example, must follow the model that you want to promulgate and that we described in the report, which is to work with people to develop a service rather than to impose something on them.

The report blows away the old model that we both agree is wrong and antediluvian. It should be

moved aside and replaced with a brighter, more positive way to embrace the future together.

The Convener: So the model that was used as recently as a year or two ago is antediluvian. However, you have still not explained to me how consultations will genuinely take on board public demands if the demands are for something that the health professionals do not want.

Professor Kerr: We specifically addressed that problem by saying that we would not impose a predetermined solution on anyone. When we consulted on the report, we did not go to public meetings with bits of paper that stated what was option 1, 2 and 3; we went with a blank sheet. We went to listen to people. I did not try to sell anybody anything at our town hall meetings. We picked up on a model that was used in Forth Valley and which Peter Bates used successfully in Tayside.

The Convener: Are you referring to one-day conferences and so on?

Professor Kerr: They went about things in a range of different ways. It is not fair to dismiss their approach. They made an honest effort to engage with citizens, bring their two groups together and try to come to a joint solution. That is what you and I want. The issue is about creating a forum that allows us to do that. The successful models that we would operate would consign the old, duff, arbitrary consultations to the dustbin of the past.

The Convener: The Tayside consultation took over four years and resulted in precisely what the health board had wanted to do at the start of the process, which caused a great deal of public alienation in the health board area. I am not entirely sure that I would be confident if you thought that that consultation should be a model. I dare say that other members will want to say something about that.

15:30

Mike Rumbles: The convener is talking about past consultations. In Aberdeenshire, the five community hospitals with maternity services are all currently under review. The public do not want them to close. We keep on saying to people that they should have the option of having their baby delivered at the hospital in Aberdeen, in the community hospitals or at home. On Friday, I visited Aboyne hospital, which is 30 miles from Aberdeen. People in Braemar have a 120-mile return journey to Aberdeen and the public want local services to remain.

Yesterday, I was at a health board briefing, which was attended by the chief executive. The word "cost" was used three times to us. It is clear to me that the consultation will show overwhelming support for retaining maternity services but, as Roseanna Cunningham said, there seems to be a view that the health professionals will want closure.

Professor Kerr: I cannot prejudge an issue that I know nothing whatever about, and you would not expect me to do so.

Mike Rumbles: That is happening now.

Professor Kerr: There is an issue for the Scottish Executive Health Department—and others—which must give advice, help and support to move things forward, but—

Mike Rumbles: I am sorry to interrupt. There is a new era now, but those consultations have ended.

Professor Kerr: There is the technical matter of waiting for the Executive to respond. I hope that the Executive will adopt the various ideas that we have proposed. In the interregnum, stuff might be going on out there that you feel uncomfortable with, but two sides must be brought together in any consultation. There are two sides in discussions and arguments, and the type of engagement that we have modelled will allow both sides to see and understand the pressures on the other and to come together to reach an approved joint solution.

Helen Eadie: Convener, I would like to—

The Convener: There are people waiting to come in on that point.

Helen Eadie: On a point of order, convener. It was said that maternity services were not covered by the report, but they are discussed on page 204.

The Convener: I know. The first sentence on that page states:

"The work streams of the National Framework for Service Change do not specifically cover maternity services."

Helen Eadie: There are two or three paragraphs on maternity services.

The Convener: I know, but the section begins by saying that maternity services are not covered by the national framework for service change.

Helen Eadie: There is a whole chapter on them.

Dr Turner: It is important to know bed numbers if we want to continue with the idea that we are in a new era. For years, we have been desperate to know the right bed model for Glasgow. As Professor Kerr probably knows, many people lie around on trolleys and cannot get into hospitals. The latest news from a board meeting that took place this morning is that in-patient and day cases over 26 weeks increased by 29 per cent between July and August.

The bed modelling report went out for consultation on 26 July, and people wanted it to be

back by 19 September or thereabouts. There has been a holiday period. Professor Kerr wants the faith of the general public to be restored, but it is difficult to restore faith for those who work in the health service. I am talking about the nurses who are desperate to find beds and who shuffle people around and try to shove them out into the community before it is time to do so. Some elderly people think that the onus should be on them to decide whether they are fit to go out into the community, but nothing has changed in the important document that we are discussing. I get the impression that people are scared that there will be centralisation whether or not you have produced a report and that health boards will continue as they want to continue without consulting people whether or not what they do is wrong and ends in a mess.

Professor Kerr: That would be disappointing and plain wrong. I could not agree more with what you say.

You mentioned beds. A bit of me believes that we in Scotland must use beds better. We have tried to say that we will be able to keep patients out of hospital, look after them better in the community, save beds and use those beds more effectively as a result of modernising and redesigning services. There is an interesting dynamic about beds.

Dr Turner: We would really need to have care in the community fixed before we could put people into the community and we would need personnel to look after them.

Professor Kerr: I agree.

Shona Robison: The questions that you are being asked today are nothing compared with some of the questions that you will be asked out there. Perhaps this is a good rehearsal for you. Do you think that the principles of your report should apply to maternity services?

Professor Kerr: Generally, yes.

Shona Robison: A number of things in the report of the expert group on acute maternity services, to which you refer in the section of your report on maternity services, could change. You talk about the role of specialist GPs, such as those who specialise in obstetrics. An awful lot more could be said about that in relation to sustaining maternity services in localities. An opportunity has been missed, in that that section could have been fleshed out a lot more to point the way to how we could develop and sustain local maternity services. As soon as the EGAMS report is mentioned, those who are fighting to retain local maternity services sigh, because it does not provide much hope of there being a different way of thinking. You have said that the principles of your report should take precedence.

Professor Kerr: I feel manoeuvred. I am not sure about the precedence issue. I think my report should be mapped on to—that would make sense—because there are generic principles that could apply to all bits of health. That is a reasonable statement. I am not sure about the precedence issue; I do not know enough about it.

The Convener: I think this set of questions has come to a natural end.

Dr Turner: I said at the beginning that I was interested in asking Professor Kerr about implementation and people. He works in England and might have more knowledge of this. The BMA is extremely concerned about bringing in private companies to do work, which has a knock-on effect on the training of doctors and other professionals. If, as is being said, the private sector takes the easy stuff, it leaves the difficult stuff for the NHS to do, which means that, no matter how hard we try, we will crumble and end up going to five big centres—

The Convener: Ask a question, Jean.

Dr Turner: What is Professor Kerr's opinion on bringing in the private sector and its knock-on effect on the education of our young doctors and all other health professionals?

Professor Kerr: I am fairly agnostic about it. I have never practised private medicine and I never will. If the private sector can be brought in sensibly without interfering and it can add capacity, why not bring it in? If it works, why not embrace it? However, it should not get in the way or do any of the negative things that you suggested.

Dr Turner: Would you be concerned if it were to be brought in in the long term? Do you see it as a short-term measure?

Professor Kerr: No. It is about getting things fixed and using any means that we can to do so. I have seen good and bad private sector involvement in England.

Dr Turner: I am surprised that you have no feeling one way or the other on that.

Professor Kerr: I am being pragmatic. Without getting involved in any small political philosophy, if the involvement of the private sector fits, adds capacity, gets people treated quicker and better and meets the needs of the populace without doing harm, why not have it?

The Convener: Thank you, Professor Kerr. It is not beyond the bounds of possibility that the Health Committee will continue to be in touch with you on a number of these issues. We will give you as much notice as possible of whatever we want to do. I will suspend the meeting for three minutes.

15:39

Meeting suspended.

15:43

On resuming—

Budget Process 2006-07

The Convener: Agenda item 5 is consideration of the budget process for 2006-07, for which we have decided to focus on the Health Department's efficient government proposals. We will take evidence from Dr Kevin Woods, the head of the Health Department and chief executive of the NHS in Scotland. Dr Woods has already spent an exciting morning in front of the Audit Committee, so he is having a long, hard day. He is accompanied by Scott Haldane, the finance director for NHS National Services Scotland; Professor Bill Scott, the chief pharmaceutical officer; and Adam Rennie, head of the community care division. I invite Dr Woods to make a brief introductory statement, after which we will move to questions.

Dr Kevin Woods (Scottish Executive Health Department): I thank the committee for inviting us. Efficient government is a substantial topic, on which I would like to make a few comments. I will try to be as brief as possible, but the subjects in which the committee is particularly interested are significant.

The aim of the efficient government approach is to release genuine efficiency savings—every pound that we save will be ploughed back into health services to supplement announced spending. Since the publication of the efficient government plan in November last year, the cash savings target for the Health Department has increased to £342 million by 2007-08. For time-releasing savings, the figure is £174 million, as announced on 6 September this year. The savings plans are subject to scrutiny and challenge by Audit Scotland, which is considering what monitoring work it will ask its auditors to carry out in 2005-06. However, responsibility rests with the department and the health boards. All the projects that were identified are now in progress, although some are in the early stages, and all are on target to deliver the intended benefits by the proposed date.

I understand that the committee would like to focus on three areas in particular.

The Convener: There will be general questions, but the three particular issues are prescribing of drugs, efficiency savings in the Scottish Commission for the Regulation of Care and NHS logistics reform.

Dr Woods: I will say a little bit about each, if that is okay, although if you would prefer to go straight to questions, I am happy to do that.

The Convener: The consensus among members is probably that we should go straight to questions. You may be able to make some of your comments in answer to our questions.

Dr Woods: Fine.

The Convener: As Janis Hughes has to leave early, she can ask the first question, which will be on NHS logistics reform.

Janis Hughes: I will start with an issue that is close to my heart, which is NHS information technology facilities. For the past 20 years or so, there has been an ever-growing conglomeration of various systems that do not talk to one another. Some individual trusts or even units have their own IT systems that bear no resemblance to systems elsewhere in the NHS. That sort of situation is detrimental to the modern ways of working that we discussed with Professor Kerr and which we are considering implementing in the NHS as a whole.

In the rest of the United Kingdom, the NHS has signed up to a 10-year agreement for the whole of the service, which has provided benefits, not least in respect of the savings that have come from it. Why has that not been done in Scotland? What moves have you made since we last considered the budget to rectify the situation? Given that some of the changes that are to happen in the provision of care, particularly acute care, are heavily dependent on robust IT systems, can you assure us that the systems that will be put in place will be efficient?

Dr Woods: I am happy to address that question. IT is important for some of our procurement projects. More generally, it is fair to say that since the days of trusts, which Janis Hughes mentioned, our approach to procurement of IT services has been turned on its head. We are now clear that we do not want parts of the NHS to go off in different directions and do their own thing with IT systems. We therefore promote either national contracts or collaborative procurement. For example, in the context of better procurement, we now regularly use e-auctions to co-ordinate purchasing of equipment. To give a small example, last week, an e-auction for personal computers and laptops saved £426,000.

Our ambition in the longer term is to move to a single IT system for Scotland, a measure that is flagged up as necessary in the Kerr report. We are committed to progressing procurement of that in the next two or three years. Between now and then, we will run a number of other national procurements for important systems to fill some of the current gaps. We believe that those measures will deliver important benefits to patients and clinical staff. An example of that will be our procurement of a picture archiving and

communications system—PACS—for radiology, which will ensure that we have a very efficient system of high-quality digital images. We will be rolling that out over the next two years.

Similarly, we are developing national systems for information for accident and emergency services. We are also rolling out an emergency care summary record. That has been piloted so far in Grampian and in Ayrshire and Arran in order for it to become a standard feature. It will enable clinical data to be passed from general practice and primary care to out-of-hours providers so that they know something about patients who enter that part of the system.

In order to underpin all that—I hope that this is not too elaborate an answer—we are pursuing vigorously the universal adoption of the community health index number. The CHI number is important in enabling us to move to a single patient record, because we need to have a unique patient identifier. Our intention is to have it in universal use by June 2006.

Janis Hughes: Most of what you say is reassuring, but I am concerned that you are still two or three years away from having a single IT system throughout Scotland. I mention the example of Greater Glasgow NHS Board, because it is about to go into a major capital procurement programme for the ambulatory care centres at Victoria infirmary and Stobhill hospital. IT will play a crucial part in the design and work of those centres. IT's role is particularly important where there is split-site working, because people might be concerned about how their records will be accessed in two sites in different parts of the city. Can you assure me that discussion is taking place to allay people's concerns about IT operations in any pan-Scotland system that you negotiate?

Dr Woods: I am not familiar with the precise details of the IT components of the hospital developments to which you referred, but I am confident that people's concerns will be addressed in a way that is consistent with what we are discussing here. That is important.

There is always an issue about when to stop procuring systems of a particular type and when to move on to another. That is something about which we are thinking carefully. However, our direction is clear: we want standardised systems that can communicate one with another. We have invested heavily in telecommunications infrastructure to make that possible. Many of the systems—PACS, for example—require the transfer of large quantities of data; networks that can do that are needed. We have already invested in that sort of thing.

Janis Hughes: I know that health boards are required to provide 25 per cent of funding for the best procurement implementation programme. Are the plans that have been discussed for a central distribution centre—in Lanarkshire, I believe—on course and will they be within budget? What long-term savings can boards anticipate as a result of such centralisation?

Dr Woods: There are several related components in that question that are worth teasing out. It is probably helpful to think about them in connection with the supply chain. We are trying to use our collective buying power to reduce the cost of goods and services; that is what we call strategic sourcing. For instance, we secured savings of 30 per cent on procurement of protective clothing and uniforms through that approach.

We are trying, again using electronic communications, to make it easier for staff throughout Scotland to order goods and services from their workplace, thus eliminating some of the paperwork that has traditionally been associated with communications. We are also trying to streamline distribution of goods and services through, for instance, the creation of a national distribution centre, which is due to come on stream in 2006. When we add all those projects together, we aim to secure savings of about £70 million by 2007-08, and I understand that all those projects are currently on course.

Mr McNeil: Going back to the summary recommendations in the Kerr report, one of the recommendations is that electronic health records should be put in place within three years. You have said this morning that that will happen. I mean this afternoon—I have lost track of time.

Dr Woods: I can assure you that it is the afternoon, sir.

Mr McNeil: Right. Let me start again. Will that three-year programme happen?

Dr Woods: That is what we are aiming to do, yes.

Mr McNeil: Now I am getting confused. Will it happen or not?

Dr Woods: All I am saying is that that is our intention and that is the timescale that we are working to, so it should happen.

Mr McNeil: So, on the basis of the progress reports that you have to date, you do not anticipate it not happening.

Dr Woods: No.

Mr McNeil: If you are not sure about that—

Dr Woods: If there is hesitancy, it is simply in my recognition that we are talking about a very large-scale procurement. We are talking about very complex systems.

Mr McNeil: Yes, but we are not talking about developing that system—we are talking about buying something off the shelf.

Dr Woods: At this stage, we are examining the different possibilities for obtaining the system. There are different things that we could consider. Some people have suggested, for instance, that systems that are used by the Veterans Benefits Administration in the United States would be worth considering; that was discussed in the Kerr report's considerations. We are looking for different ways in which we might fulfil that, and then we shall go through a competitive procurement process.

Mr McNeil: Is there conflict? Do the people who have been involved for the past however many years in delivering new technology in the Health Department have views on whether they should be developing new systems or whether off-the-shelf material is available? Is there an issue?

Dr Woods: There are bound to be different views about the best way to proceed. What we have in Scotland is an e-health project team—I happen to chair it—that is heavily populated by clinicians. One thing that has been clearly established over many years is that the key to success in the use of information systems is not just the system itself but the system's functionality and suitability, support for the system from clinicians in particular, and organisational change and training to support it. That is why some of our leading clinicians, who are heavily involved in information systems, are participating in the debate on how to proceed.

Mr McNeil: You started off by telling me that you were on schedule for the three-year timetable. Are you telling me now that you have not even agreed whether an off-the-shelf package is available? When will that issue be resolved? If the situation continues for much longer, will that affect the three-year timescale?

Dr Woods: No. I am saying that the conversations that we are having at the moment are part of the plan that will unfold over that three-year period.

Mr McNeil: Could we get more detail about the plans, perhaps in writing?

The Convener: That would be helpful.

Dr Woods: I would be happy to provide that.

Mr McNeil: As well as being compatible within the health service, are we also looking at issues to do with the system's being compatible with local government?

Dr Woods: One has to be careful about safeguards in relation to information and confidentiality—that is clearly an important consideration. We would not simply be designing in the easy flow of personal clinical information, but if we can secure appropriate linkages and provide appropriate safeguards, I am sure that that is something that will inform our work.

Mr McNeil: How significant is that in delaying the roll-out process? I accept that there is a significant issue about patient records and who has access to them.

Dr Woods: I do not believe that it is a significant factor in any delay, and I want to reassure you that there is no delay. I am trying to tell you that we have a programme that will take us the next three years to design, procure and implement. That is what we are doing. To my mind, there is no reason at this stage to think that the project is delayed in the way you seem to think it is. I hope that that is not your impression, because that is not what I am saying.

16:00

Mr McNeil: No, I am just concerned by the use of words such as "design" when we know that other health bodies throughout the world already deliver such services. After all, when people feel that they have to design something, we usually get an expensive flop at the end of the process. I am attracted by things that are bought off the shelf.

Dr Woods: For the reasons that you indicate, we are looking hard at the risks in the process. We are commissioning detailed work on mitigating and managing the risks effectively in order to avoid the situation that you described.

Mr McNeil: Page 235 contains a summary of recommendations from the "Electronic Health Record" through to "Tele-medicine". Can we have an indication—

The Convener: Dr Woods, Mr McNeil is referring to Professor Kerr's report.

Dr Woods: I was wondering which page 235 we were on.

Mr McNeil: Page 235 of the report, which contains a summary of recommendations, says that the NHS

"needs a single information technology system"

blah, blah, blah. Will you indicate the progress that has been made on each of the recommendations on page 235? When are the recommendations likely to be delivered?

Dr Woods: I am very happy to submit that information to the committee.

The Convener: That would be useful.

Dr Woods: Of course, we will say more about some of the recommendations when the

Executive's response to Professor Kerr's report is released in due course.

The Convener: I want to clarify with my colleague whether, when he envisages a single IT system that would include local authorities—which might well raise eyebrows elsewhere—he is referring to the authorities' role as providers of much community care and so on.

Mr McNeil: Yes.

The Convener: Dr Turner also has some questions about logistics reform.

Dr Turner: Is the NHS thinking about buying drugs and appliances in the same way that one might buy spare car parts? For example, are you considering which drug is the best, which drug is the cheapest and so on?

Dr Woods: I ask Mr Haldane to answer that question.

Scott Haldane (NHS National Services Scotland): Throughout Scotland, we have what are known as pharmacy zones where groups of pharmacists come together with procurement experts and buy drugs according to the approved formulary for that region. We intend to work more closely with pharmacists from a national perspective to ensure that we get the best possible leverage for the spend of public money on pharmaceutical products.

Dr Turner: That would make sense for a country with 5 million people.

Scott Haldane: We have one major warehouse at St John's hospital in Livingston, which at the moment stores—

Dr Turner: I realise that there is a big difference between primary and secondary care, which will probably require more discussions with community pharmacists. Many consultants want general practitioners to prescribe drugs. However, drugs are expensive, and it is sometimes more expensive to prescribe them in the primary care setting than in the secondary care setting.

Dr Woods: It might be helpful if I invite Professor Scott, the chief pharmaceutical officer, to say a little more about the cost of pharmaceuticals and some of our initiatives to secure effective purchasing.

The Convener: Perhaps we should hold off on that until we come to our questions on improved prescribing. It might work better in that section.

As members have no other questions about logistics reform, I return to the area of questioning that I was going to take first. Shona Robison will ask questions of a more general and strategic nature.

Shona Robison: I will begin with a general question. If the scale of the cash and time-releasing savings is as Dr Woods has alleged, why have they not been made before?

Dr Woods: For many years, the NHS has been seeking year-on-year efficiency savings and the custom and practice has been to identify locally ways of releasing additional cash for services. However, with its efficient government programme, the Executive has made it clear that it wants to take a more concerted and determined approach. Members will see from my examples that such an approach, particularly with regard to procurement, logistics and so on, brings very significant benefits.

Shona Robison: Should not officials in your department be looking constantly to make savings on the scale that has been suggested? Surely at some point over the past six years they could have told the minister that such savings could be made.

Dr Woods: I was not around then but, in general, you are right. There has been a continuing interest in securing efficiency and cash-releasing savings, because they add to the totality of available resources. The procurement initiatives that we are now pursuing in this orchestrated way have their origins, in part, in some work that is being undertaken by procurement officers on some NHS boards. Mr Haldane could give you more detail on that.

I re-emphasise that it is not as if people have not been looking for efficiencies in the past. They have and they have often succeeded; for example, in dealing with backroom functions and trying to secure services more efficiently. We are now trying to capitalise on collaborative working using the added purchasing muscle that comes from pulling together all NHS organisations in Scotland.

Shona Robison: Let us consider how robust some of the alleged savings are. I am interested in the discussions that went on between officials in your department and Audit Scotland in advance of the suggested savings being put forward. The Executive's comment was:

"Audit Scotland … are content with our detailed plans."

However, that is not really borne out when we read what Audit Scotland had to say about the plans. It said:

"the tools to measure time-released savings are 'rarely in place' … there is 'uncertainty about targets' … some claimed efficiencies are only 'proxy' savings and cannot be properly measured … assumptions on inputs and outputs, the key test of efficiency, are 'often untested'."

That does not make it sound as if Audit Scotland really is "content". I am interested to know what discussions you had with Audit Scotland and what Audit Scotland said about the proposals that you put forward.

Dr Woods: What is being said there is that we are dealing with often complex issues. For example, what is the baseline, and how are we going to develop information systems that can track things better? We have published detailed notes setting out how we are to do that. For instance, we have issued detailed notes on the reduction of absences, which would be a time-releasing saving. Those notes must be cleared with Audit Scotland so that everyone is satisfied that we will have effective measures of the savings that we are pursuing.

Shona Robison: Has Audit Scotland effectively missed the tools to measure time-releasing savings? It is saying that those tools are "rarely in place". Are they in place?

Dr Woods: Yes, I believe they are.

Shona Robison: So why does Audit Scotland not know that?

Dr Woods: I am not entirely sure to what you are referring when you make those quotes.

Shona Robison: In her letter to Peter Russell, Caroline Gardner says that the tools to measure time-releasing savings "are rarely in place". In the same letter, she goes on to discuss "uncertainty" about targets and "proxy" savings, and says that assumptions on inputs and outputs are "often untested". Are those fair concerns to raise or not?

Dr Woods: I am not familiar with the detail of the dialogue between Peter Russell and Caroline Gardener, which probably reflects the complexity of measurement in some of those areas. I mentioned reducing sickness absences. We are implementing a new workforce information system in Scotland, which will be very important for some of that measurement. The comments could be referring to something like that.

Shona Robison: Where does Peter Russell sit in the scheme of things?

Dr Woods: Peter Russell does not work in the Health Department; he works in one of the central departments of the Scottish Executive, and has an overview on efficient government in all—

Shona Robison: So he has a key role in the efficient government initiative, does he not?

Dr Woods: Yes.

Shona Robison: Let me move on to some of the specifics regarding sickness absence, which you have mentioned, and regarding the consultant contract. You have stated that there is to be a 20 per cent cut, going down to an average sickness absence level of 4 per cent by 2008. Is that right?

Dr Woods: What we have said is that we want to move from the current average level of sickness absence of 5.35 per cent to 4 per cent, which is already being achieved in some places.

I emphasise that we want to go about that by being a good employer. There has been speculation that we will approach the matter in an unhelpful way by singling out people for special treatment. However, that is not at all the case. We are trying to develop good, high quality occupational health services and good health and safety practices, which will contribute to ensuring that the NHS is a safe and healthy place in which to work.

Shona Robison: The challenge is quite large, because the sickness absence rate is going up. Two years ago, the rate was 4.64 per cent and it is 5.35 per cent now. However, there are a lot of variations. If you are saying that the target is 4 per cent, you are telling Greater Glasgow NHS Board that it must make a 37 per cent reduction in its sickness absences. If it does not do that, what happens?

Dr Woods: We expect all NHS organisations to undertake careful analysis of patterns of sickness absence in order to try to understand what the factors might be and so that we can consider the variation across places of work, departments and so on. We want organisations to develop policies, practices and plans that are consistent with our human resources procedures. I think that you are familiar with the guidance that we issue in relation to staff governance, partnership information network guidelines and so on, which is a significant advance in Scotland. Furthermore, collective work is being done in area partnership forums and so on to bring the figures down.

It is pertinent to mention at this point that the minister and I have been undertaking annual reviews of NHS wards. One of the things that we do in that context is meet staff and management locally. We have been encouraged by the recognition that a positive approach to absence management, as I have described it, is supported.

You ask what will happen if the target is not achieved. We are working on the basis that it will be. We will be working through the progress that individual boards are making. I do not know whether members of this committee have had the opportunity to catch up with announcements that were made at the end of July about how I am reorganising part of the Health Department to establish a delivery group to engage in a proactive dialogue with boards about the achievement of key targets. The target that we are discussing is one that will be in our sights.

Shona Robison: Just to be clear, if NHS Greater Glasgow does not deliver a 37 per cent reduction in sickness absences by 2008, the savings will have to be found elsewhere.

Dr Woods: The savings are time-releasing savings and, in the situation that you describe,

NHS Greater Glasgow would not have the benefit of the time that would be released.

Shona Robison: Would the savings have to be found elsewhere?

Dr Woods: The shortfall might be compensated for if someone can achieve more savings somewhere else.

Shona Robison: The answer to my question is "Yes", surely.

Dr Woods: We expect NHS Greater Glasgow to deliver its share of the overall savings.

Shona Robison: On the consultant contracts—

The Convener: Shona, can we move this along? We have quite a lot to get through.

Shona Robison: Okay, I will ask only one more question on the consultant contracts. There is an assertion that there will be a 1 per cent time-releasing saving as a result of greater productivity. How will that be delivered? What leverage exists within the consultant contract to deliver that?

Dr Woods: The short answer is that there is better job planning, which is an important component of the consultant contract. On 1 July, I distributed to the NHS a circular on realisation of benefits from pay modernisation. We discussed and agreed the contents of the circular with our partners in the Scottish partnership forum and the human resources forum and with staff representatives.

Importantly, medical directors have also indicated that they support the initiative and believe that it can be delivered through better job planning of consultant contracts in order to secure changes. We will monitor the situation through SWISS, the Scottish workforce information standard system, which I described earlier.

16:15

The Convener: Mike Rumbles wants to come in at this point. When he has asked his initial question, I want him to move on to the care commission.

Mike Rumbles: My question is on the totality of the figures, Dr Woods. On NHS procurement, you give savings of £50 million by 2007—that is a nice, round figure. On improved prescribing of drugs, there is another nice, round figure of £20 million. On NHS support service reform, there is a nice, round figure of £10 million. On NHS logistics reform, there is a nice, round figure of £10 million. With all the other things, that makes a total saving by 2007 of 5 per cent, which is up from 2.5 per cent this year—both nice, round figures.

I am trying not to be cynical, but the information that was produced for us gives me the impression that somebody told you, "I would like a 2.5 per cent cut in those areas this year and a 5 per cent cut in 2007. Go away and find out where those cuts can be made", rather than—if this were a true efficiency programme—saying to you, "Go away and really work hard to find out where efficiencies are in these departments and present the savings." Which of those two approaches was used?

Dr Woods: They are not cuts; they are efficiency savings.

Mike Rumbles: Will you answer my question: which of those two methods was used?

Dr Woods: Perhaps I will illustrate—

Mike Rumbles: It is a simple question.

Dr Woods: I will ask Mr Haldane to take you through how we approached the procurement line. Underpinning procurement and logistics are detailed business cases.

Mike Rumbles: I am sorry, Dr Woods; I do not want to be rude—I am trying not to be—but I asked a very simple question: which of the two methods was used?

Dr Woods: I am trying to illustrate the detailed bottom-up work through the procurement initiative and the business-planning process that has been used to inform the savings that can be delivered in relation to logistics, procurement, strategic sourcing and so on. I was merely suggesting that Mr Haldane might elaborate on that.

Mike Rumbles: I do not want any elaboration; I would just like to know which of the two methods was used.

Dr Woods: I am saying that generally, those areas are underpinned by bottom-up analysis of the savings that could be achieved.

Mike Rumbles: So the minister did not say to you, "I want a 2.5 per cent saving by 2005-06 and a 5 per cent saving by 2007." He did not indicate that that was what he wanted.

Dr Woods: The minister did not say that to me. Everybody is aware that we need to be more efficient, and ministers have been clear that that is what they want us to do.

Mike Rumbles: I want to know what the direction was—what method was used. I will try asking the question again, but in a different way. Did you and the department say to the minister, "These are the efficiencies that we want to produce because we are good civil servants and have worked out where to make the savings", and then come up with the figures? I would have been very surprised to discover that they were such round figures. Alternatively, did the minister responsible for the department say to you, your

predecessor or your staff, "These are the savings or cuts"—I use the terms interchangeably—"in your department that I want: a reduction of 2.5 per cent this year and 5 per cent next year"? The figures speak for themselves; they are so round that they are almost unbelievable.

Dr Woods: I am trying to convey is that there is clear ministerial interest in securing efficiencies. That is a main plank of current policy. To that extent, ministers are clear that they want savings to be made. However, reaching a view on what the level of savings should be is informed by detailed work undertaken in the NHS. I referred to Mr Haldane's work because his organisation—NHS National Services Scotland—runs many of the projects on our behalf and on behalf of NHS boards, and it has undertaken that detailed work. He might be able to assist the committee in understanding the business cases that demonstrate that the savings are genuine and that real investments are required to liberate the resources.

Mike Rumbles: Well, you certainly have not answered the question.

The Convener: Yes. This could run and run, but we are not getting anywhere.

Mike Rumbles: He has not answered the question.

The Convener: Mr Haldane, you have your hand up to speak. Are you going to be succinct? We have a lot still to do.

Scott Haldane: There is one very good example that I hope will answer two questions. The largest sum that Mr Rumbles cited was the £50 million of procurement savings. That figure originally came from a review that Audit Scotland commissioned into buying practice across the NHS in 2003, which gave a spread of potential savings opportunities. We then brought in experts who have a clear understanding of the supply chain to consider the NHS spend profile and to extrapolate what might be our actual savings potential. That work gave rise to the figure of £50 million. It was truly a bottom-up process.

The Convener: Okay.

Scott Haldane: I could cite other examples.

The Convener: I think that you have answered the question as much as you can. Mike Rumbles also wanted to ask about the care commission.

Mike Rumbles: Yes, and the £1 million of savings—another nice, round figure.

We had a recent consultation with the people of Scotland in Perth, at which we considered the care commission and its financing. There was a lot of concern about the care commission's charges, whether it can run on the amount of money that it has got and whether it is self-sufficient. For example, one individual made a case for his organisation, which is based at Inchmarlo. He used to pay Grampian NHS Board £4,000 for regulatory services, but now pays the care commission three times that figure—almost £12,000. That is a theme that we have come across.

How did we suddenly come up with £1 million that the care commission does not need?

Adam Rennie (Scottish Executive Health Department): The efficiency saving of £1 million is derived from work that was done within the care commission. It has been achieved entirely in the area of the regulation of early-years services—childminding and day care services for children. The commission identified various ways of delivering that saving, of which I will mention three.

First, while ensuring the protection of service users, the activity time required to regulate childminders has been revised and modified. Secondly, there has been increased use of unannounced inspections of day care services, which saves time because there is less paperwork. That arrangement applies to day care services but not to childminders because, as was expressed at the Perth event, unannounced inspections of singleton childminders tend to be unproductive as they might not be available. Finally, the joint arrangement with Her Majesty's Inspectorate of Education for the regulation of certain small services has been changed. Services for fewer than 20 children will now be inspected by either HMIE or the commission, but not by both, unless an inspection by one regulator throws up something of concern that is then drawn to the attention of the other.

Mike Rumbles: If there is going to be a reduction in the number of inspections carried out by the care commission—which there must be if the process is being streamlined and HMIE is doing some of the inspections—and if the care commission is supposed to be self-funding, the people who pay fees to the care commission can expect a reduction.

Adam Rennie: In the childminding sector, the reduction in the number of inspections applies to day care services for children. The regulation of the early-years sector is subsidised by the Executive, and that will continue. The policy of full-cost recovery does not apply to those services, so your point is not really relevant in that context.

Mike Rumbles: Can you tell me how the figure came to £1 million, rather than £957,000, for example, and why it does not change over the three-year period?

Adam Rennie: It may well have come to £957,000, or £962,000, or whatever.

Mike Rumbles: Can you get me the exact figure?

Adam Rennie: Certainly.

Mike Rumbles: That would be helpful. I am very suspicious of round figures.

Adam Rennie: We tend to be urged to report things in rounded terms.

Mike Rumbles: I am pursuing the matter specifically because I did not get an answer to my first question.

The Convener: Nanette Milne has some questions on improving the prescribing of drugs.

Mrs Milne: Given the increase in the number of prescriptions and in the gross costs of prescribing in recent years, savings of £20 million over three years seems quite a tall order. Dr Woods, you said that you are on target to achieve savings in all the areas that we have discussed. Health boards have been given individual targets for savings in prescribing, but are all health boards on target to achieve those savings? I also ask Professor Scott whether he can tell us what action has been taken to date to try to achieve those savings.

Dr Woods: I am not sure whether you would like me to answer the first question or to hand over to Professor Scott, convener.

The Convener: If you feel that Professor Scott is the best person to answer—

Mrs Milne: You could answer the first question, Dr Woods.

Dr Woods: Two savings issues relate to pharmaceuticals, the first of which is savings on drug purchases, which will yield £42 million through the UK pharmaceuticals price regulation scheme. The savings that we have secured already have brought down the year-on-year increase in drug costs from between 7 and 10 per cent to just over 3 per cent in the past year. Those savings are achieved.

As far as better prescribing is concerned—the £20 million to which the member referred—we have issued detailed guidance to individual health boards on the plans that we want them to produce, which will be associated with individual savings targets for each board. A number of strands of work will contribute to that—five strands in total, I believe—perhaps the most important of which is the use of generic rather than branded drugs. I am sure that Professor Scott can add more detail on that.

Professor Bill Scott (Scottish Executive Health Department): The saving of £20 million is in the context of a £900 million expenditure. This work is not new; it has been on-going for many years. We have had investigations into and reviews of prescribing and have looked at how we can improve the efficiency of drug use. Our intention—and that of clinicians—is that every pound that is spent on medicines is a pound that gives an optimal outcome. In 2003, Audit Scotland suggested ways in which we could improve prescribing efficiency. We have been working hard on that with our colleagues at the coalface—or the clinical face.

The first strand is to finish off our work on the Audit Scotland report, which suggested that savings of £14 million were still to be had from the drugs budget. We think that we can still tackle about £4 million or £5 million through better use of existing generics and drug swaps, from premium-price medicines in effervescent preparations to simpler formulas, for example, without affecting patient care. I stress that, throughout the programme, we are seeking to find methods of more effective prescribing that do not affect patient care. In fact, the savings that are released from the programme will go some way towards helping us to buy new technologies and fund even better patient care.

16:30

The next strand is the best-value scheme for dressings, which came from the service itself. The service suggested to us that there are more efficient ways to purchase wound management products, incontinence products and nutritional products—incidentally, that does not include stoma products. The boards have given us good examples and we want to spread good practice.

On the outliers in prescribing, some general practitioners could get more out of their drugs bill in certain areas of their prescribing. In each board, we have prescribing advisers who work with GPs to address those issues.

Optimal use of formularies has been recommended for some time in various UK-wide and Audit Scotland reports, and we will continue to look to formularies as one way of managing the drugs bill. Given that such a plethora of medicines is available to clinicians, it makes a lot of sense for them to sit down and rationalise their prescribing. There are also local initiatives that will save a small amount of money, which will be ploughed back into the service.

As Dr Woods said, however, the bulk of the savings relate to medicines that will come off patent in the next three years. Generic copies of those medicines will be manufactured, and by changing prescribing from the branded version to the generic we will release savings. I should say that, at present, GPs prescribe about 80 per cent of their prescriptions by generic name, so we are pressing against an open door. In hospitals, of

course, all prescriptions are written and dispensed as generic. That is where we hope to make the bulk of the savings, and we are confident that we will do so, given the history of what happens when new medicines come on to the market.

Mrs Milne: You mentioned prescribing advisers who work with GPs on their prescribing habits. In the technical notes, the Executive states that in many areas prescribing advisers are supporting clinicians in achieving prescribing improvements. Are you monitoring the cost of those advisers? Do they cost the service a lot?

Professor Scott: We do not monitor the advisers themselves but we monitor prescribing and the drugs bill, and we can see real gains from the employment of prescribing advisers.

Mrs Milne: Do you know how much they cost, offset against the savings?

Professor Scott: I am sorry. I cannot answer that question.

Mrs Milne: Is it possible to find out?

Professor Scott: I will try to get their wages bill.

Mrs Milne: Thank you.

I notice that Audit Scotland mentioned its concern that medical students nowadays might not get enough pharmacology training to understand medicines, their side effects, how they work and so on. Is that a factor? Can something be done about that?

Professor Scott: As you will be aware, the way in which medical students come on to the course and are trained has undergone a revolution. The course now involves whole-systems approaches, so instead of studying pharmacology on its own, as you and I did, they learn about the systems and look at the overall drug effects. I understand that that approach is under review, but that rests with the medical education experts.

Mrs Milne: Audit Scotland clearly thinks that that is worth looking into.

Earlier, we talked about IT and electronic prescribing. When can we expect that to be up and running in all GP practices?

Professor Scott: We have made good progress on IT and the development of links between community pharmacies and general practices. By March or April next year the N3 network will be connected to all community pharmacists. In England a few months ago, an electronic prescription sent by a GP to a community pharmacy was heralded in the pharmaceutical medical press. In Ayrshire, we have transmitted 1 million prescriptions in that way. It is not just the transmission of the prescription that is important; it is how that fits into the overall e-pharmacy and e-health scheme. We are continuing to develop those electronic links. We want to see them in place for the start of the new pharmacy contract in 2006 and developed through to 2007 and beyond.

Mrs Milne: In relation to the new pharmacy contract, you mentioned that you were excluding stoma appliance provision. You are probably aware that there was a lot of contention about the provision of stoma appliances when the Smoking, Health and Social Care (Scotland) Bill was going through. Is the new contract likely to result in savings or will it add financially to the prescribing burden?

Professor Scott: It will be cost neutral. What is important is that we take an area in which there has been some confusion and put it on a footing by itself. We can take that provision out of the pharmacy contract—more than one player is involved—and build quality measures and indicators into it. Most of all, however, we can safeguard the patients who are affected and ensure that the nurses who are currently employed by the commercial companies involved have an opportunity to work within the NHS to develop the service into one of even better quality.

Mrs Milne: Presumably, the cost of the nurses will add to NHS costs if that cost is currently being met by pharmaceutical companies.

Professor Scott: Part of the reason why we have efficiency savings is to ensure that we can plough those savings into improving the quality of patient care. I cannot say that I am sorry if there are additional nursing costs in the system. What I can say is that improving our prescribing and making it more efficient releases money to allow us to invest in such things.

Mrs Milne: I am sure that we and people outside will be watching this space.

The Convener: Jean Turner had a question about procurement of drugs.

Dr Turner: Something has to smooth out the boundary between primary and secondary care. You may not be able to answer this point right now, but it is important that it should not be cheaper for a hospital to pass the cost on to the GP. I do not know whether you have considered the idea of NHS Scotland manufacturing its own drugs when they have come out of patent. It would help to cut costs to some extent if, instead of buying drugs from manufacturers, we made them ourselves. The other point is that when drugs are procured cheaply, it is vital that patients—they are the important people—do not get different coloured tablets and different sizes of the same drug in one prescription because their pharmacist, in making up the prescription, has used different companies' preparations. I understand that cost is of the essence, but we should consider the patient.

An issue arose when Nanette Milne was questioning you. Would buying cheaper incontinence pads mean that there would be a let-up in efforts to limit the number of pads that patients receive when they are assessed? Sometimes people are restricted in the number of pads that they use—I am thinking of children as well as adults. It is quite stressful for patients to be restricted to a certain number of pads per day or per week—that does not always work for them. Can you assure me that you will ease up on some of those restrictions?

The Convener: I am not sure whether you can answer some of those questions, Professor Scott, but please do so if you can.

Professor Scott: I can answer some of them. First, through the judicious use of formularies between primary and secondary care, we eliminate the preferential pricing whereby a product is one price in the hospital sector but more expensive in the primary care sector, on the basis that the bulk of that product is going to be used in primary care. We have asked health board managers to be aware of the cost in both primary and secondary care.

Mr Haldane and Dr Woods referred to zonal purchasing in the hospital service, which is an efficient way of purchasing medicines through central tenders. Specialist centres use specialist products, and zonal purchasing encourages them to purchase together so that they have greater purchasing muscle.

In the community, it is slightly different, in that the NHS never owns the drugs. The medicines are purchased by and are the property of the pharmacists; they are dispensed to the patient and the NHS then reimburses the pharmacists. By using that method, the pharmacists take the risk in relation to how much they purchase, what they purchase and the safekeeping of those medicines. The Scottish Executive looks at the discounts that pharmacists get on those medicines and claws them back. For example, we clawed back £26 million in relation to generics last year; that money went back into the NHS. That was done through efficient purchasing by community pharmacists.

We must avoid creating a bureaucracy that would cost just as much as it does to purchase the drugs. Pharmacists form buying groups and have purchasing muscle, and we think that that is an efficient way to purchase the drugs. The situation was examined by an Oxford research group, which considered whether it would be better to tender for generic medicines. It concluded that there were some merits in such an approach but that, on balance, the community pharmacist approach should be used as our method of achieving the best price.

Dr Turner asked about manufacturing our own generics. Manufacturing drugs is quite a complex process that is regulated by both European and UK licensing authorities. It would be a high-cost business, because we would have to maintain the same standards as the GlaxoSmithKlines of this world. It would also involve continual investment, both capital and resource. I am not sure about the suggestion, but we continue to press for more efficient generic manufacturers so that we can get better prices.

On incontinence garments, our experience is that when continence nurses are involved, so that matters are not simply left at the supply of products, better-quality garments are used and the patient gets a better service. I agree that that is an issue in which we should involve health board tendering.

Dr Turner: There is pressure on people to keep the number of pads down.

16:45

Helen Eadie: On the issue of non-drug prescriptions, Ken Macintosh had a members' business debate earlier in the year about people who suffer from alopecia. As we saw last week, Edinburgh-born lass Gail Porter suffers from the condition. One of the things that Ken Macintosh and I discovered was that every health board across Scotland uses a different method of prescribing wigs. It strikes me that that is an opportunity that you seem to have missed, and I wonder what you intend to do about it. There are discrepancies between health boards, and although cancer patients get their wigs free, patients with alopecia have to pay for them. Similarly, people who are over 60 get free prescription drugs but have to pay for wigs for the rest of their lives. It seems that there is a massive inefficiency there. It is not just about savings; the matter is dealt with in an utterly inefficient way.

Professor Scott: I am not passing the buck, but wigs are not within my bailiwick.

Helen Eadie: A wig is a non-drug item, but, like incontinence pads and other items, it can be prescribed, so somebody on the panel must be able to answer the question.

Dr Woods: I am not sure that anybody here can answer the question, but we are happy to write to you about that.

Helen Eadie: Thank you.

The Convener: That is probably the best thing to do.

We do not have any more questions left, so if Dr Woods would like to make a closing statement, he may do so.

Dr Woods: Helen Eadie's comments about differential practice reminded me of one thing that has been a great concern in relation to pharmaceuticals—postcode prescribing. We have not talked today about the important work that the Scottish medicines consortium does. It has been a big success in helping to manage the introduction of new technologies, and we would be happy to elaborate on that if that would be of interest.

The Convener: I am not sure that it is central to the questions about the specific proposed savings that concern us at the moment, but that is not to say that we will not come back to the matter at some point.

I thank all the witnesses for coming along this afternoon. We have yet to hear from the minister on the budget. We shall be questioning him on 3 October, so you might want to keep an eye on that.

16:47

Meeting continued in private until 16:59.

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