HEALTH COMMITTEE

Tuesday 24 October 2006

Session 2

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by Astron.

CONTENTS

Tuesday 24 October 2006

HEALTH COMMITTEE
22nd Meeting 2006, 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)
*Euan Robson (Roxburgh and Berwickshire) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Mr Kenneth Macintosh (Eastwood) (Lab)
Mr Stewart Maxwell (West of Scotland) (SNP)
Margaret Smith (Edinburgh West) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Bill Butler (Glasgow Anniesland) (Lab)

THE FOLLOWING GAVE EVIDENCE:

Robert Anderson (NHS Lothian)
Professor Sir John Arbuthnott (NHS Greater Glasgow and Clyde)
Paul Gray (Scottish Executive Health Department)
Jane Kennedy (Convention of Scottish Local Authorities)
Mr Andy Kerr (Minister for Health and Community Care)
Richard Norris (Scottish Health Council)
Professor William Stevely (NHS Ayrshire and Arran)
Councillor Pat Watters (Convention of Scottish Local Authorities)
Dr Kevin Woods (Scottish Executive Health Department and NHS Scotland)

CLERKS TO THE COMMITTEE

Karen O'Hanlon
Simon Watkins

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 24 October 2006

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

The Convener (Roseanna Cunningham): Good afternoon, everyone, and welcome to the first meeting of the Health Committee since the recess. I have received no apologies. I welcome Bill Butler, who is the member in charge of the Health Board Elections (Scotland) Bill and who has been advised that our normal practice is to bring in the member in charge of the bill to ask questions after members of the committee have had a chance to ask theirs. I know that that can be a little frustrating, but it is our practice.

Items in Private

The Convener: Item 1 is to ask the committee to agree to take in private items 4 and 6, which are discussions on evidence. It is our practice to take such items in private. Do members agree to do so?

Members *indicated agreement*.

The Convener: Do members also agree to take further discussions on the budget and work programme in private?

Members *indicated agreement*.

Health Board Elections (Scotland) Bill: Stage 1

14:01

The Convener: Item 2 is the first evidence session on the Health Board Elections (Scotland) Bill, for which we have allocated an hour. We will hear from six senior representatives of area health boards, the Scottish health council and the Convention of Scottish Local Authorities. I welcome Sir John Arbuthnott, chair of NHS Greater Glasgow and Clyde; Professor William Stevely, chair of NHS Ayrshire and Arran; and Robert Anderson, interim chair of NHS Lothian, who I understand has been in the job for only two weeks. Is that correct?

Robert Anderson (NHS Lothian): It is three weeks.

The Convener: Right.

I also welcome Richard Norris, director of the Scottish health council; Councillor Pat Watters, president of COSLA; and Jane Kennedy, team leader in health and social care at COSLA.

A number of documents have been circulated to members of the committee. The bill is intended to democratise Scotland's area health boards through the provision of local elections. It proposes that a simple majority of health board members be elected directly by postal ballot.

In the call for evidence we focused on four issues, on which members will focus this afternoon also. They are: support for the general principles of the bill and, specifically, direct elections to health boards; omissions from the bill; the quality of consultation and the implementation of key concerns about the accountability of health boards; the practical implications of implementing the provisions and any alternative approaches.

The bill would have no other impact on the constitution or operation of health boards or the powers of the Scottish ministers. I would be grateful if all members and witnesses could bear that in mind when they ask and answer questions. The meeting will be long because there are many items on our agenda and I do not want us to drift off into discussions that are not relevant to the job in hand.

My first question is for all the witnesses to answer in turn. Do you support the bill—yes or no—and why?

Professor Sir John Arbuthnott (NHS Greater Glasgow and Clyde): I have submitted evidence on behalf of the board, which does not support the bill.

My reason for not supporting the bill is based on my four years' experience as chairman of NHS Greater Glasgow and NHS Greater Glasgow and Clyde, which was a period of rapid change. Much has changed in health boards under the headings of accountability, public involvement and democratic representation and responsibility. I understand the nature and purpose of the bill and I have some sympathy with it, but we have intelligence to share with the committee under those headings, which will indicate why we do not support the bill.

Professor William Stevely (NHS Ayrshire and Arran): The health board that I represent is not in favour of the bill.

The board thought that in taking on board the principles of the bill we would risk ending up with something that was no longer a national health service, which could lead to inefficient and ineffective provision of health care. I am happy to amplify those comments.

Robert Anderson: NHS Lothian's submission hedged its bets a bit, but, if you read between the lines, you will see that we do not support the bill.

We feel that fairly recent developments, such as the implementation of community health partnerships and the coming into being of public partnership fora, have still to bed in. We believe that, through both those avenues, the public will have a role to influence the future shape of the service.

Richard Norris (Scottish Health Council): After internal discussion, we in the Scottish health council decided that we did not want to give a view on whether we support the bill. However, it is fair to say that we have some concerns about the bill's impact on regional planning, which we are keen to encourage among boards. Also, as others have said, the current system is fairly recent and is still bedding in.

Councillor Pat Watters (Convention of Scottish Local Authorities): The policy of COSLA is that we do not support the bill.

Our main reason is that we believe that democratisation of the public services is vital but needs to be discussed in total. The bill would simply tinker with part of the public services. We also believe that any change to how we organise the public services must be able to deliver improvements. We fail to see how the bill would demonstrably improve the public service.

The Convener: Does Jane Kennedy want to add any comments?

Jane Kennedy (Convention of Scottish Local Authorities): I would just echo what Pat Watters has said.

The Convener: We will move to questions from committee members.

Kate Maclean (Dundee West) (Lab): My questions are for Pat Watters. When COSLA leaders discussed the bill, they decided that they were not in favour of it. First, what is the justification for requiring that the delivery of important services other than health, such as social work and education, be controlled by directly elected individuals?

Secondly, the COSLA submission states:

"The matter is one that requires to be considered in the wider context of public sector reform, and particularly the current debate initiated by Tom McCabe".

Does COSLA think that, in future, in the context of a different structure for delivering public services, health services could be delivered by directly elected individuals, or does it think that the idea just does not have any mileage?

Councillor Watters: Our view is that we need to consider how the whole public sector fits together. We have an opportunity to look at how we deliver public services in Scotland as a whole. We should not take out one part of the public services in considering proposal X, because we might end up doing something entirely different when we look at the whole picture.

For instance, why does primary care need to be part of the health sector when hospital care is entirely different from primary care? Does primary care naturally fit in with the health service? How do we enable local communities to become healthier? How does that fit in? Local authorities have a role in delivering healthy communities, but that role has been sectioned off so we end up in competition with others.

Our main objection arises from our view that we need to look at the whole picture rather than just part of it. If we look only at bits of the public services, we might find that they do not fit when we try to put them together. We need to look at the whole picture of how the public services are delivered and who delivers them. The idea of having fewer, rather than more, organisations involved would be attractive to me.

Kate Maclean: Has COSLA taken only a temporary position on the bill until it sees what happens with public services in general? At the moment, the health service stands out as the major public service that is not governed by a directly elected body. Even the police and fire service boards, which sometimes have boundaries that are coterminous with those of health boards, are made up of directly elected people. At this stage, I am not necessarily in favour of or against the bill, but the health boards seem to me to stand out as the only such organisations that are not governed by directly elected bodies.

Councillor Watters: Health boards have had elected members only within, I think, the past three years. There is an analogy between health boards and police and fire service boards, but police and fire are firmly local government services and, as such, they should be administered by elected local government members. That is where the analogy ends. Only two health boards—Fife NHS Board and Dumfries and Galloway NHS Board—have coterminous boundaries with the police and fire boards. The other police and fire service boards are joint boards that include members from several local authorities. For instance, the Strathclyde area covers several health board areas as well as 12 local authority areas.

Partnership between local authorities and health boards is vital. We can see how that is being delivered. The comment was made that the health service is a national service rather than a local service. We need to examine how the health service interacts with local services such as housing, education and social work services, which have been mentioned. The relationship that we have built with the health service through the joint future agenda should be encouraged. That would not necessarily happen as a result of the bill.

Helen Eadie (Dunfermline East) (Lab): I have two questions, the first of which is to Pat Watters. Do you not have two contradictory policy papers? A COSLA policy paper says that quangos that are advisory committees need not be elected bodies and can comprise professionals who give sound professional advice, but that when major public spending is concerned, directly elected politicians should be involved, to be accountable for that spending. How does that sit with the position that you adopt today?

Councillor Watters: I have no problem with directly elected politicians forming the majority on health boards throughout Scotland.

Helen Eadie: You are happy to support directly elected politicians on all health boards throughout Scotland; you are just not happy with the bill.

Councillor Watters: I do not think that we should have direct elections to health boards; I made a distinction between that and having directly elected politicians on health boards. I am an elected politician and if I were a member of a health board, I would represent my constituents just the same on that health board.

Helen Eadie: I am sorry—I am missing the difference and I am being slow on the uptake.

Councillor Watters: You ask whether I support direct elections to health boards and what the difference is. I support having directly elected politicians—there are many in this room—on health boards and making them the majority on health boards.

Helen Eadie: Do you support holding elections at the time of local government elections to elect politicians directly to health boards?

The Convener: I do not want to paraphrase Pat Watters out of place, so he should correct me if I am wrong, but I think he is saying that he has no difficulty with councillors or parliamentarians spending part of their time as members of health boards. However, he does not say that they should be separately elected to health boards. Is that right?

Councillor Watters: Yes.

The Convener: Pat Watters has no problem with elected politicians being members of boards.

Helen Eadie: That is helpful.

The Convener: What is Helen Eadie's second question?

Helen Eadie: Members know that I am a passionate pro-European. We can look at some of our European partners, such as Denmark, where looking after the entire health budget is part of the remit of all local politicians. How would that work in Scotland in relation to reform of how we deliver public services, which you have talked about, and how might it fit in with direct elections?

Councillor Watters: Health is a responsibility of local government for many of our European partners, including Finland. It operates extremely well. Before the 1970s, health was a responsibility of local government here. After then, health and local government were separated. I do not think that, as a local politician, I should say how Hairmyres hospital should be run. Clinicians are far better at deciding that. The correlation and interaction between us and primary care bode well for better co-operation between primary care and the rest of the public sector through local government.

Helen Eadie: What are other panel members' views? I notice that, in its evidence, Greater Glasgow and Clyde Health Board has underlined the "national" in "national priorities". I find something wrong with that, because the balance with local priorities has not been given. The interest in the discussion concerns locally elected politicians, so I ask witnesses to embrace that in their answer.

Professor Arbuthnott: I am happy to do that. The two sets of priorities are closely related. I welcome the opportunity to respond and follow up what Pat Watters said.

14:15

As a result of the formation of the community health partnerships and community health and care partnerships, 43 locally elected politicians—I totted up the figures on the train across—now either sit on our board after being appointed to it, or sit as chairs or members of community health and care partnerships, or sit as members of community health partnerships. The idea that—

Helen Eadie: Could I just clarify—

The Convener: Please let Sir John finish. You can come back in later.

Professor Arbuthnott: The point I was trying to make is that we are becoming closer and closer to those who are involved in shaping and delivering local policy. The whole idea of community health and care partnerships and community health partnerships is to ensure that we deliver improvements through primary care policies—such as anti-smoking policies—all of which are directed towards making our communities healthier. I really welcome the fact that we are doing that in partnership with locally elected individuals.

Helen Eadie: You gave a figure of 43. Is that 43 across Scotland?

Professor Arbuthnott: No, it is 43 in our health board area.

Robert Anderson: Before I became interim chair of NHS Lothian, I chaired the community health and care partnership in West Lothian, which is quite an interesting model. Four councillors from West Lothian Council are on the partnership board, as are four representatives of NHS Lothian. That partnership is opening up all sorts of new opportunities for working together and breaking down barriers across services. The model is due for review in 2007. It will be interesting to see how the review turns out, but the early signs are very positive.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I want to ask about the politicising effect of electing people who are not on councils, but before I do so I want to pick up on something Pat Watters said, because it nearly blew me out of my seat. Correct me if I am wrong, but I thought I heard you wonder whether primary care really needed to be part of the health service. I hope that I did not hear you correctly because, having worked in the NHS for many years, I would—

The Convener: Can I just—

Dr Turner: This is important.

The Convener: It is an interesting discussion but we can perhaps have it later. I do not want our discussions just now to get taken down alleyways.

Dr Turner: I want Mr Watters to clarify the matter now in case I continue with the wrong impression—

The Convener: I do not want us to have a long discussion about this, but I think that that was what Pat said.

Councillor Watters: Yes.

The Convener: Right. That is what he said, Jean.

Dr Turner: Well, I have a major problem with that.

I cannot understand why people would think there was politicisation. I have read comments to the effect that it would be politicising to have elections for people who are not councillors. At the moment the Scottish Government is Labour and Lib Dem, and it is usually Labour and Lib Dem councillors who sit on boards, although it might well be different in some places. How would people feel if the dominant parties in government were different? Would you hold the same views if the Scottish Executive was Scottish National Party and Conservative?

The Convener: Pat Watters will never live so long as to see an SNP and Conservative Executive.

Dr Turner: But hypothetically—

The Convener: No, Jean, I am sorry—I do not see how this is relevant to our discussion.

Dr Turner: It is—

The Convener: I suggest that it is not. Pat's views on the myriad possible combinations of parties in future Executives are neither here nor there. Please come on to a question that is more directly related to the bill.

Dr Turner: Honest to goodness. Right. I think it was Sir John Arbuthnott who suggested that elections could encourage single-issue candidates who would not represent people in the full range of services. What single issues within medicine are you thinking of? Are you thinking, for example, of people with diabetes, or people with chronic pain?

Professor Arbuthnott: I was not thinking in terms of individual long-term illnesses or conditions. We are talking hypothetically, because we do not know how the system would actually work, but it is quite possible that an activist who wanted, or did not want, something to happen in their area could become an elected member of a health board. As a result of all the legislation and advice on governance that Governments have given us, we are expected to work as a team. Such a person might say, simply, "I am totally opposed to the proposal and unless what I propose happens in my area, I will not support the

health board." There could be great difficulty if there were a group of such people.

I can speak without prejudice because I am in my final year as chairman and the situation I have described will not affect me, but I can imagine that future chairs would find it very difficult. I am talking about corporate responsibility, governance and team working. Partnership is essential in running big public services; in my case, we are responsible for £2.3 billion of public spending.

Dr Turner: It is said that if people do not do their jobs properly, they will be fined. How many people have been found to be not up to doing their job on a health board and hauled over the coals for it? That came out in evidence.

The Convener: If you are referring to specific evidence can you—

Dr Turner: It is definitely in the information we were given; I will try to lay my hands on it.

It is in the submission from NHS Greater Glasgow and Clyde at the top of page 3.

Professor Arbuthnott: Pat Watters knows more about that than I do. The accountability of local councillors for their work is very precise and there are penalties if they do not do it right. Whether someone is a member of a health board or an elected member of a local authority, they are subject to the Scottish commissioners who, each year, review complaints against people who are alleged not to be doing their job properly, to have some special interest, to be trying to bend the rules, or whatever. There is a public document that shows when that happens, what the penalty will be, the number of committees missed and so on. A system exists, and I have given you an adequate and accurate description of how it goes.

Without prejudice, almost all such cases seem to involve local councillors of some sort. I think I know of only two health board individuals who have been investigated in that way.

Shona Robison (Dundee East) (SNP): I have two questions. One is specifically for Mr Anderson, the other is more general.

Behind the bill is the perception that the public are not held in very high regard by those who sit on health boards. The evidence that we have heard so far bears that out. I draw attention to point 4 in Lothian NHS Board's evidence about the practical implications of the proposed provisions. The part I am talking about is entitled "Disenfranchisement" and it boils down to the

"risk of confusion with papers being received away from polling stations",

the fact that electors could be interfered with by third parties,

"40% of adults are estimated to have a reading age of nine or less",

and there could be

"Public confusion about the differing systems particularly by some elderly people".

It makes me wonder why we allow people to vote at all. Does that type of evidence not highlight and confirm the perception that health boards have a bit of a patronising attitude towards the public they are supposed to serve?

Robert Anderson: The evidence you quote was in response to a question about what the practical implications might be. In my two and a half years at NHS Lothian, the board has set great store by the views of the people of Lothian and has gone out of its way to consult and talk to them. Earlier I mentioned my work with the community health and care partnership. Part of that job involved going out and talking to the public and patients. As interim chair of NHS Lothian, I intend to continue with that; it is vital that we listen to what people have to say.

Shona Robison: Do you accept that with the right information and explanation of voting systems, people who have got to grips with the different voting systems that they use for voting in different levels of government would get to grips with health board elections? Does the evidence underestimate the public's ability somewhat?

Robert Anderson: I do not think that I would ever underestimate the public's ability.

Shona Robison: Perhaps the evidence could have been better worded.

I have a more general question for the health board representatives—[*Interruption.*]

14:26

Meeting suspended.

14:39

On resuming—

The Convener: I understand that we have been given the all-clear. We will reconvene quickly as I understand that Pat Watters has to leave at 3 o'clock.

Shona Robison: I was about to ask about alternative approaches. Beefing up the role of non-executive directors is a common theme in the health boards' evidence, but Pat Watters from COSLA proposed the alternative of removing primary care and placing it in local government control. What is the health boards' view of that proposal?

Professor Stevely: I do not think that that is a good idea. Health boards try to balance the need to get care as close to communities as possible—which involves considering the provision of care, including primary care—and the need to ensure that specialist care is available to meet specialist needs; that specialist care might be more centralised than local. It is easier to strike the right balance within a single organisation. If two separate organisations tried to achieve that balance, it would not happen as readily.

Professor Arbuthnott: The pathway is a continuous one and the continuity is vital, especially in urgent areas such as cancer diagnosis.

Robert Anderson: The public regard the NHS as one continuous service that includes primary care, secondary care and tertiary care.

Mrs Nanette Milne (North East Scotland) (Con): I return to accountability and the suggestion that direct elections would politicise health boards. We know that health boards are accountable to ministers and to the Parliament, but I am not convinced that there is accountability down the way. Pat Watters says that the fact that there are elected councillors on health boards provides accountability to service users, but I would like to know how councillors are appointed to health boards. Perhaps Pat Watters can help me with that.

To give an example from the old days when I was a councillor, my council's appointees to health boards all came from the administration and not from other parties, regardless of the expertise in the other parties. I do not know whether that is how the system works today, but that was politicisation and I was concerned about it. I would welcome clarification of the current situation.

Councillor Watters: Jane Kennedy will correct me if I am wrong, but I think that it has to be the leader of the authority or the chair of its social work committee who is appointed to the health board. The role cannot be delegated to anyone else.

Mrs Milne: The briefing from the Scottish Parliament information centre covers the experience of other countries, including New Zealand. I do not know whether any of the witnesses from the health boards has a detailed knowledge of how things work in New Zealand, but it has had direct elections to health boards since 2001. Do you have any information on the experience of your counterparts in other countries?

Professor Arbuthnott: The information from SPICe was new to us. We would have to look into the matter to see how things work. I think that the briefing suggests that the New Zealand system works in bits, but I could not say.

The Convener: No one else has an opinion.

No other committee members have indicated that they want to speak, so I go to Bill Butler. Bill, Pat Watters has to leave at 3 o'clock, so if you have questions for him you might want to ask them first.

Bill Butler (Glasgow Anniesland) (Lab): Thank you. I hope that our COSLA colleagues do not take this as a slight, but I do not have any questions for them. I will direct my questions to colleagues from the health boards.

First, I have a simple question for the health board chairs. Do you accept that, under the bill's provisions, NHS boards will remain accountable to ministers and the Scottish Parliament? I think that that is a yes-or-no question.

Professor Stevely: I am sorry, but you will not get a yes or a no from me. Although there might be a line of accountability to Scottish ministers and the Scottish Parliament, it is much more difficult to hold an elected body to account in the way in which health board members are currently accountable to the Parliament.

Bill Butler: Do you accept that that is a value judgment? My question was straightforward and direct. Do you accept that, under the bill's provisions, NHS boards will remain accountable to ministers and the Scottish Parliament? That is a yes-or-no question, I am afraid.

Professor Stevely: You have had my answer.

Bill Butler: Sir John?

Professor Arbuthnott: The answer is, "Yes, but." If you do not want to hear the but, then—

Bill Butler: I will come to that.

The Convener: I will allow you to hear the buts.

Bill Butler: I do not mind the buts, but I wanted to start off with that simple question. I did not realise that it would cause such controversy. Mr Anderson?

The Convener: Let us go back to Sir John. He wanted to qualify what he said.

14:45

Professor Arbuthnott: The point was made earlier about the increasingly regional dimension of the health service. Although Bill Butler's bill would do as he said, we are saying that you have to be careful that you do not throw out the baby with the bath water to introduce a change that is seen as dealing with a problem that might not quite be the same as it was. If you endanger the national element of the health service, where

boards are held accountable by ministers and by the Health Department for the implementation locally of national and regional policies, you could be interfering with the delivery of health services in a way that is counterproductive. I am asking the committee to bear that in mind.

Bill Butler: Do you accept that, under the terms of the bill, boards will still be required to deliver—I quote from your submission—

"national targets, guarantees, strategies, initiatives and policies",

and that, at the moment, boards respond anyway to local needs within those guidelines or within that framework? If they did not respond to local needs, would they not simply be administrative units? That question is for all the chairs of the health boards.

Professor Arbuthnott: Again, it depends on how things fall into place. I have tried to give a picture of the considerable effort that we have made to deal with what was alleged to be a democratic deficit, through the involvement of locally elected politicians in local authorities to a large extent in our community health and care partnerships and community health partnerships. They have chairing duties, which makes them directly responsible to the people who elected them. I hope that Bill Butler agrees that the spirit of that is good.

If we have a completely different cohort of people who are elected in a different electoral process, we have to ask what the link is between those directly elected people, the locally elected members of our local authorities and the local and nationally elected members of our Parliament. There is a constitutional element there that we have to think through. If the locally elected people who are in a majority said, "Well, actually, we're not beholden to any of that and we think that this should happen," the delivery of the national and regional policies, which you began by saying was our duty, could become quite tortuous.

Professor Stevely: I echo what Sir John has said. It seems to me that at some point down the road there would be the kind of scenario that has been suggested, which would leave the local agenda at odds with the national agenda in a way that could damage the level of care available to a local community. It is a risk. That is not to say that the present system is perfect, but it is better than the one that is being proposed.

Robert Anderson: We have a national framework of policies and targets, which gives the guarantee of service to the population, but we also have a series of diverse communities with different needs. Part of the potential success of community health and care partnerships is the ability to focus in on those local needs. I am asking for that experiment, if that is what it is, to be judged next year, at the right time.

Bill Butler: Are community health and care partnerships and the proposals in the bill mutually exclusive? I would see them working in a complementary fashion. Would they inevitably be antagonistic?

Robert Anderson: I do not think that I am saying that.

Bill Butler: Do you fear that they could be working at cross-purposes?

Robert Anderson: I am not a constitutional lawyer, so I do not know, to be honest.

Bill Butler: I accept that you have expressed a sincere point of view, but I think that you are overegging the pudding somewhat. I accept that improvements such as "Patient Focus and Public Involvement"—the title rolls off the tongue—regular meetings between ministers and NHS boards, the annual review meeting and meetings with local councillors from 2001 are all good things. However, according to a Scottish Executive survey,

"73% of the public felt that they had little or no influence over the way the NHS is run. This was up from 57% in 2000."

Are you disappointed about that?

Professor Arbuthnott: I am glad that you said that "Patient Focus and Public Involvement" rolls off the tongue, because it does not always roll off my tongue. PFPI was introduced after 2000. The procedures that culminated in the formation of community health and care partnerships and CHPs are only now in place. My colleagues are saying that there will be uncertainty about the future if we change the system again.

We now have a database of more than 3,000 people from the community in the NHS Greater Glasgow and Clyde area who are in almost daily contact with us. They can get any information that they want from us at any time. Each edition of "Health News" goes out to 300,000 people. Between 200 and 300 people come to our health events, which take place three or four times a year. The level of public engagement has ratcheted up tremendously. The most valuable contact does not come through what people say in surveys or opinion polls. We have a team of people who use their shoe leather to go round shopping centres, bingo halls and so on, where they ask thousands of people what they think are the issues in relation to particular health care centres. We get fantastic interaction from those exchanges. I am not arguing for my position in the future. I am simply asking the committee to take care not to unpick what happens at the moment, because we have worked hard at it.

Professor Stevely: Over the past three or four years, we have seen probably the most dramatic change that has been suggested for the health service for some time. That change was agreed by the Parliament—there is a national policy. Undoubtedly, the way in which the policy is implemented locally has caused a great deal of concern in a number of communities. That does not mean that the policy is wrong. The fact that people feel that they have less influence does not mean that local decisions are wrong. It will take some time before we see the outcome of the policy. I can think of other examples of policies where there has been great initial public hostility but people have come around to recognising that the changes were for the general good.

I recognise the perception that exists and am disappointed about that. Sometimes we have not been as good as we ought to have been at explaining to the public exactly what they will get out of the changes in the long term. That is an issue for us.

Robert Anderson: We are getting better at implementing change, in partnership with members of the public. I am disappointed with the figures that Bill Butler quoted for public opinion. However, if we asked the people who are engaged in public fora what they think now and again in a year's time, the picture would be different.

Bill Butler: I do not disagree with what you have said about greater public participation. That is good—it is progress. However, it strikes me as strange that the public are still dissatisfied, and in even greater numbers. Could it be that public engagement is seen as good and as an improvement but that people want the essential feature of democracy, which is direct accountability, at least for an element of health board members? Do you agree with Voluntary Health Scotland's submission, which states that progress toward patient focus and public involvement

"could be accelerated by introducing a further"—

and more directly accountable—

"means of promoting local voices"?

Robert Anderson: I hear what Voluntary Health Scotland says, but I do not agree with it.

Professor Stevely: The problem is fairly straightforward. I am not persuaded that having elected people sitting on health boards will necessarily change public perception over a period.

Bill Butler: Neither am I.

Professor Stevely: Some members of the public want a referendum on specific issues—that would make them feel that they had voted in favour of a change and got it. However, we cannot run a system in that way.

Professor Arbuthnott: I am pleased that Bill Butler mentioned public voices. We are at a crucial stage of developing a new children's hospital in Glasgow. From the outset, we have included the voices of a group of people who are not able to vote—children. The children, who are between the ages of 11 and 15 and who have all been in hospital for long periods, have had a hugely important role and have told us what services they think children in hospital require. That group of kids went to Aberdeen, by themselves, looked at a new hospital there and came back and told us what they think works and what does not work—in their view, not everything there works. That kind of advice is invaluable, but that is not covered by the provision that Mr Butler suggests.

Bill Butler: I do not disagree with much of what the gentlemen have said. I do not disagree with involving people who are below the age at which they can actively vote or become candidates—one aspect of the bill is that people would be able to stand for election at 18. The bill would not prevent such engagement.

Convener, do I have time to ask a couple more questions?

The Convener: We have very little time—the minister is waiting.

Bill Butler: We must not keep the minister waiting.

To interpret Sir John Arbuthnott's words, he talked about a kind of ubiquitous activist who would be—

Professor Arbuthnott: I was speaking hypothetically.

Bill Butler: Yes. You suggested that having such parochial people on boards would lead to stasis in the health service—nothing would happen and no difficult decisions or hard choices would be made. I know that you did not mean your comment to be taken in this way, but is that not in essence an anti-democratic argument? Do you accept that difficult decisions are made every day in local government and the Parliament? Why should not a locally elected health board with a democratic element, working with a minority of appointed people, be a balanced and reasoned way of progressing the health service? Are you not all doom and gloom?

Professor Arbuthnott: Absolutely not. Like any leopard, I cannot change my spots. I have just written a report called "Putting Citizens First", which dealt with Scottish democracy and voting. I believe firmly that our electoral and constitutional processes should, first and foremost, serve the needs of citizens. Those needs should be served

in the same way by health boards. You said that you do not necessarily disagree with us—I do not think that we necessarily disagree with you, but my counsel is that, in considering the measure, one must be aware that it might become destabilising for reasons that you or we have not fully thought through.

Bill Butler: Perhaps that was the conflict that faced the framers of the reform acts of 1832, but I understand what you are saying.

Professor Stevely, do you want to have a go at answering the question?

Professor Stevely: I return to the point that I have tried to make more than once, which is that I believe that we are trying to run a national health service that takes account of local needs. The democratic process puts you people in place to ensure that the overall national policies meet with democratic approval. The local authorities then become involved in providing local input. The risk of conflict between the local and the national is a risk that is not worth taking. Although there is some merit in the proposal, if we were to take the steps that are set out in the bill, the risk of conflict could arise.

15:00

Robert Anderson: We have set in train a series of reforms. We need to give them time to work.

Bill Butler: I have one last question to put, convener.

The Convener: As long as it does not go on for too long.

Bill Butler: I will be very quick. Do you think that there is a danger that, if the bill is enacted, the legitimacy of health boards could be affected by low voter turnout? There were indications in your evidence that you thought that that may be the inherent danger in the proposal. Do you have any evidence for that view?

Professor Arbuthnott: The evidence that I gained in writing the report on voting systems shows that there is no continuing upward trend in people's interest in politics as reflected by their voting intentions. To come back to the New Zealand evidence, the outcome depends on the conditions under which the vote is carried out and how voters are registered. If voters have to register and are expected to vote, the turnout will be reasonable. If the vote depends on a volunteer turnout, the outcome will be something like 11 per cent. A huge risk would be posed if we were to take the latter route.

Professor Stevely: It is inevitable that elections will be required to fill casual vacancies of one kind or another. My concern is that the turnout for those elections could be even lower than for the regular cycle of elections where at least a concerted attempt is being made to elect a group of people.

Robert Anderson: The issue goes more widely than the national health service; it affects democracy in Scotland and the United Kingdom. We need to look carefully at how we can increase voter participation in elections across the board.

Bill Butler: Would it surprise you to learn that, under the scheme for elections to the Cairngorms National Park Authority, which was created by the Parliament, turnout in the five directly elected wards ranged from 48.8 per cent to 66.4 per cent? Does that encourage you?

Professor Arbuthnott: I am encouraged by anything that increases voter turnout.

Bill Butler: Snap.

The Convener: Very diplomatic. Notwithstanding the fact that we lost a little bit of time as a result of the fire alert, we need to move on. The minister is waiting. I thank the witnesses for coming before the committee. We will have further evidence-taking sessions on the bill, which you can keep your eye on.

Budget Process 2007-08

15:03

The Convener: I welcome the minister and his officials to the meeting. We hope that the fire alert that we had earlier is the only one that we will have to deal with today.

The Minister for Health and Community Care (Mr Andy Kerr): I hope so, too.

The Convener: As we indicated, we will not ask you to make an opening statement but will launch straight into questions.

Your letter of 26 September indicated that targets have not been met, particularly on time-releasing savings. The projected savings of £50 million have turned out to be only £11 million. Are you disappointed by the failure to meet targets? What is the way forward in trying to make the savings that you wanted to make at the outset?

Mr Kerr: Dare I say it, I am very satisfied and happy that the Health Department is picking up a range of cash savings that can be reinvested in patient care. We are doing an extremely good job. Time-releasing savings are difficult to achieve. We have got work to do on, for instance, the efficiency and productivity of consultants. When we do some further work on that area, I am sure that we will deliver those savings.

We should celebrate the success of the national health service in relation to purchasing and procurement, logistics and the valuable efficient government efforts that it has been involved in. It has produced the goods. Further, I should say that I always say to board chairs that I am disappointed by the time-releasing savings. Kevin Woods and I and the rest of the team are working on that issue and I expect to recover the position. The annuality of measurement acts against us in that regard. We are putting plans in place to ensure that we measure performance better as well. That is a difficult area for us with regard to measuring productivity in the health service.

Dr Kevin Woods (Scottish Executive Health Department and NHS Scotland): There is a slight difference in the way in which cash and time-releasing savings are approached. For cash savings, we have annual targets whereas, for time-releasing savings, we have what we call milestones, which help us to achieve a target at the end of a three-year period. We remain of the view that we will reach that target.

The Convener: In fairness, the indication of failure was in the letter to the committee that you sent. We simply wanted to establish what had gone wrong. Was the target miscalculated in the first place? Were you, perhaps, overoptimistic? Was there another, specific, reason?

Dr Woods: I do not think that anything has gone wrong. We always knew that there would be some difficult issues relating to the measurement and attribution of time-releasing savings. I think that that comes through in the detail of the letter.

As the minister indicated, we are reviewing fundamentally our approach to the measurement of consultant productivity. We concluded that the original approach to that was far too limited and did not take account of, for instance, the important work that was done in the Atkinson review of health service productivity. We believe that, when we put the new measures in place, we will make up the ground.

Janis Hughes (Glasgow Rutherglen) (Lab): Minister, can you clarify what you mean by "annuality of measurement"?

Mr Kerr: I think that Kevin Woods described the situation better than I did. We have to meet our target for time-releasing savings by 2008. The report on our progress that we gave to you related to a slice in time. We are talking about an annual measurement of progress that we are making over a three-year period.

Shona Robison: When the time-releasing savings were announced, there was a lot of scepticism about the ability of the Health Department to achieve them, particularly in relation to the consultant activity. However, we were told that there would be no difficulty at all in achieving the savings. Now, though, when only one of the six planned time-releasing savings targets has been met, you are saying that you always knew that there would be difficulties. Why was that not said at the time? Why were you so bullish and bold?

Mr Kerr: We have to remind ourselves that we are talking about a target for 2008. That is a key point. We should also bear in mind the fact that the negotiation of the consultant contract was the first major negotiation of that contract in more than 50 years. By bedding that in, getting the work plans locally agreed, getting all the consultants to sign up to the contract and driving through some of the service redesigns that we have been involved in, I am confident that we will get there.

The NHS is now controlling much more effectively than it ever did its relationship with consultants, the effective management of their time, the planned downtime that they now have in which to pursue academic studies and so on.

Dr Woods: The target is unchanged and our belief that we can deliver the target is unchanged. We have simply revised the method of measurement to reflect some of the suggestions

that were made in the Atkinson report so that we will be able to measure consultant productivity more comprehensively and on a basis that will enable comparisons to be made across the UK.

Shona Robison: Are you saying that the changes will be about how the measurements are made rather than being to do with finding ways to recover your position? You said that you would expect to recover the position. Did you mean that you will just measure things in a different way?

Mr Kerr: I am confident that we will achieve the target. The Atkinson review is throwing up some interesting issues to do with quality and time and how we measure the effectiveness of consultants. Yesterday, I was at a conference on productivity in public services, which was organised by *Holyrood* magazine. There was general agreement at the conference that it is difficult to measure that, but the Atkinson review is taking us a lot closer, and Robert Black, the Auditor General for Scotland, recognises that. The measures that we use to get to where we want to be on measurement are developing, but we expect to achieve the productivity for which we have set ourselves a target and we will improve the measurement of that to ensure that we have achieved it.

The Convener: I think that Jean Turner wants to ask a question on consultants too.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): Can I follow up on what the minister has just said?

The Convener: I will bring Jean Turner in because she also wanted to discuss consultants.

Dr Turner: Some of what I want to ask about has already been discussed. There are difficulties. Giving a new contract and a new financial settlement does not necessarily increase the number of consultants that we have. Sometimes, the patient is not there on time and the consultant does not have a theatre or the notes on time. Any consultant's productivity changes, so it would be nice if the minister could elaborate on how he will help the NHS consultants to keep to the European working time directive and meet targets.

Mr Kerr: The 14 per cent growth in the NHS workforce—the additional consultants, doctors, nurses and other health care teams that we have employed—cannot be ignored, but I fully understand your question. Our approach, which we have discussed before, is a whole-systems approach. It is concerned not only with the consultant's time, but with the whole process of referral and how the patient gets to the appointment. For example, patient-focused booking reduces the number of do-not-attends; we have reduced those considerably in parts of Scotland—by 14 per cent in Glasgow, if my recollection is correct. By reducing the number of patients who do not attend, we avoid consultant downtime. The whole-systems approach also involves the use of technology, day-case surgery, keyhole surgery techniques, increased skills and the diagnostic pathway that we have set ourselves. That approach will lead to the efficiency not only of consultants but of the whole health care team being pushed to the limit.

We are not asking how we can make consultants more efficient, but trying to make the whole health service more efficient, from general practitioners making electronic referrals into the system for allocating individual tasks to the appropriate consultant, through ensuring that the patient turns up on time and has a health care team allocated to undertake the task. We are segmenting the approach to ensure that we drive efficiency in the whole organisation.

I hope that that answers your question about how we use the consultants' time more effectively. We do it through a whole-systems approach that tries to drive in efficiencies. The management technique in the health service is to segment the patient journey and to try to ensure that we drive a hard bargain at each stage of the process. We are doing that through e-health and other techniques.

Dr Turner: Are you considering trying to persuade some of the consultants who are on part-time contracts and work in the private sector to work wholly within the NHS? Many people in the NHS, including some consultants, think that if all consultants worked within the NHS, its work—including teaching and everything else that is in its remit—would be done more effectively.

Mr Kerr: I have never heard a calculation that says what difference it would make to service delivery if we had all the time of every consultant in Scotland for the NHS. However, one of the benefits of the contract is to determine—for the first time in the NHS's history, astonishingly—exactly what the consultants will do for us over their 10 to 12 or, sometimes, 13 programmed activities for the service. We have much stronger managerial and systems control over the consultants' role in order to drive efficiency. If a consultant wants to work in the private sector, we need to know about that and what impact it will have on their NHS workload. They will not be able to say, "I'm sorry, I'm going off to X hospital to do some operations today," because the process is agreed with local management. That is, I believe, paying dividends locally.

Perhaps Kevin Woods is closer to some of those issues than I am.

15:15

Dr Woods: That is absolutely right. The new contract provides much greater transparency and

the opportunity for a dialogue about making use of additional consultant time. Two of the time-releasing savings programmes that we are pursuing are specifically intended to support redesign to make better use of consultant time. I refer in particular to the redesign of out-patient services and the patient-focused booking programmes, which are going well.

Another point, which we discussed at some length with the Audit Committee, is that we are now in post-consultant contract implementation. A process of benefits-realisation planning is under way and we get six-monthly reports on the benefits arising from the consultant contract and the other pay modernisation contracts. We will be getting an update on that in about two weeks.

Mr McNeil: I have an old question that I asked the minister's predecessor a couple of years ago. When we introduced the expensive United Kingdom deal for consultants, one of the major objectives was to affect the waiting lists by ensuring extra theatre sessions with consultants. How many extra theatre sessions do we get from consultants in Scotland as a result of that deal? Although it is a crude measurement, it might give some indication of what we are getting for our money.

Mr Kerr: That is a fairly crude measurement. I will say a few things before Kevin Woods gives you the exact details on theatre sessions, if he can. The first is that the number of operations is up by 11 per cent. There has also been a drive to move care out of the acute setting and into a more local environment in primary care and other hospital environments.

We need to be careful about how we measure the NHS's performance. The more day-care surgery that we do, the more productive we are and the better it is for patients. We need to do less work in the acute setting and more diagnostics and investigations at a local level, which are not measured in the crude way that Duncan McNeil described and which might lead to a misunderstanding of that crude measure.

My final point concerns a matter that consultants have raised with me publicly and privately—they perceive that the quality of the service is improving, which is partly because they have longer to engage and do more work with patients. I want to improve on a number of dimensions of that crude measure.

As I said, the number of operations has increased by 11 per cent, but I want to ensure that quality is not sacrificed as a result. As evidence, we have achieved our waiting-times targets and the number of knee, hip, cataract, angioplasty and angiography operations is increasing by a huge percentage. I am happy to correspond with the committee on performance data. If you want to monitor inputs and outputs, you can do it with those measures. I am not sure whether Kevin Woods will speak about the availability of theatre time.

Dr Woods: I am afraid that I do not have at my disposal the number of theatre sessions, but we will be happy to give the committee a note about it. Such information needs to be located in the broader context of job planning and benefits realisation, which are fundamental features of the consultant contract. It is through those processes that we can track whether we are getting the benefits that we want from that investment and the early indications are that that is indeed happening. As I said, we presented evidence to the Audit Committee earlier in the year to that effect, but I will be happy to share a note about it with the committee.

The Convener: That will be useful information.

Mrs Milne: We know that there are gaps in consultant provision, so I presume that there are workforce issues, in some specialties more than in others, although I cannot think which off the top of my head. Has progress been made on that? How many vacancies are there and how will that impinge on the budget? Is there a prospect of filling some of those gaps in the next year?

Mr Kerr: The committee will be aware of the target to recruit an extra 600 consultants and I have reflected that we need to revisit that principle while seeking to recruit as many consultants as we can for our health service. "Delivering for Health" and the workforce planning initiative with which we are currently involved give us greater signs about workforce numbers and demands.

Using the word "shortage" is loaded because we have significantly more consultants per head of population in Scotland than elsewhere in the UK and we continue to recruit. The evidence that I have is that there is a startling difference between this year's annual review and last year's on how we are getting on with recruitment in pressured areas. The response is positive on the whole. There is one group of consultants that were not—

Dr Woods: The obstetricians in Caithness and Orkney.

Mr Kerr: So, there were groups around the service. However, I am happy to provide evidence on recruitment to the committee to show that we are filling the posts that we are seeking to fill. We ran major recruitment campaigns at a UK level to attract consultants to Scotland, and those are paying off. In my view, however, we will not meet the target of 600. I need to reflect on what the organisation—the NHS—needs from us, in terms of recruitment, to ensure that we fill the vacancies

in pressured areas. Kevin Woods might have more detail.

Dr Woods: The only point that I would add is that the solution is not always to increase the number of consultants. We can also increase the number of practitioners with extended and specialist roles, and we have been doing that. There are several examples, but there is one that I think is particularly useful because it is possible to see the read-across into the jobs that consultants have traditionally done. We have funded a national programme for non-medical endoscopists. We are beginning to see people graduating from that, and non-medical endoscopists devoted to that task are increasing the throughput and productivity of that important service. It is wrong to focus just on consultants. The numbers are increasing as the minister has described, but so are the numbers of the other people with specialist and extended roles.

Janis Hughes: The minister will be aware that the committee has been specifically examining the mental health budget this year. From our scrutiny, it appears that there has been a reduction in real terms of the mental health specific grant. That has been borne out by some of the evidence that has been given to the committee. Can the minister tell us whether, in his view, that decline reflects a reduction in priority for mental health services?

Mr Kerr: Kevin Woods will answer that point in detail. I have been trying to follow the discussions that the committee has been having, as has Lewis Macdonald. I am strongly of the belief that mental health remains one of our key priorities; therefore, mental health services are funded to that degree. We put money into the system and we put money into the system further down, through local authorities. In terms of a financial focus, it remains a key priority for us. I invite Kevin Woods to give some detail around the numbers.

Dr Woods: It is correct to say that the mental health specific grant has been retained at its cash level of £20 million. However, it is important to see the way in which resources for mental health services have been expanding more generally. Quite apart from the substantial increases that have been made in funding for the NHS overall, we have invested considerable resources in the implementation of the Mental Health (Care and Treatment) Scotland Act 2003. We have also invested about £18 million, over three or four years, in our programmes on positive mental health and well-being—the anti-stigma campaigns and things like that. The background is of increasing resources going into mental health services more generally, as I have described. About 370 important projects are being supported through the mental health specific grant and we wish to retain it.

Janis Hughes: I hear what you are saying. However, as we scrutinise the budget—some of us do not have a financial background—we perhaps look at cruder measurements of where decline appears to be happening in budget spend. When we looked at the mental health budget, we saw that, across health boards, there has been a decline in the amount of spend over the past few years. We considered that that could be due to things such as the joint futures initiative, community care and health partnerships, other joint working and initiatives that were perhaps being financed by local authorities. However, in order for us to correlate that and decide whether that was correct, we needed to know what local authority spend on mental health was. We discussed that with the deputy minister. Do you have any further information on whether that explains some of the decline in spending on mental health across health boards?

Mr Kerr: There is no decline in mental health spending. There is a straight line in the budget for grants but, in the other finance and resource that we are putting in through well-being projects, the suicide projects and the other things that we are doing, we are spending money on mental health. I have sought reassurance that, when we give local authorities money from our budget for them to carry out a task for us, it is the responsibility of the locally accountable officer to ensure that that money is spent. I do not know whether that answers your question, but—

Kate Maclean: I want to clarify the position. In all the health board areas except Lothian there has been a reduction in expenditure on mental health as a percentage of the boards' total spend. We are not referring to the amounts allocated.

Mr Kerr: You are talking about the share of the budget for mental health services.

Kate Maclean: I am talking about the percentage of the total budget. In every health board area, the spending on mental health as a percentage of the total budget has reduced—except in Lothian, where there has been an increase in such expenditure.

The Convener: The picture was pretty consistent across health boards.

Mr Kerr: I would argue that the money is continuing to go in and is continuing to grow. You are saying that the share of the NHS cake for mental health is declining.

Kate Maclean: Yes. The share of health boards' total budgets for mental health services is getting smaller.

Mr Kerr: I would argue that the cake is growing, but because we are engaged in numerous activities such as redesigning services, making

them more locally driven and introducing the diagnostic project, your point stands. However, that does not mean that mental health is not a priority. It is probably a fact that although there is growth in the budget, the slice of the cake for mental health has reduced, but that is not to say that we have a strategy that ignores the importance of mental health. It is simply the case that we are spending more money on other services and patient interests, such as waiting times and waiting lists. We are making huge investments in GPs, community health and pharmacy work. It is not that mental health is less of a priority; it is that it is part of a wider picture of overall growth.

Janis Hughes: Given that the percentage of money for mental health is going down, you must understand our concern. If that is because more care for people with mental health problems is being provided in the community, we would be willing to accept that.

Mr Kerr: You say that the money for mental health is going down, but it is not. The share of the budget is reducing in comparison with the rest of the budget. Is that a fair point?

The Convener: That is a semantic distinction. The share of the health spend that is allocated to mental health is declining in all but one of the health board areas. We wanted to find out whether that was being balanced by increasing spend on other areas of service provision, such as that for which local authorities are responsible. That is harder to get at in the budget. We wanted to establish whether that is what is happening.

Mr Kerr: I do not think that it is an issue of semantics. If the NHS budget halved but the share for mental health increased, that would be no good to anyone because the service would receive fewer resources. I am trying to make the point that the position that you describe exists because of growth elsewhere in the budget and that it is only a decrease in comparative terms.

According to the total that I have, expenditure in the NHS on mental health services amounts to £687 million, which is a significant sum of money. The figure may not be growing at the same rate as expenditure on other aspects of the service, but "Delivering for Health" explicitly states that we want to deliver more services locally. We have employed more allied health professionals and are striving to deliver diagnostic services locally. We are putting additional resources into providing services in different ways.

As regards the point on expenditure through local authorities—

The Convener: And the voluntary sector.

Mr Kerr: —I will have to bow to Kevin Woods's understanding, but I am assured that any money that we put in is spent in the way in which we want it to be spent.

Dr Woods: The figure of £687 million includes resource transfer, of which NHS board accountable officers must keep track. I cannot offer you a figure on what local authorities are spending from their own resources to support their mental health activities, although I know that we have allocated £13 million to the implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003.

I have another important point to make. We are talking about figures that relate to specialist mental health services—essentially, they are secondary mental health services. I do not believe that the data under discussion include general practice costs. A great deal of mental health care takes place in general practice settings. If we went through a process of attribution, we could probably carve out the figures but, in general, we do not budget on that basis because such activity all takes place in a primary care setting. We could look into the issue in greater detail.

The Convener: That would be useful.

Helen Eadie: In table 4 on page 7 of the SPICe briefing entitled "Draft Budget 2007-08: Health and Community Care", the final column under the heading "Mental Health Specific Grant" gives an increase in expenditure of -2.9 per cent. There are only two minuses in that column—the other one relates to expenditure on health improvement. There are increases under all the other headings, including that for the national health service as a whole. It is clear that the funding of mental health services is an issue.

15:30

The Convener: I think that the minister has absorbed the fact that we have an issue with this. We were not trying to be wholly negative. We were trying to get at what money was being spent through local authorities and through the voluntary sector. That proved to be difficult to ascertain. We were trying to find out whether those things balanced and where the money was going.

Kate Maclean: Mental health is a Scottish Executive priority, so the committee was surprised to note significant reductions in the percentage of health boards' total spend on mental health in some cases. We supposed that that must be reflected in increased spending elsewhere. Only one health board showed the same level or an increase. Because mental health is a Scottish Executive priority, we wanted to find out where the spend is coming from.

Dr Woods: Over many years, mental health services have been going through some important changes, from an institutional base of care to a community base of care. For many years, we ran a bridging finance scheme for boards. That finished in 2001. At that time, it was running at about £18 million per annum. We specifically put that funding into the baseline funding for NHS boards. If you consider cancer and coronary heart disease in the budget book, you will see specific lines in there. Mental health came before them, in a sense, in the form of the bridging finance scheme.

The Convener: We recognise that the mental health spend might be more than what is coming through the health boards. On the face of it, the relative share of the health boards' spending is declining, with one exception. We accepted that there might be other ways in which money is being spent. We are trying to get at those other ways.

Mr Kerr: I now have a better understanding of what you are looking for. We need to provide that evidence and to reflect the secondary and primary care elements. We will seek to do that for the committee.

The Convener: We have spent quite a lot of time with Lewis Macdonald on the subject of mental health, so I want to move back to the overall budget issues.

Shona Robison: In a way, this question touches on a similar point about what will be delivered from additional resources and how that can be evidenced. The mental health spend is a good example. The minister tells us that X amount of money should be allocated to mental health but, when it comes to the health board level, we hear evidence that all is not as it seems and that a reducing proportion of the budget goes on the mental health spend. It is a matter of how you can evidence to us through the budget process that what you intend and hope will be delivered with the resources available is actually being delivered.

I might have picked you up wrongly on this, but you seemed to indicate that, if the waiting times initiative took priority, mental health moneys would be moved across at health board level. I take it that you would expect what you deliver at the centre, be that for mental health or anything else, to find its way to such priorities at health board level, and that you would expect that that could be demonstrated. To date, that demonstration has been lacking at national and health board levels. Will that improve?

Mr Kerr: There is plenty of evidence around. Judging from the briefings that have been provided for the committee, there is an indication that the investment is bringing a substantial return.

I want to return to the principles around what we are doing with the NHS budget, which we are growing significantly. What are we doing with that money? First, we are increasing our investment in capital infrastructure. That is not just about buildings. It is possible to redesign how health works by investment in property and assets. We are doing that to a significant extent out of the capital budget, which used to be £167 million and is now around £500 million. The use of public-private partnerships and other initiatives is allowing us to invest massively in the acute setting and in the community, with community health centres and other facilities. That applies to projects all round Scotland.

Secondly, we have used the money to invest in our workforce, which we have grown by 14 per cent. We have increased the number of allied health professionals by 3,500; we have increased the number of nurses by 4,500; we have increased the number of consultants by 300—that number is growing—and likewise with general practitioners.

We are investing in care and in the service to ensure that we provide the product for patients. The impact of some of the work is easy to measure, while some of it is not. It is easy to measure the fact that cataract operations went up by X per cent, knee and hip operations went up by X per cent, and waiting times and waiting lists came down. However, the real success of the health service is the turnaround that has been achieved on the big issues such as coronary heart disease. Death from such disease is down by 44 per cent; death from strokes is down by 40 per cent; and death from cancer is down by 15 per cent. Operations are up by 11 per cent. We are making significant inroads on some of the big health challenges.

As we discussed earlier, it is hard to measure the success of some of the work. Yesterday, I visited midwives in Fife who run smoking cessation sessions with pregnant mothers. How do we measure the impact of such work? How do we deal with the issue that a baby will be born with greater well-being, will have better health and will live a longer and happier life because we managed, by means of a midwife who worked at close quarters with that baby's mother, to get her off cigarettes? We can talk about developments that are a badge of great success for the NHS—in relation to waiting times, knee and hip operations and all the other examples that we give—but initiatives such as the legislation on smoking in public places and work on alcohol are not measurable at this stage. The Atkinson review is trying to drive us towards better measurement of quality outcomes.

I return to your point. First, I can put my hand on my heart and say that the money that goes into

our health service is going into people, property and assets; that is what it should do, because patients and staff deserve good places in which to work. Secondly, the results are shown by some of the outcome measures. Although those are simplistic in one way, they are also an indicator of productivity and success.

Dr Woods: The minister is referring to table 6 in the SPICe briefing "Draft Budget 2007-08: Health and Community Care", which gives a comprehensive analysis of progress on a series of objectives and targets. One of those relates specifically to mental health, because it is about suicide; that is a narrow indicator, but it is headed in the right direction.

There are now local delivery plans on 28 key targets, which we track; as part of that work, we have reflected on the next version of that process and on whether we should extend or replace some of the targets and include some more specific targets on mental health. That is a matter for the delivery plan.

The Convener: We look forward to the annual shifting of the goalposts that makes our budget scrutiny an interesting experiment in trying to understand what is happening year on year.

Mr McNeil: I welcome the minister's statement and his confidence that we are making headway. The evidence is staring us in the face.

The table on page 9 of the SPICe briefing refers to reducing health inequalities. As we increase all the targets across the board, there is improvement among those who are already living the longest. That gives us a challenge when we try to close that gap. A target that is mentioned in the table proposes to increase

"the rate of improvement across a range of indicators for the most deprived communities by 15%".

One of the indicators, which are listed on the other side of the table, is that mortality rates from coronary heart disease have been reduced by 12 per cent in the most deprived communities. What was the figure in the affluent areas? Do you see my point?

Cancer deaths have been reduced by 7 per cent in the most deprived communities, but what is meant by the 15 per cent target? Is the target an increase from 7 to 15 per cent, or is a clear improvement of 15 per cent required between now and 2008? How will the target be achieved and what money is being directed towards addressing the issue?

Mr Kerr: Working to close the health inequalities gap is one of the Executive's key founding values. The work that we do in education through hungry for success and health promotion in schools contributes to that, as does the work that we do in our nurseries on supplying free fruit and water and on supervised tooth brushing. Our work on sexual health and our work on healthy workforces through the Scotland's health at work initiative and the centre for healthy working lives also contribute. Our transport strategy includes walking promotion and cycling promotion. I could mention many such initiatives across the Executive, in the portfolios of many ministers who sit round the Cabinet table.

The key point that Duncan McNeil wants to address is how that plays into challenged communities and areas of poverty and deprivation. That is why the prevention 2010 programme has been launched, which has been given resources in addition to the funds that health boards get. The programme is targeted at the 15 per cent of worst-off areas in Scotland, and the number of areas that it seeks to cover will grow by 2010. I am well aware of Mr McNeil's interest in relation to Inverclyde and I am confident that, as we develop prevention 2010, Inverclyde will become part of the mission. General work is being done around Scotland, but the work in areas of deprivation is more focused. This morning, in Glasgow, I talked to the active schools co-ordinators and to the school cooks and chefs who are beginning to make substantial differences. We have set ourselves additional targets in relation to teenage pregnancy and smoking in deprived communities.

You asked about the inequalities gap. In one health board area—I cannot remember which one, which is probably just as well—when more affluent women started smoking during pregnancy while the figure for deprived communities stayed the same, the gap closed. However, such a statistic is no good to anybody, because all that it shows is that more affluent women were taking up smoking. The fact that the health inequalities gap had closed was no cause for joy, given that it had closed only because more affluent women had started smoking again.

As a result, I am cautious about the gap. We know that it exists and we know where it is. The small area indicator data—I cannot remember the formal title—tell us where our challenges are. The chief medical officer can tell me how many heart attacks there will be in the east end of Glasgow, and I can set targets to reduce the number of heart attacks by a certain amount, so the science is becoming more focused.

I assure Duncan McNeil and other members that we are tackling health inequalities in a focused way. We are allocating additional resources, and GPs, allied health professionals and communities in those areas are working away and, in my view, having some success. Glasgow is no longer the coronary heart disease capital of Europe, and the city is now turning round its oral health and hygiene situation as a result of supervised tooth

brushing. We are making great strides and there are more to be made. Those are longitudinal, generational shifts. The Executive has focused on those issues, but I am not complacent and I understand that there is more to be done. The work is on-going and is highly focused.

Kate Maclean: I do not think that the minister answered Duncan McNeil's question. Perhaps Dr Woods will be able to answer it.

There has been a 12.7 per cent reduction in coronary heart disease in the most deprived communities, and Duncan McNeil asked what the reduction had been in the most affluent communities. The question is pertinent, because statistics can demonstrate that resources are not being targeted properly if the gap stays the same or widens, as sometimes happens. Across all the portfolios, additional money sometimes benefits more affluent people rather than the people who were targeted. If that figure is not available now, it would be interesting to find out what the reduction has been in the most affluent areas, to see whether the targeting has been effective. It would concern me and Duncan McNeil, as members who represent areas of multiple deprivation, if—

The Convener: I would just like to add, as a cautionary comment, that I hope that none of us would be happy if any section of the community did not show a reduction in heart attacks.

Mr Kerr: I have in my head, but not in my possession, a graph that will give you the statistics to show that, from 1990 until now, there has been a substantial drop in coronary heart disease and also a closing of the inequalities gap. I used that graph yesterday at another presentation, and I can give a copy to Kate Maclean.

The Convener: Thank you. I remind members that the minister is here only until 4 o'clock. If a sudden forest of hands goes up, we will never get through all our questions. Helen Eadie may make a small point if her question is on the same issue.

Helen Eadie: I commend to the minister the report by the coalfield communities campaign, which has just been published. It highlights the fact that, in former coal mining communities throughout Scotland, there are specific equality issues about mortality rates. One of the figures that I read about just a fortnight ago showed that the area of Fife that Christine May represents and other parts of Fife, but not my constituency, had the worst mortality rates for the lowest age group in the whole of Scotland.

An issue that the minister has not mentioned, on which he knows that I have campaigned long and hard, is the skin cancer epidemic. I have heard nothing to reassure me that that is being targeted as a priority for the Executive. Education about the dangers of going out in the sun needs to be made a priority throughout Scotland.

15:45

Mr Kerr: I hear what you are saying about coalfield communities. We know where they are, because we have good data. The issue is how to address ill health in such communities. That is about not just the health service, but people's confidence, community safety, housing, transport, green and open space and other such issues that affect people's well-being. I am happy to look at the report that you mentioned and to see how the boards that cover such areas are dealing with those issues.

Perhaps I will have an offline discussion with Helen Eadie on her question about cancer. Skin cancer is an integral part of our cancer strategy and is reported on as assiduously as breast cancer, bowel cancer and other forms of cancer. There might be arguments about the campaigns that we run and public information efforts that we make. We continue to run a certain type of campaign, about which I know that Helen Eadie and Ken Macintosh have disagreed with us. I am happy to continue that discussion elsewhere, if that is appropriate.

Mrs Milne: I have three brief questions, the first of which is on e-health. Given that there have been significant problems south of the border, are you confident that there will be sufficient resources here to support the comprehensive health system built around the electronic patient record?

Mr Kerr: I am confident of that for two reasons. One is that we have put aside the resources to do the job and the other is that we have built a governance arrangement and strategy that I think have inherent value. We want to grow what works in the health service around current and future technology. Paul Gray, who manages that issue in his day-to-day role, is here with me.

I am confident that we are taking clinicians with us, which is incredibly important. It is about not technology, but re-engineering cultures and approaches. It is about not boxes and software, but how we get people to work differently. I am confident that the e-health strategy will allow us not just to have fairly simple emergency patient information and the picture archiving and communications system, which allows the exchange of diagnostic information from X-ray and scans, but to connect the health service, which is vital in "Delivering for Health". We put our money where our strategy is and I am confident that our strategy is right. Paul Gray can give you further details on work to date.

Paul Gray (Scottish Executive Health Department): I will amplify what the minister said

about building on what we have. We have made it clear that simply ripping up and replacing everything that exists will not work. The minister mentioned the PAC system. We are making good progress with the emergency care summary and modern systems to support accident and emergency departments, which were set out in "Delivering for Health". The one thing about which we have to be absolutely clear is that there is no single system on the market that will do everything that a national health service would want. At a certain point in our development the market told us that such systems might be becoming more mature, but thorough research showed that that was not the case. We are joining up what works, rather than applying a single panacea.

Mrs Milne: The joined-up thing has been a big problem in the health service for many a long year.

I am not surprised that there is no mention of free personal care, given that a review is under way. Should the review indicate that further resource is required, is it likely to be put in place?

Mr Kerr: If any review threw up a finding that we are not providing the service that we should be providing, we would have to deal with that. I am sure that you have heard from Lewis Macdonald that we have resourced free personal care as per the recommendation when it was introduced. The care development group, to which COSLA and all the other providers bought in, recommended that we put in a certain amount of money; in fact, we put in slightly more than was recommended. I am still confident that we are providing the proper resources, but if the review throws up areas in which we are not doing so, of course we will have to address that because free personal care is a key Executive policy.

Mrs Milne: I hope that you will do so. Are you aware of the frustration that exists at the delay in the publication of the findings of the independent budget review group?

Mr Kerr: I should check which review group you are referring to.

The Convener: I think that Mrs Milne is talking about stuff that Tom McCabe deals with.

Mrs Milne: I am sure that the minister is aware of the frustration that exists as a result of the publication of the findings being delayed until next year.

Mr Kerr: I do not want to sound like Tom McCabe, but I agree with what he has said. We commissioned a report. As ministers responsible for Scotland's budget, we will trawl for ideas about how we can improve that budget. It will be for us to act on what the report suggests—that is an appropriate way of doing Government business. It is appropriate to publish the report when the spending review is taking place, otherwise there will be a host of wild and inappropriate misunderstandings about the advice that has been given to ministers. We must take advice, analyse it and then deliver. Information will become available in due course as a result of the spending review.

The easier answer to your question might have been that the matter is Tom McCabe's responsibility.

Mrs Milne: It seems that it is.

The Convener: We should confirm that Mr Kerr is not responsible for Tom McCabe's department.

Mr Kerr: Indeed.

Euan Robson (Roxburgh and Berwickshire) (LD): The Executive has focused heavily—and rightly so—on health improvement. In recent years, two step changes have taken place in resource levels for health improvement. Earlier, it was said that there has been a real-terms reduction of 0.5 per cent in the health improvement budget for 2007-08 compared with that for 2006-07; in cash terms, we are talking about an increase of around £2 million. There was a slight percentage decrease in the budget for 2006-07 compared with the high budget for 2005-06. Do you agree that it is important to keep the health improvement budget at such a high level in real terms so that there is no progressive erosion in the budget's real-terms purchasing power over the years? In addition, is there any hint anywhere that too much money was made available too quickly? Are we talking about budgetary decisions with only marginal effects?

Mr Kerr: I understand that the minus figure is the result of a book transfer of drugs money between my department and the Justice Department. The Executive thought that the Minister for Justice, Cathy Jamieson, and I had dual responsibility for drugs policy and that there was a danger of that policy falling between our responsibilities. Therefore, on behalf of the taxpayer, I have given that element of our budget to the Justice Department so that it can manage the drugs strategy. Health improvement moneys have therefore gone to the Justice Department. As a result, I hope that members will see somewhere else on a bit of paper a plus 0.5 per cent increase in the relevant moneys.

Significantly improved moneys for health improvement have been made available. I was the Minister for Finance and Public Services when we discussed the wider definition of health, and we have moved significantly towards having a wider definition. The hungry for success programme, with £67 million of additional resource, is transforming school meals and the money that we are making available to encourage walking and

cycling and to improve public transport aims to improve people's health.

I defend the budget position first on the ground that a book transfer has taken place and secondly because I am proud of the Executive's work across its portfolios. We are talking about the long term—not four-year paybacks on electoral-cycle money—and sustained improvement in the nation's health. The money that we have made available is paying off. Things take time, but kids in schools and nurseries and people in our workforce are getting healthier as a result of the investments that are being made.

Euan Robson: So measurements are available that will indicate the budget's efficacy. I appreciate that other budget lines reinforce the general line, but are you content that all the programmes that fall within the real-terms figure of £107.6 million for health improvement will be consistently delivered?

Mr Kerr: I hope so. In conference speeches, I always say that my job as Minister for Health and Community Care is to improve people's health and tackle health inequalities—I hope that anyone who has heard those speeches will confirm that. We must also run the health service as effectively as we can. The policy position is absolutely clear to everyone who works in the health service, because I say what it is everywhere I go. We can back up our claims by pointing to not only the investment that we are making, but the results that we are getting.

The Convener: I thank the minister and his officials for giving evidence. We have reached the end of the public part of the meeting.

15:55

Meeting continued in private until 17:30.

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

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

The deadline for corrections to this edition is:

Monday 6 November 2006

PRICES AND SUBSCRIPTION RATES

OFFICIAL REPORT daily editions

Single copies: £5.00
Meetings of the Parliament annual subscriptions: £350.00

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

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Standing orders will be accepted at Document Supply.

Published in Edinburgh by Astron and available from:

Blackwell's Bookshop
53 South Bridge
Edinburgh EH1 1YS
0131 622 8222

Blackwell's Bookshops:
243-244 High Holborn
London WC1 7DZ
Tel 020 7831 9501

All trade orders for Scottish Parliament documents should be placed through Blackwell's Edinburgh

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

Telephone orders and inquiries
0131 622 8283 or
0131 622 8258

Fax orders
0131 557 8149

E-mail orders
business.edinburgh@blackwell.co.uk

Subscriptions & Standing Orders
business.edinburgh@blackwell.co.uk

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

sp.info@scottish.parliament.uk

All documents are available on the Scottish Parliament website at:

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by Astron