HEALTH COMMITTEE

Tuesday 4 November 2003
(*Afternoon*)

Session 2

£5.00

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

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HEALTH COMMITTEE
11th Meeting 2003, Session 2

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

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

COMMITTEE SUBSTITUTES

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

*attended

THE FOLLOWING ALSO ATTENDED:

Dr Andrew Walker (Adviser)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Graeme Elliot

ASSISTANT CLERK

Hannah Reeve

LOCATION

Committee Room 3

Scottish Parliament

Health Committee

Tuesday 4 November 2003

(*Afternoon*)

[THE CONVENER *opened the meeting at 15:00*]

Item in Private

The Convener (Christine Grahame): I welcome everyone to the 11th meeting of the Health Committee in session 2. I hope that the meeting will be quite short. I tender the apologies of David Davidson and welcome as substitute to the committee Nanette Milne.

I ask members to agree to take in private item 3, which is consideration of possible witnesses to give oral evidence on the National Health Service Reform (Scotland) Bill. Is that agreed?

Members *indicated agreement*.

Budget Process 2004-05

15:01

The Convener: Item 2 is consideration of the draft report on the budget process—paper SC/S2/03/11/1—which we said we would consider in public. I welcome back Dr Andrew Walker, whose presence is helpful. I thank him for his work so far, because he has helped us a great deal on the budget.

As a preliminary, I thought that I might mention why there are questions in the draft report. It has been explained to me that those are the questions that the Finance Committee asked us to answer. That is why they form part of our report. I had not seen that format in previous committee reports.

I am not sure how members want to proceed. I do not think that we need to go through the report blow by blow. We will deal with particular issues, unless Andrew Walker wants to say something.

Dr Andrew Walker (Adviser): There is nothing that I desperately want to say. One of the main points that I recall changing was the recommendation under paragraph 18 at the bottom of page 5. That was where we tried to decide what we needed from the Arbuthnott data. We considered whether we wanted each part individually and whether we wanted a comparison of this year's data with last year's. We had a discussion about that. I think that the final paragraph reflects what we agreed. I hope that everyone is happy with that.

The other main thing that I did was to stick the discussion of future directions, which was at the start of the report, at the back of the report, because it seemed to follow on slightly more naturally in that position.

The Convener: What are you referring to?

Dr Walker: I refer to paragraph 44 on page 14. I have basically taken the discussion of where we go next from the front half of the report and put it in the back, because I think that it flows a little more naturally there.

The only part of that section that I have changed in any way is the final paragraph, which, if the committee remembers, petered out slightly. It still has that tendency, but it is a little more finished off.

The Convener: Where are we now?

Dr Walker: Paragraph 54 on page 19. I finish off by saying:

"After consideration, the Committee will explore the feasibility of developing the options on (i) inputs and (ii) proxy outcomes."

The Convener: I am sorry, but I am still not clear about where you are.

Dr Walker: I am just below the table on page 19.

The Convener: Okay—now I see where you are.

Dr Walker: That paragraph continues:

"The intention is that some of the data will be available in time to inform discussions of the 2005-06 expenditure plan."

I thought that that was probably all that the Finance Committee needed to know. I have brought along some more numbers for us to examine, to help us to understand what that means. As far as reporting to the Finance Committee is concerned, I thought that that was all that we would want to say.

The Convener: Could you indicate where those numbers are in the papers?

Dr Walker: The pink paper that—

The Convener: Is that the paper called "Examples of the approach to scrutinising NHS board expenditure plans"?

Dr Walker: The pink paper, which is called "Reviewing NHS boards' use of resources: inputs and proxy outcomes", was what I could get done by Friday, when we had to e-mail the papers out to members. Now that I have had a little bit longer, I have managed in the "Examples" paper to do some more numbers for members to have a look at. Is that okay for the report that is going to the Finance Committee?

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I did not have time to read the "Examples" paper, which stumped me, to be quite truthful. I knew that we were on a journey, but I did not fully understand where we were going and how we were going to get there.

Dr Walker: The "Examples" paper gives you some numbers to look at and some examples of how we might scrutinise NHS board expenditure plans.

Mr McNeil: Has anyone else had a chance to have a look at it?

The Convener: No. It has just been tabled. The report is now signed off and the "Examples" paper is separate. If members are quite content, we shall just say that that is the report signed off. Now we can get Andrew Walker to do a presentation on the new paper.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Before we move on, I must say that I am not terribly happy with the format of the report. On page 1, for example, under "2002 Recommendation 1", the report states:

"All NHS Boards should provide details on how their allocations are accounted for and that the information be publicly available."

That is followed by the question, "Addressed?", and the statement:

"No evidence of this being addressed from the Draft Budget document."

I am not sure that "Addressed?" is a useful thing to have in the document. That comment applies throughout.

The Convener: Obviously, it means that there is no evidence of the matter being addressed in the draft budget. We could take out the references to "Addressed?" That is just a drafting matter and an example of duplication. Are members quite happy for that to come out wherever it appears?

Members *indicated agreement*.

The Convener: Fine. Let us move on.

Janis Hughes (Glasgow Rutherglen) (Lab): Before we move on, could we clarify exactly what it is proposed that we do with the pink paper and the accompanying paper on examples, which we have not had a chance to look at?

Dr Walker: I am sorry that you are asking me that question, because I was going to ask you.

The Convener: They could also go to the Finance Committee, not as a report but just as accompanying papers with a covering letter from the committee outlining our concern that the previous committee's concerns have not been addressed in the presentation of this year's budget and that there remains a problem for the committee in tracking spending.

Janis Hughes: That letter does not have to go today.

The Convener: No.

Janis Hughes: The "Examples" paper looks like a fairly substantial paper, and I would not like to think that we were just sending it off without studying it.

The Convener: Oh no—we are all in the same boat.

Dr Walker: I hope that the report is now ready to go. The clerks can send it today and it will be with the Finance Committee tomorrow.

The Convener: With Mike Rumbles's amendment.

Dr Walker: Yes.

The Convener: That is all that will go today. Are members agreed on that?

Members *indicated agreement*.

The Convener: We shall now move on to look at the paper that Dr Walker has tabled. Because it is a late paper, it is not yet publicly available, but we will put it on the committee's website.

Dr Walker: I tried to take the two ideas that had received the most support at the previous meeting—on inputs and proxy outcomes—and to develop them a little. I was aware that they seemed like good ideas, but I wanted members to see some of the numbers and information that they could get to judge where the £5 billion that goes down to the NHS boards was going. In that way, members can see what it is that they are being asked to agree to. The pink paper was all that I could get done by Friday, when we had to e-mail something round to members. The paper that I have brought with me today is a little more detailed and contains some numbers. If we have a look at the numbers, rather than at more text, that should help us to see what is going on.

First, I tried to look at the total number of inputs across the health service. To summarise the text of page 2 of "Examples of the approach to scrutinising NHS board expenditure plans", I am arguing that we should probably look at one set of data for Scotland, not one for each health board, because that would mean looking at 15 sets of data, which would be pretty indigestible. Also, that approach would not take account of the fact that some people who live in one health board area are treated in another health board area. It may look as if Greater Glasgow NHS Board is well provided with oncologists while Argyll and Clyde NHS Board has none, but the reason for that is that the regional cancer centre is in Glasgow and patients from Argyll and Clyde go there. Looking at the data for all of Scotland allows us to take such factors out of the equation.

We still need some context, because otherwise we will just have totals. We may have a line saying that there are 927 psychiatrists in Scotland, but how do we judge whether that is the right amount or not? I have therefore included time trends, so that we can see what is going on. With that in mind, page 3 of the document gives members a first cut of the data on the total number of staff in the NHS. This is simply an example based on data that I happened to have lying around—we probably have more recent data. However, you can see how the total number of doctors, nurses, midwives and staff in other categories has increased over time.

Medical doctors come in two varieties: hospital doctors and general practitioners. The two varieties are shown in italics in two rows under the "Medical doctors" row to allow us to see where various numbers of people are employed. The table at the bottom of the page shows the average annual increase during the periods surrounding the years that are detailed in the first table. That enables us to see whether the rate is going up or down.

Those data could be broken down into greater detail. We could say how many doctors there are in each specialty; for example, we could say how many cardiologists or oncologists there are—I was not sure how much information the committee wanted. However, members can imagine that, if we did that for each of the health boards, there would be quite a wodge of data.

Mr McNeil: The objective of the exercise is to inform the public. Given the complexity of the data, how will using the method that you are describing ensure that the public are better informed at the end of the day? Rather than give us clear answers, it might raise some issues that would not arise otherwise. When I read the pink paper, I thought that it was an interesting experiment but I do not know where it leads us.

Dr Walker: There are different takes on how the money is being used locally. The basic contention is that the committee cannot see where the £5 billion is going and data such as those that are in the document give us some information on that, given that 70 per cent of NHS costs are staff costs. The data that I will show you in a minute relate to beds, which will give you more information about where the money is going. We are not looking for extremely fine detail in relation to what is going on locally; we want to see the general direction of travel. We want to see whether the funding—£5 billion one year, £5.3 billion the next year, £5.6 billion the year after that and so on—is going in roughly the same direction. At the moment, we seem to have no information on which to base such a judgment.

Mr McNeil: I understand that that is the position that we are starting from, but I would need to be a lot more convinced that we will end up with something that will be understood easily across the board and will inform people rather than add to the confusion that already exists.

Mrs Nanette Milne (North East Scotland) (Con): I ask you to appreciate that I am new to this subject and do not know what has gone before. Is there a means by which the information could be related to the need for various groups in the service? I am constantly having my ear bent about the lack of physiotherapists, occupational therapists and speech therapists. I understand that the numbers are going up, but they are not going up enough to satisfy demand.

Dr Walker: That exercise would be extremely difficult, I am afraid.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): The information that we are discussing is essential if we are to scrutinise the decisions that

are made by the Executive. It might well be that, as we have found out in relation to acute services, although there appears to be more money going in, patients are not getting their physiotherapy appointments or are having to lie in a hospital corridor because they cannot get beds and so on. That is the sort of information that patients use to determine how well the system is working.

We have to know how the money is being spent. If all that money is being spent and there are not enough beds, physiotherapists or surgeons, we need to be able both to have access to the sort of figures that we are discussing and to communicate that information to the patients. The Government has to provide for the people.

Dr Walker: I was just thinking about Nanette Milne's point about the comparator. I have used the time trend to try to give us some context. An alternative would be to say what the figures are for each health board, which would give us 15 columns, and then we could see, for example, that one was higher and one was lower. Although we could take that approach, another approach would be to consider norms in other countries. For example, we could consider how many doctors we would have if we had the European Union average number of doctors and compare that figure against how many doctors we actually have. However, that assumes that the EU level is the appropriate level, which may or may not be true.

It is hard to think of a good way to judge whether the figures are right, as every method has its flaws. I can see what Nanette Milne is getting at, but I struggle to see how we could do it.

15:15

The Convener: Perhaps it would be helpful if you went through the paper—I would find that helpful—so that we could see what the point of it is. Then we can come back and ask about it.

Dr Walker: There is information on bed numbers, for example, on page 4. I concentrate on acute and obstetric beds—we could also concentrate on psychiatric beds, learning disabilities and other areas—and then I look at all surgical and medical beds. I list some of the main specialties under the surgical and medical headings so that we can examine those and see how they change over time.

My only concern about such tables is that the numbers could be slightly misleading. If the number of patients who go through each bed is increasing, despite the fact that the total number of beds is decreasing, we are using the beds more productively and might be treating more patients. Therefore, to try to take us away from concentrating on bed numbers only, I have put at the bottom of page 4 a table about activity in two time periods, which shows figures such as the total number of people seen in out-patient clinics and the total number of emergency admissions.

We are building up to a picture that runs across the health service. On Duncan McNeil's question about what the paper shows us, it shows us something about the staff, something about the bed numbers and something about the activity, which is what the health service is about at the end of the day. Page 5 shows us something about the number of people who go through each bed each year, which is a measure that we loosely call productivity in the health service—it is about how hard each bed is being worked, if you like—and then something about waiting times at the bottom.

None of those data is conclusive. The data all give the committee an impression of the general direction of travel that underpins how the £5 billion is being spent to enable us to find out whether we think that that £5 billion is about right or not enough, or even whether we do not have enough data to judge.

The Convener: I am going to ask something really stupid: I do not know what "No. of episodes" means.

Dr Walker: I am sorry—that is health service jargon. One person in one bed is a hospital episode, but if a patient is transferred from one part of a hospital to another, that would count as two episodes, despite the fact that they are one patient. I apologise, as I meant to take that column out.

The total number of inputs that are used at health board level is one way of looking at the data. The second way in which we could examine inputs starts on page 6 and focuses more on growth money. I can tell you from personal experience that, at health board level, it often feels as if we have more control over only the uplift—the new money that has come in since last year. I went back to the local health plans of a couple of years ago and tried to extract the data that show us where that new money goes. After page 6, we have a complicated table, which is an abstract from the local health plans. I needed to go back to 2001—I apologise for the fact that the data are quite old—but that illustrates the information that ought to be available.

At the top of the columns, we have Argyll and Clyde NHS Board, Ayrshire and Arran NHS Board, Borders NHS Board, Dumfries and Galloway NHS Board, Fife NHS Board, Forth Valley NHS Board, Grampian NHS Board, Greater Glasgow NHS Board, Highland NHS Board, Lanarkshire NHS Board, Lothian NHS Board and Tayside NHS Board—I have ignored Western Isles NHS Board, Shetland NHS Board and Orkney NHS Board for the minute. In the top five or six rows, we have

figures for the additional resource from the management executive, or the Health Department, as we call it now.

If you run your eye down about six or seven rows, you will see a row called "Total new funds available". That ought to be almost the total of the new money or growth money that each of those health boards had available in 2001. Then the money starts to leak away, because below that row we have figures for pay awards, price inflation, financial pressures at the local acute and primary care trusts and other miscellaneous factors, including the prescribing budget. About three or four lines up from the bottom of the page, there is a line called "Total pay, prices and pressures".

If we look at the figures for Argyll and Clyde, we can see that the total amount of new funds available is £37 million and that the total amount for pay, prices and pressures is £31 million. Although the headline figure suggests that Argyll and Clyde NHS Board has a lot of money, by the time we have taken account of all the pressures, pay awards and price increases that it faces, much of that money has gone. The bottom row shows the amount "available", which, for Argyll and Clyde, is nearly £7 million. Ayrshire and Arran NHS Board thinks that it has less than £1 million to spend; the figure for Borders NHS Board is £2 million and for Dumfries and Galloway NHS Board it is just under £1 million.

That is a first cut at where the new money goes, based on what appears in health boards' local health plans. I often say of any money that is given to the Scottish health service that roughly 75 per cent is used to cover pay awards, price inflation, financial pressures and other things over which managers at local level probably feel they have no control.

The Convener: I feel a headache coming on.

Helen Eadie (Dunfermline East) (Lab): What happened to Fife NHS Board?

Dr Walker: I am afraid that Fife NHS Board is not good at putting information on its website. Helen Eadie should prod it along.

The Convener: Borders NHS Board is the same.

Dr Walker: The figures for Borders NHS Board are tucked away in each month's board papers.

The Convener: There are quite a few boards like that.

Mike Rumbles: I will use Grampian NHS Board as an example. The total amount of new funds available to the board is £22,080,000, the contribution to pay awards is £4.8 million and the contribution to inflation, assuming that it stands at 2.5 per cent, is £15 million. That adds up to £19.8 million. What is the £1 million that is described as "available" in the bottom row?

Dr Walker: I see what the member is getting at. It looks like the figure should be £3 million.

Mike Rumbles: I do not follow the calculation.

Dr Walker: I am not sure about the figure—I will have to check it.

The Convener: Are the figures your calculations or do they come from the boards' websites?

Dr Walker: I think that they were taken from each board's reports. I will have to check the figure to which Mike Rumbles refers. The aim was simply to give members an example of what the figures would look like if we pursued this line of inquiry.

The Convener: We need to track developments, but we cannot expect the figures to be accurate to the n^{th} degree.

Dr Walker: They ought to be. The aim was simply to give the committee an idea of what the figures would look like. However, if I were to present the information to the committee formally, I would try to track down the figures that Mike Rumbles seeks.

Mike Rumbles: I am happy to have rounded figures that give us an idea of the situation, but they should add up.

Dr Walker: Absolutely.

Mr McNeil: From which year do the figures come?

Dr Walker: They are the figures for 2001. I would be interested to see whether Argyll and Clyde NHS Board achieved its expected savings of £7.7 million—I think not.

Members will recall that the sums listed in the bottom row of the table add up to about £50 million of new money. The next eight pages show where that £50 million went. According to the health improvement programmes, these are the new service developments that were funded. The first two columns contain the health board code and the letters that were used previously. The other columns contain the amount spent on a service and indicate what the money was spent on.

Members can see how thinly the money is spread. About £52 million is spent over 280 different projects. At one point I knew the average project size, but I have forgotten. However, it is not very big. I suggest to the committee that there are never big changes in the health service because there are many different ways of using money. When funding reaches health boards, they tend to try to cover everything in some depth, but never in quite enough depth to satisfy anyone on anything.

We always end up just keeping going but never really cracking the problem.

I appreciate that these pages are almost indigestible, but they are intended to give members an idea of the level of information that we can get out of local health plans if we examine them in more detail. It might help if we brought summary figures to the table by distinguishing between primary care, acute hospitals and cancer and heart disease schemes.

Shona Robison (Dundee East) (SNP): Do we know whether the new developments that are listed went ahead?

Dr Walker: No. The paper is based on what was written down in what were then called health improvement programmes.

Shona Robison: We need to check how many schemes went ahead and how many were put on hold because of financial pressures.

I return to the issue of the new funds that are available and the figures for "Total pay, prices and pressures". Why does the percentage—not the total—of money that is given to a board to spend on total pay, prices and pressures vary hugely among boards?

Dr Walker: I suspect that not everybody fills in the figures in the same way and with the same definitions. When 15 organisations return different figures, the first thing to do is to quiz the accountants on what they filled in.

Shona Robison: That is a bit difficult, too.

Dr Walker: That is difficult, but members may remember that Trevor Jones gave evidence back on 30 September that the Executive was exploring ways to collate all the figures from local health plans and that it would get back to us on that. The way to proceed is to say that we need to sort out the variations by next year to have meaningful information. The best thing to do is to flush out the matter, after which people will start to do something about it. When people think that they will never be checked on, they have no incentive to present information properly.

The Convener: So boards do not present their information in a standard fashion.

Dr Walker: That is a possibility—it is the number 1 suspicion. Perhaps others will have experience of that. The headings will be the same and I am sure that boards will try to present information in the same way, but somebody might have a slightly different interpretation. For example, in the row on prescribing, which is about a quarter of the way up the page from the bottom of the table, some boards have specified prescribing separately, while others have not, although it is a big item.

Not everybody is doing exactly the same thing, but I do not think that anything underhand is going on; different people have different styles. I have always thought that local health plans are a rich source of advice and information but—as Shona Robison was right to say—they are plans, not done deeds. They provide one way to find out where the money goes at health board level. Is that okay? Do members want a minute to digest that or are they happy to finish off?

Two ways to consider inputs have been dealt with. We have examined the total number of inputs at local level and we have examined what information we can obtain from local health plans. The final matter that we said that we would examine was the proxy outcomes approach. At the end of the lists of service developments, I have given some examples. I suggest that we know from the available evidence that some procedures give us quite a lot of health gain for the budget that is committed to them. I have put down some examples that we would probably think about under the headings. One example is health promotion initiatives that have proven cost-effectiveness, such as nicotine patches for people who smoke. I know that the committee was concerned about the healthy eating phone line, which was a health promotion initiative that might not have shown evidence of cost-effectiveness in the first place.

Cataract extractions, hip and knee replacements, angioplasty and coronary artery bypass surgery for angina are all good examples, because they are also in the performance assessment framework. We need to start thinking about how we can tie in what we do with that existing exercise, because that will make life easier when we try to convince the Executive that the approach is a good one. Statins in secondary prevention of heart disease are another example of good value, and chiropody services have also been shown to be cost-effective.

Health services that would fall into the category of poor value are services on which evidence shows that they do not work well, such as grommets for ear problems. Other such services might exist. Measures that the National Institute for Clinical Excellence and the Scottish medicines consortium have not recommended—the SMC has not recommended about 18 drugs—should probably fall into that category. The use of medicines outside the area that is indicated or approved would also fall within the category.

A third heading for services that are of questionable value might be appropriate. I have not developed that very far, because I have not had time fully to consider the evidence base, but we could develop lists of services that should fall under the headings of good value and poor value

just based on the fact that some procedures are not recommended or do not work. We could try to see what each health board does to put money into good-value services and to take money out of poor-value services. That is my hope, but I did not have time to do that properly. All that I had time to do was to examine quickly the numbers of some types of procedures and whether they were increasing or decreasing. Those figures are on page 8.

I guess that I am saying to the committee that it is not easy to come up with one set of performance information that will allow us to say how the £5 billion at NHS board level is being allocated. I can give the committee various flashes of light into the darkness, which will illuminate different things. One of those will tell us what they spend the money on in terms of staff, another will tell us a little bit about what services they spend their new money on and another will give us guidance on whether they spend on services that provide good value. There are three different options. I am looking, perhaps not right now, for feedback as to whether that is the sort of information that might be helpful, whether the format works and whether the level of information is right. I ask members to consider whether having information like this next April when we examine the 2005-06 budget would get us anywhere.

15:30

The Convener: I remember that last week we discussed option 3—the inputs option—and option 5, the proxy outcomes option. I am trying to get my head round what we can do to take forward the work that the adviser has done. Can somebody perhaps help me?

Shona Robison: I will go back a step. The reason why we started considering approaches to scrutinising the budgets of NHS boards was that we are not satisfied that we are able to track how the money is spent or to see the outcomes that the spending produced. The information that Andrew Walker has produced is a starting point for discussion of how things could be done better to, as he says, shed some light on the issues.

I presume that the intention is to inform the process the next time we examine the budget. The only way forward is to enter into discussions with the Scottish Executive Health Department and the Minister for Health and Community Care, or his officials—we can make a judgment on that. Once we have honed down the approach that Dr Walker has outlined in the report and after we have got more information and we are happy with it, we can ask the Health Department whether it is prepared to take some of that on board in scrutiny of the budget next time. That would enable us better to understand the money that is going in and the outcomes.

Some of the information that Dr Walker has produced is extremely interesting generally and it will probably be of use in the investigation that we will carry out into how decisions are made and what the driving forces are behind them. We can begin to see that in the information about pressures on budgets, the level of activity and so on. Some of the information will be a useful starting point for that piece of work, so it will have a number of uses. Given that we started the process with the budget process in mind, I suggest that once we are happy with the information that we have, we start discussions with the Health Department about the budget process next year.

Janis Hughes: I agree with most of what Shona Robison said. I was a bit confused because I was not sure where we were going with this approach, but I now understand better.

We asked a number of questions in the budget report for the Finance Committee that we signed off today. We asked, as we do every year, for a fairly large amount of clarification from the Executive on a number of issues. Perhaps we will have the opportunity to take forward the approach that is outlined in the adviser's research once we have answers from the Executive. We could see how some of the answers that the Executive gives us fit in to what we are asking for in relation to next year.

As Shona Robison said, we could enter into dialogue with the Executive about how we would like the budget process to be improved next year so that our scrutiny might not throw up as many questions, but come up with more answers.

Dr Walker: I agree.

One issue is that local health plans sometimes do not come into the public domain until July or August of the financial year in which they are supposed to come into effect. The Executive could get access to draft copies earlier than that. Even the committee's budget adviser cannot do that, although I suppose I could go and raid the safe at a health board. The current approach is not a good one and the Executive could change it. If we can persuade the Executive that that is what is needed, that would be a much better vehicle to do this work than getting the budget adviser to do the work.

Mike Rumbles: That is the point that I was about to make. I want to go back to the report that we have just signed off and link it to this research. The first question on the front page of that report asks:

> "Is the Committee satisfied that any outstanding issues from last year have been addressed in the budget proposals?"

Our report states that the Health and Community Care Committee's recommendation of 2002 focused on the boards by recommending that

"All NHS Boards should provide details on how their allocations are accounted for and that the information be publicly available."

In other words, we should have something like the research that Dr Walker has provided. That is what I thought we were arguing for.

Over the page, paragraph 4 of our report makes the comment:

"The Chief Executive of the NHS said that all NHS Board spending decisions were in the public domain via annual accounts and financial reports, and that all spending decisions were made at public NHS Board meetings".

However, our next paragraph states:

"The Executive said that they were willing to work on a way of collating data on five-year spending plans from NHS Boards for the Committee … This would be helpful but more needs to be done to address this recommendation."

What I am trying to say is that, in a way, the targets have shifted. Last year, our predecessor Health and Community Care Committee said that it wanted NHS boards to provide proper information that we could get our teeth into. However, our report focuses on the Executive's having said that it is

"willing to work on a way of collating data".

Our report does not say that the Executive will be required to produce the data. I believe that our report is not strong enough on that.

When I looked down the columns that are given in the table that has been provided by Dr Walker, my eye was caught by the column on Grampian, which I will use as an example. I have not looked at the other columns, but that is why I ask my question. Given the limited resources that are available, Dr Walker had an impossible task. He has done that task very well but, by the very nature of what he has been asked to do for us, there will be holes in the information. However, we cannot proceed if there are big gaps and holes. Those gaps are no fault of Dr Walker's—I do not criticise him—because we have set him an almost impossible task.

Where does that get us? I was thinking this through as I looked through our report. I wonder whether we were perhaps too quick in signing off our report just now.

The Convener: You say that there are gaps and holes. Are you referring to the detailed statistics?

Mike Rumbles: Yes.

The Convener: I took the details that Dr Walker provided to be just an example of what we were trying to look at. Rather than get lost down those tracks, we want to look at the broader substantive issues such as staffing, bed numbers and activity, for which we have firm statistics.

Mike Rumbles: My point is that I am not sure that the statistics are all that firm. In the example that I used, the information is pretty broadbrush stuff. The table shows a gain for Grampian of £22,080,000. Only two other items of spending are given in the column and there is a gap of £3 million. That is not a small issue. The point is that if we have such gaps and things are missing, how do we know that similar gaps do not exist in the other statistics, such as for the number of staff. We should not rely on the information. I know that Dr Walker has given us only an indication of what we should be looking for—he has done a great service—but we cannot use the information other than to say that the headings are a model for us.

Dr Walker: Absolutely—I agree that the table provides a template.

Mike Rumbles: I think that our report is far too lenient on the Executive.

The Convener: You can say that in the debate—the report is now signed off.

Mike Rumbles: I know, but I think that we were a bit too quick in signing it off.

The Convener: Well, we have passed that stage.

Dr Walker: The staffing and beds figures come from statistics that are published by the NHS information and statistics division, so they are probably as good as they are ever going to get. If the truth be told, there are probably small inaccuracies in those data, but they are as good as they are ever going to get. As has already been alluded to, the local health plans that are shown are statements of intent. As we have already discussed, they might have slightly different styles. That does not excuse arithmetical errors—I cannot tell you how that came about—but my intent was only to show the committee the type of information to be used or the template that one hopes could then be better filled in, especially if we get the Executive involved in saying that it requires to see such a table. I presume that the Executive would then pore over it and ensure that it was filled in consistently and that it was arithmetically correct. I just wanted to see whether such a table would be useful to the committee.

Helen Eadie: I congratulate Andrew Walker on producing an immensely complex document. You have managed to produce it in a way that allows people to understand it—"easily" might be the wrong word, but it is understandable. As someone who likes to look for the good news, I highlight page 8 of the document, which shows a staggering increase in activity in a number of areas. For example, the number of angioplasties has increased from 550 in 1991 to 2,637 in 2002. The data begin to answer some of our questions about where much of the money is going. That is encouraging to see.

There is also bad news in the documents, which we need to consider. I accept your counsel at the start of the document, where you mention that

"There is always the danger of getting sucked into the hydrotherapy pool at Fort William!"

Dr Walker: Tempting as that sounds.

Helen Eadie: You also state:

"the Committee is supposed to be monitoring the national picture."

I agree with that. You have drawn our attention to provision that is available under the planning system. If I were to look down from a cloud away up in the sky, I would probably ask myself what the need is, as well as what is provided. Where are the clusters of specific need? I am not suggesting that there are clusters of specific illnesses—although there might be. I do not know; I have no information to tell me that. If, in the end, we have to give some kind of verdict on what we feel represents better value for money for certain procedures and on the question of discarding some other procedures, that will depend on the level of need for the services concerned.

Dr Walker: I see what you mean.

Helen Eadie: I would feel handicapped in coming to such a judgment without having sufficient information before me. I am not sure whether there are ways to obtain such information.

Dr Walker: Information will vary according to the type of service. Somebody asked earlier about the need for different staff. That is difficult to pin down, but it is a bit easier to deal with other services. We could say that the total need for nicotine replacement, for example, is the same as the total number of smokers in Scotland. We could say that the total need for cataract extractions is the total number of people on the waiting list for that. It might be easier to quantify that than to identify the need for different types of staff.

Helen Eadie: I was thinking of the example of a friend of mine, who is a psychologist. Where she works, there is one psychologist for that area, serving a population of about 66,000. How does that compare with other parts of Scotland? What are the ratios elsewhere?

Dr Walker: I would like the committee to use the information that is before it to prompt that sort of question. Members might wish to ask how we are using psychiatrists, for example. The researchers or I—or whoever—could go away and find more detailed figures. We could examine information from the various health boards. As I think Janis Hughes said earlier, the document that is before members is a prompt for further questions and it would be appropriate for the committee to use it in that way. It would be impossible to achieve everything through one document, but if it nudges the committee towards doing other things, that would be a suitable way in which to use it.

Mrs Milne: I have a question about page 4 of your examples document, which shows activity by year-end figures, specifically in relation to the "Emergency admissions" entry in the middle table on that page. Do you have any broken-down detail on that? Does that entry show the total number of emergency admissions, including trauma? Are medical admissions covered? I note that the number of emergency admissions has gone up by about 20,000 in the four years to 2002. Is that an indication of the fact that there have been difficulties with waiting lists and waiting times? Have any non-emergency admissions been translated into emergency admissions over that period?

Dr Walker: I see what you mean. I am not sure whether we could break that down. If we were to ask the information and statistics division of the NHS it could probably break that information down for us. In the source that I consulted, the figure was not broken down in that way. If we asked it to, the ISD could break the number down by specialty. That would not necessarily be the same thing as attributing a problem to waiting lists, however, which would be more difficult.

Mrs Milne: The figure is clearly not just down to an increase in trauma and accidents—there must be more than that.

Dr Walker: Yes. It would be right across the board. It could be emergency psychiatric admissions or a whole range of things. Such a breakdown would be quite difficult to do.

Mr McNeil: I want to be supportive of the general principle and of your phraseology about nudging us towards having such information, which would allow us to ask searching questions about the priorities that are being set—quite rightly—by health boards, rather than us. God forbid that politicians set medical priorities. We might get too involved in local difficulties. There is a clear role for communities in setting priorities.

The figures that Dr Walker has are interesting only in relation to the opportunities that they will give us in future to have an up-do-date list that cannot be dismissed and pooh-poohed on the basis that they are from two years previously and the situation is much changed. I am much clearer about the journey that you were on in the pink private paper with regard to what we are trying to achieve. The information will empower the committee to ask hard and searching questions of the boards and the Executive. An amount of money is going in, and asking those questions would answer the fundamental question that we are continually asked, which is, "Where is all the money going, because it is not getting to me on

the front line, or making a difference to me in the community?" If that helps, we should be supportive of it.

15:45

Dr Walker: Duncan McNeil put his finger on something in saying that the information is all largely retrospective; in April we will be looking at the budget for 2005-06, and will be looking back at data up to 2003, which is a weakness. All I am saying is that we are told about the general direction of travel over a five-year period. We cannot be precise about what will happen in 2005-06, because nobody knows, to be honest. We know what the total will be, but we do not know exactly what will happen. All we will ever be able to use the information for is to ask generally, "Are we moving in the right direction", rather than to ask a very fine set of questions.

The Convener: We have had a lot to take in, so would it be of use if members took time to put together questions on the paper? We all know what we are trying to do. We are trying to track funding and to see whether—as it is limited—it is going to the right places and creating the right solutions nationally. We may want to consider that and put together some questions for Andrew Walker.

I suggest that we bring Andrew Walker back again and then have an informal meeting with the Executive, after we have given it a paper, rather than lurch backwards and forwards. We can say to the Executive, "Look, here are the problems for the committee. This heroic man has prepared all this stuff, but you have got far more in the way of research. This is the kind of stuff that you could deliver to us, and it would be useful to you as well."

Andrew Walker could put together the questions that arise from the paper, and we could have another meeting with him. We will give him time next time, because he has done a hell of a lot of work in a short period. Good grief—I wish he had sat my exams for me. We could then have an informal session with the Executive about the way in which we get information. Are members content with that?

Members *indicated agreement.*

The Convener: So we know what to do. Andrew—could you let us know when you will be free to come back?

Dr Walker: Yes.

The Convener: The clerks will sort it out with you. There is no rush. You do not have to get the work done by a week today. [*Interruption.*] That will be recorded. Pooh-poohs get recorded.

I thank Andrew Walker. We will get back to you with questions. As was agreed at the beginning of the meeting, we now move into private session. I ask members of the press and public to leave the room.

15:48

Meeting continued in private until 16:29.

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Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178