OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 9 January 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 9 January 2018

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HEALTH AND SPORT COMMITTEE
1st Meeting 2018, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Emma Harper (South Scotland) (SNP)
Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Catherine Calderwood (Scottish Government)
Geoff Huggins (Scottish Government)
Christine McLaughlin (Scottish Government)
Shona Robison (Cabinet Secretary for Health and Sport)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 9 January 2018

[The Convener opened the meeting at 10:03]

Draft Budget Scrutiny 2018-19

The Convener (Neil Findlay): Good morning and welcome to the first meeting in 2018 of the Health and Sport Committee. I hope that everyone had a very nice break, and I wish all of you a happy new year.

I ask everyone to ensure that their phones are switched to silent. People can, of course, use them for social media, but not to photograph or record proceedings.

Agenda item 1 is an evidence-taking session on the draft budget 2018-19. The committee's approach to scrutinising the draft budget reflects the approach that was recommended by the budget process review group, and entails addressing budget implications throughout the year and bringing that information together to inform a pre-budget report for the cabinet secretary's consideration.

Our pre-budget report, which we issued on 13 November, set out some recurring themes and issues that we had identified in relation to the Scottish Government's draft budget. The timing of the report, in advance of the draft budget's publication, was to enable the Scottish Government, if it so chose, to endorse our recommendations for implementation in the draft budget, and a response to the report was received from the cabinet secretary on 12 December.

I welcome to the committee Shona Robison, who is the Cabinet Secretary for Health and Sport, and Christine McLaughlin, who is the director of health finance for the Scottish Government. We have received apologies from Paul Gray, who is unable to join us today. The committee has also received apologies from Alison Johnstone. I invite the cabinet secretary to make an opening statement.

The Cabinet Secretary for Health and Sport (Shona Robison): I thank you, convener, and wish you and the committee a happy new year. I welcome the opportunity to give evidence this morning on the budget proposals for our national health service. As we start 2018, we look forward to an important year in which the NHS will turn 70 years old. We also look forward to Scotland's year of young people. In that context, I am grateful to have the opportunity to discuss with the committee how we can ensure that the NHS, which is our most treasured public service, is equipped to serve the people of Scotland now and for the generations ahead.

In terms of equipping the NHS through investment, the Government has committed to increasing the health resource budget by £2 billion by the end of this session of Parliament. In 2018-19, we will take a step further towards that, with the resource budget increasing by more than £400 million, which is an uplift of 3.4 per cent. We will continue to prioritise investment in front-line services, so investment in our front-line NHS boards will increase by 3.7 per cent—or 2.2 per cent in real terms.

It is important to emphasise that that additional funding for our NHS is being provided as part of our twin approach of investment and reform, which recognises the increasing demand and expectations that are being placed on our front-line services, and makes it clear that the status quo is not an option. Through that approach, we will see more care being delivered in the community through primary and social care services, and we will deliver our triple aim of providing better care, better health and better value.

By equipping the NHS through additional investment, the Government acknowledges that the staff in our health and social care services do an outstanding job of caring for the people of Scotland. We have seen that particularly over the past few weeks, as they have dealt with winter pressures. It is right that hardworking NHS Scotland staff will, in fulfilment of our programme for government commitment, receive a pay settlement that acknowledges rising inflation. Our draft budget reiterates our commitment to lifting the 1 per cent public sector pay cap and providing a guaranteed minimum pay increase of 3 per cent for all public sector workers who earn up to £30,000. We will also be mindful of any developments for NHS staff elsewhere in the United Kingdom, to ensure that our health service staff are treated at least as fairly as those in any of the other UK nations.

We are making those commitments on investment at a time of significant financial challenge. Following the UK autumn budget, Scotland is facing real-terms reductions in our day-to-day budget—reductions of £200 million in 2018-19 and of £500 million by 2019-20. In the face of those real-terms reductions to our block grant, it is possible to support our level of investment in the NHS without damaging other portfolios only as a result of our proposals on tax. The draft budget sets out proposals that are designed to make our tax system fairer, and to generate revenue in support of public services,

including an NHS that remains true to its founding principles of being free at the point of need and publicly owned and operated.

A central component of the health and sport budget for 2018-19 is that it will allow further progress to be made in delivering our commitment that by the end of this session of Parliament more than half of front-line spend will be in community health services. The funding in 2018-19 is also designed to support a further shift in the share of the front-line NHS budget that is dedicated to mental health and to primary, community and social care. We are increasing the level of investment in child and adolescent mental health services: in 2018-19, a further £17 million will be invested, which will go towards funding the commitment to increase the workforce by an extra 800 workers over the next five years, for transformation in CAMHS. I expect that that funding will be in addition to real-terms increased spending on mental health services by NHS boards and integration authorities, which is already in excess of £1 billion a year in 2017-18. I therefore expect that the budget will deliver an increase in mental health spend in excess of 3 per cent and will support a shift in the balance of spending.

Spending on primary care will be supported through the primary care fund, which will increase to £110 million in 2018-19. That will support the transformation of primary care by enabling the expansion of multidisciplinary teams for improved patient care, and by enabling a strengthened and clarified role for general practitioners as expert medical generalists and clinical leaders in the community. That forms part of our commitment to increasing funding for primary care by £500 million by the end of this session of Parliament.

On spend on social care, in 2018-19, an additional £66 million will be included in the local government settlement allocation to support additional expenditure by local government on social care, in recognition of a range of pressures that local authorities and integration authorities are facing, including implementation of the Carers (Scotland) Act 2016, maintaining our joint commitment to the living wage—including our agreement to extend it to cover sleepovers, following further work that we have undertaken—and an increase in free personal and nursing care payments.

A central part of our activity in 2018-19 will be a continued focus on our early intervention and prevention approach to public health, which will be balanced by efforts to support everyone to lead healthier lives, regardless of their circumstances. We are consulting on a new diet and obesity strategy and are progressing measures to limit marketing of products that are high in fat, sugar and salt, which contribute disproportionately to ill health and obesity.

Addressing the use and impact of drugs is a challenge that is not unique to Scotland, but it is one that we are determined to meet, so we have begun an overhaul of our drugs strategy, guided by the principle of ensuring the best health outcomes for people who are or have been drug users. We will expand its scope to set out a new vision for alcohol and drug treatment together. As was set out in the programme for government, the renewed focus on alcohol and drugs will be backed by additional investment of £20 million in treatment and support services.

Our vision is of a Scotland where more people are more active more often. The active Scotland outcomes framework sets out our ambitions for achieving that, and is underpinned by a commitment to equality. Along with additional investment of £2 million, we will underwrite the potential shortfall in funding of up to £3.4 million for sportscotland in 2018-19, and we will continue to encourage the United Kingdom Government to take the appropriate action that is required to address National Lottery funding reductions.

In conclusion, I emphasise that this is a budget to equip the NHS to serve the people of Scotland now and for the years and generations ahead. I have set out our twin approach of investment and reform. The additional funding for health and sport will support fairness for all across society, and deliver the reforms that are needed to equip our health and social care services for the years ahead by allowing people to live longer and healthier lives at home or in a homely setting.

The Convener: Thank you very much. Ivan McKee will start the questions.

Ivan McKee (Glasgow Provan) (SNP): Thank you for coming along to talk to us, cabinet secretary. I want to cover a couple of issues on overall funding, but it is important to make the point at the start that, although I am talking about inputs, ultimately outcomes are what are important. Later in our discussion, we will focus on performance in a bit more detail, so I will leave that to one side for the moment and focus on the inputs. Just for clarification and for the record, I say from looking at the numbers that there is a £373 million cash increase in the budget for 2018-19 over to the budget for previous year, which translates to a £175 million increase in real terms. Therefore, it is true to say not only that more cash will go into the service but that more will go in in real terms.

Shona Robison: That is correct. There will be a real-terms increase, in recognition of the fact that investment is important, but as I said in my opening remarks, that real-terms investment has

to go alongside reform, which I think is what Ivan McKee pointed towards in referring to outcomes. Those reforms need to ensure that every single pound of that additional money and the money that is already in the system deliver the most effective and efficient services. We have laid out that programme of reform over the past few months and have focused on, for example, the drugs budget, on how we can deliver elective capacity more effectively and on how we can shift the balance of care to keep people out of hospital. It is very much a twin-track approach. The resources that will be generated through reform to be reinvested are as important as the real-terms increase in resources.

Ivan McKee: Absolutely.

When we talk about health board spending, we tend to have a conversation about efficiencies. However, in the context of there being a real-terms increase in funding, when we talk about efficiencies we are not talking about people spending less in real terms, but about people reallocating money from one area of spend to another. Is that a fair comment?

10:15

Shona Robison: That is right—and we are also looking to meet the increasing challenges. Although more money is going in to the NHS in real terms, I have often said that the demands, especially demographic challenges, on our services continue to grow, which means that we need to do things differently. Therefore, we are working with boards on how to ensure that our services work in the most effective way. Christine McLaughlin can give you more detail. There is a lot of focus on regional boards working together to do things differently, including using our capacity—including elective capacity—differently and making sure that for the drugs budget there is a common approach to prescribing practice, because there has been variation in that. The chief medical officer has often said that the focus is on addressing unwarranted variations so that all our services operate as best they can. Resources that are then used more effectively are in addition to the additional investment that this budget will deliver.

Ivan McKee: Finally, the SNP manifesto commitment was to increase by £2 billion spend on the health service over the current parliamentary session. So far, the spend has increased by £743 million, so it looks as though that is on track, given the inflation impact going forward. It is not far off the 40 per cent that we would expect after two years. The real-terms commitment was to increase spend by £500 million. We saw a £370 million increase over the first two years, so that looks to be running far ahead of target. Are you comfortable that the manifesto commitments are on target and will be met over the course of the five-year parliamentary session?

Shona Robison: Yes, I am. This year's budget makes an important contribution to the headline £2 billion commitment and to the shift in the balance of care, as has been laid out. The budget is a really big step in those directions.

Christine McLaughlin (Scottish Government): I say for clarity that there will, for the overall portfolio, be an increase of more than £400 million in cash in 2018-19. Additional funding will still be required in the last few years of the parliamentary session to meet the £2 billion commitment. As Ivan McKee has said, the spend is heading in the right direction. The other key target is about primary care as a percentage of front-line spend; a bit more than half of front-line NHS spend has gone into community health services, so we are seeing an increase in its proportion of spend.

It will be important that the pace of the increase of both those measures over the next few years grows faster—hence the importance of investing in reform. The information from our published data suggests that we are heading in the right direction, with increases in both those areas.

Ivan McKee: Thank you very much.

Emma Harper (South Scotland) (SNP): Good morning. I am interested in NHS Scotland resource allocation committee allocations. I am aware that the national resource allocation committee calculates funding based on age, geography, deprivation and rurality—which is important for me as a South Scotland MSP. The NRAC funding is often not decided until other allocations have been made. Is the Scottish Government committed to the NRAC? Is it still considered to be the best way to allocate?

Shona Robison: I will ask Christine McLaughlin to comment on the detail. Over the years, this and previous Administrations have applied various formulas. By and large, they have all been criticised in one way or another. The difficulty with any formula is that adjustments have to be made over a long period of time, or we risk destabilising boards as transitions are made. The NRAC allocations that are planned for 2018-19 will bring all boards within 0.8 per cent of parity, which I think is the closest that we have been to parity for some time.

Christine McLaughlin: I ask Emma Harper to give me a wee bit more detail on her first point, as I did not quite understand it.

Emma Harper: Our briefing papers say that NRAC funding calculation is often based on the

Scottish Government making adjustments to the allocations before assessing progress towards NRAC parity. How will we get parity in allocation across different boards?

Christine McLaughlin: I will need to go into that in a wee bit more detail. At a high level, the NRAC is the basis of all the recurring funding to boards, so funding is calculated as part of the budget and the NRAC is updated annually. It is not an afterthought. We have always taken the approach that we do not want to destabilise boards, which is why movement towards parity takes a long time. In 2017-18, no board was more than 1 per cent from parity, and in 2018-19, the extra funding will mean that no board will be more than 0.8 per cent from parity, which is the closest we have been to parity since the NRAC was introduced. Eight boards will receive additional funding towards parity from the £30 million that will be put in.

Emma Harper might be talking about the proportion of funding that does not go to NRAC funding: that is, all our programme spend for funding health visitors and so on, which has been given out specifically to meet the agreed increases in health visitor numbers in parts of the country. One of the issues is the extent of funding that does not sit within NRAC funding. That formula cannot apply to the eight national boards because their services are not population-based.

To answer the question, there are always opportunities to look at different ways of funding the system. England has now realised that in a system that is under pressure, payment by results and volume-based funding are not always the right way to go.

We can all learn from each other. We are considering the extent to which we can incentivise the performance and outcomes that we are looking for rather than fund just the population that we serve. We are always open to looking at that in more detail, particularly given that with health and social care integration there is a different funding model for local government.

It takes quite a long time to do all the research and to look at different options whenever a new funding mechanism is to be introduced. We do not want to destabilise the system, so there is a long lead-in time before we introduce change. That is not to say that we should not consider change, but it would take quite a few years to introduce something that was markedly different from what we have.

Miles Briggs (Lothian) (Con): The Scottish Government's proposed budget looks to reduce the NHS capital budget by £70 million. Given the backlog of repairs that we know exists, would you like to comment on whether that is the best use of resources?

Shona Robison: The first thing to say about capital budget is that it fluctuates from year to year. In 2017-18, we saw the conclusion of a number of big capital projects. Capital budgets reflect where we are in the cycle of capital build, but I am sure that Christine McLaughlin can say a bit more about that.

Within the priorities for capital investment, we will obviously be making sure that essential repairs and maintenance are carried out and that the boards are supported to do that. In addition, we have other priorities such as the Scottish Ambulance Service ambulance replacement programme, radiotherapy equipment replacement, the NHS Highland theatres upgrade and the electrical upgrade at Ninewells, among other local projects.

Christine McLaughlin will say a bit more about why the capital budget fluctuates.

Christine McLaughlin: The new Dumfries and Galloway royal infirmary, which opened in December and is a fantastic facility, is one of the reasons why our total capital budget for 2017-18 was higher than it is in 2018-19. That project is now complete, as is the Scottish national blood centre.

The 2018-19 capital budget covers all our planned commitments, so we have not had to pull back on anything. The reduction reflects our planned spend, which covers what we expect to spend on elective centres and on initial work on core programmes such as the Baird family hospital and the Aberdeen and north centre for haematology, oncology and radiotherapy—or ANCHOR—in Aberdeen and the Balfour hospital in Orkney. Every year, we give approximately £150 million in core funding to NHS boards for maintenance and minor replacements, and we expect that to stay fairly static.

On Miles Briggs's point about the level of maintenance in the system, backlog maintenance has stayed fairly static for the past few years. The latest figure was £187 million. The general wisdom is that the best way of dealing with significant backlog maintenance is through replacement and rationalisation of sites, and that has been our approach. Next year, approximately £60 million of the funding to boards will be for reducing backlog maintenance. However, the committee will appreciate that as we reduce backlog maintenance in Dumfries, we will also face an increase in such costs at Ninewells, because of the investment in electrical issues that we are making next year. Things will always come off the list, but other things will be added to it.

Some fairly large investments might be coming up over the next five to 10 years. Initial business cases are coming in for projects such as the Monklands replacement in Lanarkshire, an eye pavilion replacement in Lothian and potentially a new south-east cancer centre in the Lothian area. We will not only look at as much as we can for 2018-19 but look ahead at what is in the pipeline to see how we might build those projects into the Scottish Government's overall infrastructure programme.

Miles Briggs: When will the Government undertake a strategic review of such projects? As an MSP for the Lothian region, I have been involved with the Edinburgh cancer centre. I see that £26 million is going towards its backlog, some of which is very significant, but it is quite clear that a new centre for the whole of the south-east of Scotland is required. How is the Scottish Government scoping work that is taking place and prioritising projects across the country? When is such a review likely to be introduced?

Christine McLaughlin: One of the Audit Scotland report's recommendations was about the development of a capital investment strategy, and that is under way just now. We have told boards that we do not expect any cases to come forward for consideration by the capital investment group without, as a minimum, their being part of the regional plans for all areas. We are not looking for individual board submissions to help us with prioritisation; instead, we are consulting with the system about setting up a national infrastructure board that will allow us to prioritise nationally and deal with the precise issue that Miles Briggs has raised.

However, I am well aware of the situation and of the balance to be struck between investing in maintaining the existing cancer site and investing in a new centre. It is partly a matter of timing; we have work that we need to do now and which cannot wait for a couple of years, so we have, on balance, decided to invest now in the existing cancer services.

The Convener: According to our papers, the changes mean that non-profit-distributing projects can, in the way that they are structured, continue to be treated as private sector projects for the purposes of accountancy and operation. In that case, is it correct to say that there is very little difference between NPD and the private finance initiative?

Christine McLaughlin: What we are saying is that we have resolved the accounting issues for NPD. The main difference with the structure of NPD projects is that there is a mechanism to deal with the generation of profits and how that fund is resolved. The level and balance of risk are more where we want them to be with the NPD projects that we have in place.

The Convener: Do we need to change the name, then? The term "non-profit-distributing" suggests that there is no profit to be distributed whereas, in fact, there is very significant profit to be had. Is the name misleading?

Shona Robison: Such projects are now classed as being publicly owned and therefore require capital funding. The committee will know the history of the position that the Office for National Statistics has taken, and it is probably helpful to track back to see which projects were funded through which pipelines. We do not intend to change the definition.

The Convener: I am not disputing that. However, if you were to say to somebody that you had a project for which there was a non-profit-distributing system, they would say, "Oh, well, there's no profit to be distributed" when, in fact, that is far from being the case with these projects.

Christine McLaughlin: People are generally confused by terms such as PFI, public-private partnership and NPD. It might be helpful, particularly now that we have some fairly substantial NPD projects, to look at the way in which they operate compared with some of our earlier PFI deals, because we are always looking to have a balance that feels like it is in the best interests of all the parties involved.

The Convener: Absolutely.

10:30

Shona Robison: Despite what you have said, convener, I think that it is fair to say that a lot of progress has been made from the earlier PFI projects. Unfortunately, we are still paying great amounts for some of the poor deals that were struck in the early days. I cannot remember the current figure that we are paying out for PFI, but it is substantial.

Christine McLaughlin: I do not have that figure, either. I would add, though, that part of the work that we have done this year involves further reviews of the earlier PFIs. As a result, we have generated almost another £1 million just from looking at the annual contract values. There is still more to go out, particularly with the earlier PFIs. You will be aware that, whenever we have the opportunity, we are looking at things such as buying out domestic services, just as we did at the Royal infirmary of Edinburgh.

We need to keep a really close eye on these deals. The NPD deals seem to be structured in a way that feels more appropriate; however, they involve private sector funding, and I do not think that we have sought to hide that.

The Convener: Perhaps more detailed work needs to be done on that to assess whether those deals are as good value as people portray them as being.

Alex Cole-Hamilton (Edinburgh Western) (LD): For the first time, the money for social care is being paid directly to local authorities instead of going through the convoluted route of the health service. Given the presumption against ring fencing, how are we going to keep tabs on that money, particularly when the budget covers the 3 per cent uplift in the health service but the wider budget for local authorities does not? In fact, it was almost a flat-cash settlement for local authorities. How will we prevent them from seeing this money as an easy way of meeting some of their obligations with regard to the 3 per cent uplift outside the social care workforce and make sure that the money is spent on social care?

Shona Robison: The £66 million has to be seen in addition to the £550 million that is already in the system. Essentially those resources have passed through the health budget to support social care, and it is now recurring money within the system. It is over half a billion pounds, and it is important to see the matter against the backdrop of that substantial resource.

We have discussed with the Convention of Scottish Local Authorities and local government the priorities with regard to the £66 million. As I set out in my opening remarks, they cover commitments such as the carers legislation, the living wage including sleepovers, and the uprating to free personal and nursing care. I guess that the short answer is that there is a common commitment to those priorities. Given that local government has agreed with us that paying and maintaining the living wage to social care staff are important to recruitment and retention, it would not be in its interests not to do that. There is a common commitment to and interest in making sure that those priorities are delivered.

You are right that we do not ring fence as such. However, we have clear agreements on the focus and purpose of those resources, and we have had no indication either from COSLA or any individual local authority that they do not share those joint priorities for delivering that money.

Alex Cole-Hamilton: Is there a process for monitoring that adherence to those collectively agreed priorities and for pulling in local authorities that might not be spending the money as they should be spending it?

Shona Robison: We do that through regular meetings with COSLA, and I also have very regular meetings with local partnerships that tend to involve not just the local authority but the chief officer of the integration joint board and often the NHS chief executive, too. We tend to meet on a partnership basis, and we will continue to do so. There is also the ministerial strategic group that I chair jointly with COSLA and which, if you like, oversees the delivery of integration priorities.

We would therefore pick up quite quickly if a local authority, for whatever reason, was not going to maintain the living wage, say, but the fact is that it would not be in its interests to do that. Why would an authority invest in the living wage today and then suddenly decide not to? We have all been working on the issue of sleepovers, for example, and it would be counterproductive for any local authority not to address that issue.

We have a mature relationship that is based on the jointly agreed priorities. As Christine McLaughlin regularly meets her financial colleagues in local government, she will get a sense whether there are any issues in that regard.

Christine McLaughlin: Indeed. There is a lot about transparency in the report that the committee produced in December, and we have introduced a number of measures to make it easier to understand and get information about spend, including planned spend. We have also agreed with the integration authorities that, from February, we will start consolidated reporting on spend.

As part of the budget, we will be looking to gather information on the planned spend on all the key areas. In your report, you used alcohol and drug partnerships as an example of the need for better transparency on spend. We all want to see what the outcomes are, too, but we also want to try to get a better understanding of spend in areas such as mental health, primary care and community care. That information will allow us to see very clearly whether social care spend is going up, going down or staying the same; it will also make it easier for us to look at and understand why that might be the case.

In some cases, there might be genuine reasons for the changes in spend; for example, a one-off investment would not be included in the next year's spend. The approach that we are taking for next year gives the system the flexibility to calibrate. However, if that did not happen, we would seek to understand why that was the case and whether any intervention would be appropriate.

Sandra White (Glasgow Kelvin) (SNP): You mentioned February. I do not know whether you will be producing the report in February or whether that is when you will be looking at the issue, but in its report the committee expressed concern that there had been no update on the matter. Can you update us on when you will be able to produce the figures?

Secondly—and I wanted to ask about this earlier—it is very difficult to extrapolate how much has been spent on community care. Will we be able to extrapolate how much money from front-line services is being spent on community services, including health officials?

The Convener: Just to add to that, we have tried to find out what is going on in integration authorities, but that has been extremely difficult. Do you know what is going on? How can the Parliament, this committee and others play their role in monitoring what is going on when we cannot find out what is going on?

Shona Robison: A lot of work is going on in this area, particularly in response to the issues raised by the committee. Christine McLaughlin will talk about that.

Christine McLaughlin: I will try to cover a few of those points. On Sandra White's first question, we are working with integration authorities to make a first pass at a consolidated report in February, and it will probably include the January data. I am involved in that work, and I will be looking at the report to see whether it gives us all that we are looking for. It is absolutely true that you can go on to every integration authority website and look at its board papers, but that is not the same as trying to get a consolidated picture. I suspect that, when we start the reporting, we will find inconsistencies that we will then need to iron out, but we have agreed to make a first pass in February.

On the wider question about community spend, I started off by saying that we are seeing the information moving in the right direction. We take information from the annual cost book, but it probably goes back too far for us all to feel particularly satisfied with that approach. By introducing routine reporting, we will be able to measure regularly the key areas of primary care and community services spend. I hope that that information will be produced quarterly, and I see no reason why we would not want to share it and allow people to access it by making it publicly available.

Shona Robison: We will make sure that we send that information on to the committee.

Christine McLaughlin: On the third strand of the question, we said at the time of Audit Scotland's overview report that we were planning and developing a financial framework. We are doing that work, which also covers social care data. With regard to the medium term, we will be looking to set out our expectations on funding for, expenditure on and reform of health and social care, and we have designed things to help us answer questions about shifting the balance.

As for the points raised in the committee's report, I have the same difficulty in trying to get that single picture. I can go to individual parts of the system and ask for information on a reactive basis, but the information is not all in one place. We are seeking to put it in one place; my only slight caution is that it might show us some odd things at first, but that is probably because people have put things in different places. We will need to do a bit of work to tidy that up, but I can assure the committee that that work is well under way.

The Convener: Who will be doing that work and who will be reporting on it?

Christine McLaughlin: The consolidation will as a matter of routine be undertaken by the integration authorities and the information will be publicly available. We will work through whether it will be published on our website or whether it will be available—

The Convener: Are you talking about the consolidated information?

Christine McLaughlin: Yes, the consolidated information. We have committed to publishing the financial framework in spring, either at the end of March or at the beginning of April. I think that the committee would be interested in that.

The Convener: When are we likely to get the consolidated information?

Christine McLaughlin: The first part of it will be available in February, but it might be March before we have it in a state that would be fit to publish. However, I do not expect it to be any later than that. If the committee wants to comment on the financial framework before it is published or wants to ask the Scottish Parliament information centre to comment on it, I am more than happy to take such comments on board. We are trying to deal with all the comments that people have made about it being hard to get the big picture and to understand what things are moving in the right direction. We are working hard to try to simplify that and make it as straightforward as possible, but I would be happy to get the committee's thoughts in that respect.

The Convener: Thank you.

Ash Denham (Edinburgh Eastern) (SNP): Good morning. Under the health board allocations, the line for transformational change shows that the budget has gone up from £38 million to £145.7 million, which is a significant increase. What do you anticipate being achieved by that extra funding? Can you give an example of what it might fund?

Shona Robison: I can give you the headlines and Christine McLaughlin can comment on the detail. The transformation fund is important, because we have listened to what boards have told us about how challenging it can be to make changes, shift resources and do things differently.

The transformation fund is a way of helping boards to drive that change. The priorities for that are around shifting the balance of care and ensuring that boards can build up community health services, for which primary care is a key priority.

It is also about having more regional working. Christine McLaughlin mentioned earlier that the message that we are sending out to boards is that their plans need to have a regional dimension in terms of both their capital outlook and their resource spending. For example, if a board is considering development of a new hospital, that should be about not just the impact on that board's services but the impact on the region.

In terms of resource spending, we would expect the transformation fund to result in a shift in the balance of care and a shift to primary care spend and mental health spend to ensure, for example, that there is work around the drugs budget with regard to more effective prescribing. The transformation fund is about helping to gear up and accelerate the pace of change, and we decided that a funding stream was the best way of helping boards to do that. Christine, do you want to say a bit more?

Christine McLaughlin: I can give a couple of other examples of important funding investments. The funding stream will help make improvements in elective care through the elective access collaborative programme and it will provide investment for the digital health and care strategy, which will be launched this year. In terms of other investment, there is work under way on radiology services and we are moving on to work on laboratories and on shared business systems across the system.

10:45

That all underpins the health and social care delivery plan and the milestones in it. It is about trying to carve out funding on a non-recurring basis to support that fund. In addition, as has been said, the single largest investment is in primary care, and there is the investment in mental health services transformation.

We deliberately did not allocate that money on an individual-board basis. It is an example of money that has not gone out on an NRAC basis. We will fund some things once for the whole system, and other things will be funded on a regional basis. In March, we will get the next version of the regional plans from the three regions and the national boards, and we will seek to use that as the main basis on which we will decide to allocate funding. However, we expect that funding to go out to boards and integration authorities in-year.

Ash Denham: So the boards may come to you with their proposals on what they would like to spend the money on, and you would then evaluate them and decide where to allocate the funding.

Christine McLaughlin: Yes. For instance, we know that digital services are one of the biggest propositions that the national boards are working on—particularly how NHS 24, the Scottish Ambulance Service and NHS Education for Scotland can come together to provide them. We would expect one funding stream for that and for the business systems. The work on radiology is being done as a national programme. Therefore, the money will not be allocated to all the boards, but we expect all of that money to be used directly within the system next year.

The Convener: Will some of that transitional money be allocated to bed space? There is a huge demand for beds at a time when the policy is to reduce the time that people are in hospital and the social care system is not functioning as it should be to get people out of hospital. Will some of the transitional cash go to maintaining bed spaces as demand increases?

Shona Robison: It is about ensuring that the system is in balance, and that has to be done carefully. The reduction in acute beds that we have seen over many years has been mainly due to the different way in which services have been provided. In day surgery, for example, people now have operations and are out of hospital within 24 hours. That simply was not the case 10 years ago or even five years ago. The way in which beds are used is different, and we have to ensure that we get the right number of acute beds.

There are two main areas of reform, one of which is elective services. We must ensure that we deliver our elective services as efficiently and effectively as possible. Derek Bell is undertaking that work and looking at how we can ensure that, with the plans for the elective centres, we maximise the best way of delivering elective procedures. That will be done with a regional focus.

The other area is unscheduled care. Without a doubt, the work that is going on to reduce unscheduled admissions and delayed discharges will release capacity in the acute system, but it is about putting things in the right order. Obviously, we have to ensure that the reductions of pressure in the system and therefore the reductions in bed pressures happen before we remove any acute capacity. Things have to be done in a way that shifts the balance of care safely and ensures that both systems remain in balance. However, we know that the acute system is being used by people who would be better treated elsewhere in a different setting, and that is really where the focus of the next few years will be.

The Convener: Is that where some of the transitional money will be put? I am still not very clear about that.

Shona Robison: The transitional money is partly to build up services in the community to ensure that they reduce pressure on the acute services. It is about doing things in the right order. A huge chunk of money is going into primary care to ensure that those services are built up, to try to reduce admissions to hospital and to reduce delayed discharges so that people who do not need to be in an acute bed are not in it and pressure on the acute system is released.

If we were to do nothing, we would need far more acute beds. We would need to build a huge number of new hospitals but, if we did that, we would not be able to spend that money on developing community services, so the budget is not about the wholesale closure of acute beds but about getting the system into balance so that we can cope with future demands on it. We cannot invest in community services and build a whole new generation of additional hospitals because the resources to do both just do not exist. Therefore, we need to ensure that the acute system is able to cope with not only current demands but future demands.

The Convener: However, prior to Christmas, Edinburgh integration joint board said up front that it was sending people home with no appropriate social care package in place because it could not keep them in hospital. At the weekend, St John's hospital was sending home cancer patients who were supposed to be in hospital. It does not have the bed capacity. If a board made a proposal for more bed space as a transitional option, would it be funded?

Shona Robison: There will be more bed capacity through the elective centres. They will provide additional capacity in the same way as the Golden Jubilee national hospital does for elective procedures that are not interrupted by the flow of unscheduled patients. I will say something about the cases that you cited.

The Convener: Will you answer the question, though? If a board applied for transitional funding for more bed space would it be granted?

Shona Robison: A board would be unlikely to do that because it flies in the face of the direction of travel. We cannot say that we want to shift the balance of care and then put the money that would have gone into doing that into more acute beds.

I say to you directly that you cannot measure the demand for beds based on a period of exceptional winter pressures. You have to consider acute bed capacity over the year. You cannot look at a two-week period and say that that shows what acute bed capacity is needed. We need to ensure that we build winter pressures into our planning and we have done that, although there have been exceptional winter pressures this year.

On the cases that you cited on social care, people should never be sent home without any support. What sometimes happens is that people are sent home so that they can be assessed for social care packages in their own home environments rather than in hospital.

I acknowledge that the pressures in the Royal infirmary of Edinburgh and St John's hospital are partly exacerbated by delayed discharge within the NHS Lothian system. At the moment, that system accounts for about half of all the delays in Scotland. There is a particular problem that you and I both know is partly to do with an inability to recruit care staff, the local market and concerns within Edinburgh. We are working hard with the relevant partnerships to overcome those local pressures and are considering really innovative solutions. However, we have to base our acute bed capacity on what is required throughout the year, not just what is required in the winter.

The Convener: Nobody was suggesting that it was just about the winter period. I certainly was not.

Colin Smyth (South Scotland) (Lab): Good morning. As things stand, the budget proposes a 1.8 per cent increase in funding for local health boards. Some increases, for example those for NHS Dumfries and Galloway and NHS Borders, are as low as 1.5 per cent. The most recent estimates suggest that health inflation is at about 2.3 per cent this year and will be 2 per cent next year before we take into account the Government's proposed pay policy. Do you therefore accept that, from a health inflation point of view, the budget is actually a real-terms cut for local health boards?

Shona Robison: No, I certainly do not. As I said, it is a 2.2 per cent real-terms increase. If I am not mistaken, NHS Dumfries and Galloway is already well above NRAC parity.

I acknowledge that there are additional pressures as well as general inflation—the drugs budget is one. That is why we need not only to make up-front investment in our health service, as we are doing, but to reform the way we do things. Therefore, it is important that prescribing practice, for example, is the best and is common throughout Scotland rather than differing in different areas. We need to ensure that every pound of investment is used as efficiently and effectively as possible. That is why we always talk about investment and reform in the same sentence, because ensuring that pressures are met and that the transformation of services goes ahead at the same time will

require reform to release resources to be spent in a more effective way, as well as the real-terms increase to funding. Perhaps Christine McLaughlin would like to say something on inflation.

Christine McLaughlin: Overall, the funding for boards is increasing by 1.8 per cent, but Colin Smyth is right that we have increased board funding by a minimum of 1.5 per cent for general inflation. Again, that comes back to the consequences of the formula, based on which Dumfries and Galloway NHS Board is overfunded, although I know that it will not feel overfunded. That is the reason for the 1.5 per cent increase. Unless we start putting additional money into the boards that are below parity, we will not reach parity. We do not want to take money from boards and nobody would support us in doing that. The 1.8 per cent increase is above general inflation.

Everybody accepts that what is real terms is based on general inflation, which is a measure that Government uses. In its report, Audit Scotland is content to reference general inflation as the way in which we calculate real terms. It is true to say that there is a real-terms increase but, as the cabinet secretary said, we must acknowledge that there are other pressures on the health and care system that are over and above that, which is why we are investing so much in reform. That position means that, until the system finds a way to recalibrate, it will still be required to make savings of a similar level to those that it has made up until now.

Colin Smyth is not wrong in what he said about the pressures on the system. There are different ways in which people calculate health inflation, which is calculated as anything from 2 per cent to 4 or 5 per cent, depending on what they include. I do not deny that there are further pressures beyond general inflation, but there is a real-terms uplift in the system and there is additional funding of £175 million for reform. It is important that we find a way to use that money not to further fund existing pressures but to get the change that we are looking for. Anything that we can do that will mean that people can be treated outside the acute sector will take us in the right direction, so we need to make sure that we invest the total funding in transformational change to get the best return over the next five to 10 years.

Colin Smyth: In all that, you have confirmed that the uplift to local health boards is 1.8 per cent. Whatever way you look at health inflation, it is above that figure.

Shona Robison: The real-terms increase including transformation funding is 2.2 per cent. That money will go out to boards, but it is just kept as part of the transformation fund.

Colin Smyth: With respect, we do not know what the allocation to health boards is. Christine McLaughlin just appeared to suggest that Dumfries and Galloway NHS Board gets too much money, but you have no idea how the transformational change fund will be allocated. You cannot take that into account as being allocated to local health boards when you have already said, specifically, that it is for additional pressures and not for current work that is being carried out.

I want to look at one of the main pressures on health boards, which is pay policy. SPICe has estimated that that will cost about £170 million in the forthcoming year. Do you agree with that figure, and has that figure been taken into account in your allocation of funding to health boards?

Shona Robison: First, Christine McLaughlin did not say that Dumfries and Galloway NHS Board had too much money; she said that it was above NRAC parity. I am sure that there are members around this table who represent NHS boards that are below NRAC parity and, as health secretary, I need to balance that, because I am regularly asked questions in the chamber by members representing Lothian or Grampian about being under NRAC parity. We have a system that has to be fair to all, which means that there has to be a formula that gradually ensures that all boards come to parity. It is not about whether a board has too much money; it is about what distance it is from NRAC parity.

In my opening remarks, I laid out the position on pay. We have resources in the budget that will go towards the pay settlement. We have taken at face value what the Treasury has said, which is that the recommendations from the independent pay review body will be fully funded. We would therefore expect consequentials to flow from the Treasury to help to meet those recommendations. As well as setting out our pay policy, we will ensure that staff in Scotland are treated at least as fairly as staff in the rest of the UK.

However, the fact that we await the recommendations of the pay review body, which will have consequences for the level of funding that is available to meet the pay policy, means that we have an unusual set of circumstances this year in the way in which pay is being funded, which we have probably not faced previously.

11:00

Christine McLaughlin: To clarify, the figures that Colin Smyth mentioned are the same ones that we are working to. If the pay policy was applied to the NHS in Scotland next year, the impact would be just under £160 million. Boards had always been planning a 1 per cent increase,

which is about half of that, so that is already factored into their plans for 2018-19. The unknown is the pay review body recommendations for the NHS and the extent to which additional consequentials will flow from the UK Government. We do not expect to know that until about June this year.

Colin Smyth: My question was whether your allocations to health boards take into account your proposed pay policy, which is a 3 per cent rise for NHS staff.

You touched on the possibility of Barnett consequentials from the UK Government, depending on what it does about NHS pay in England. Are you giving a commitment to fully allocate to the NHS in Scotland all Barnett consequentials from additional funding to the NHS in England?

Shona Robison: Yes.

Colin Smyth: I go back to my previous question. Do your allocations to health boards take into account your current preferred minimum pay policy, which is to provide a 3 per cent rise to NHS staff?

Shona Robison: As Christine McLaughlin set out, boards have already built in an element of that pay policy. However, the final policy will require us to utilise consequential resources that will flow from the recommendations of the independent pay review body. The resources are already partly allocated, but we will ensure that NHS staff in Scotland receive at least as fair a settlement from the independent pay review body as staff in the rest of the UK. We will have to see what the independent pay review body says before we know the final cost of the pay review settlement. It is in unusual set of circumstances this year, which to some extent requires us to try to predict the final cost.

Colin Smyth: I am not entirely clear how you propose to meet what you say in the draft budget is the minimum pay rise.

If you will not say whether that funding is built into allocations already proposed for health boards for pay, let us look at social care pay, given that we have health and social care integration. The draft budget proposes to cut council funding by £135 million in real terms. Whatever way you define “real terms”, that is a fact. Social care demand is rising. You said in answer to a previous question that the £66 million that is contained in what is, frankly, a flat-cash local government budget is allocated for things such as sleepovers, the living wage, free personal and nursing care payments and the carers strategy. That is effectively ring fenced—it is supposed to cover those areas—so where exactly will the funding come from to meet an increase in pay for social care workers?

Shona Robison: As I said, the £66 million is in addition to the £550 million that has already been invested in social care via health resources. More than £0.5 billion is already in the system, working now to improve social care provision; indeed, it has helped to deliver the living wage for non-council staff.

The £66 million that you have referred to is additional money in 2018-19 that will help meet the commitments that I have set out, including the uprating to the living wage for non-council staff, the requirements of the carers legislation and the sleepover rates. Discussions have been going on with local government to prioritise those elements in the overall local government allocation and, as we have said, we have no reason to believe that local government is not going to deliver on those shared priorities. Why would it pay the living wage up to now and then not continue to pay it when, as we know, it is an important part of the recruitment and retention of social care staff? Those priorities have been agreed with local government. Neither I nor Christine McLaughlin has any reason to believe that they will not be delivered, and we will continue to work with local government to ensure that that is the case.

Colin Smyth: Can we just make it clear that your pay policy goes beyond the living wage and includes a minimum 3 per cent increase for public sector workers earning £30,000 or less and a 2 per cent increase for those earning between £30,000 and £80,000? You have said that the £66 million covers the uprating to the living wage and sleepover shifts, but where is the funding coming from to cover the increase with regard to social care as a result of your other pay policy proposals? It is not contained within the £66 million. Local government is getting a £135 million real-terms cut in its budget; at the very least, it is getting a flat-cash budget, which includes amounts now being ring fenced for social care. Where is the funding coming from to pay for the increase in social care, given that demand, too, is increasing?

Shona Robison: This is a Government pay policy that is effective across government and which will be paid for out of the allocations that have been made. Today we have laid out our position on the NHS and how we will meet that commitment, and I have also laid out the additional support that is being given to local government to ensure that the living wage commitment is met. However, the general pay policy for the rest of government is also laid out in that policy, and it would be expected to be delivered in other sectors.

Did you want to come in, Christine?

Christine McLaughlin: To give the clarification that I think the member is asking for, I would point out that there is no specific funding stream for pay awards in any of the other sectors, and there will be no specific funding stream for the NHS beyond the uplift to boards until we have clarity on consequentials from the UK Government. If that is the bit in the budget that the member is not clear about, I just want to clarify that there is no specific line for pay awards.

The Convener: If there is a difference between what the pay review body awards and the pay policy, will the Government make it up?

Shona Robison: We have made our commitment, but with regard to the commitment that the Treasury might make to deliver on the pay policy recommended by the independent pay review body, we have in our input to that body laid out our Government's pay policy. That is a commitment that we have made; I would be disappointed if the Treasury did not make good on it, and we would expect Scotland to receive its fair share of resources flowing from it.

I have had an indication of some of the discussions that have been taking place at a UK level. Nothing leads me to believe that the commitment is not going to be made—as things stand, I would hasten to add—and as things stand I am confident that the independent pay review body recommendation and what flows from it will enable us to deliver on our pay policy commitment. Of course, if there is any shortfall, we will make it up to ensure that we deliver what we have said will be delivered, but I am confident that what we will see from the independent pay review body will be in line with our pay policy.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): Cabinet secretary, in your opening remarks you mentioned Scotland's year of young people. That is obviously a huge focus for the Government this year, but waiting times for child and adolescent mental health services continue to impact on some of Scotland's most vulnerable people. The budget line projects a £17 million increase for mental health services in 2018-19. How will you ensure that health boards use that funding directly to support CAMHS if it is not ring-fenced within that budget line?

Shona Robison: As you said, the 2018-19 budget has been increased by £17 million, or 32 per cent, as part of the commitment to increase the mental health workforce by an extra 800 workers over the next five years and for the transformation of CAMHS. The budget also includes £30 million as part of the existing commitment of £150 million to improvement in innovation and mental health services over five years. We need to make sure—I think that this is the point that you are getting at—that that increase follows through into the decisions that are made by boards and integration authorities. A lot of work is going on to make sure that it does.

The ministerial strategic group that I referenced earlier, which we jointly chair with COSLA, has made investment in mental health one if its key priorities. It is looking at how we ensure, through some of the processes for tracking where planned investment goes that Christine McLaughlin talked about earlier, that mental health is visible and seen within those local budget-setting processes.

It is fair to say that we have come to a collective view that it is not enough just to allocate the resources from the Scottish Government that I have highlighted and then assume that they will always find their way to the front line in a way that we need to see, given that we have those very specific commitments to grow the workforce. Therefore we will be doing things in a different way. Christine McLaughlin will elaborate more on that, but it has been identified as a priority of that strategic group, as has making sure that mental health has visibility in the planned spend at a local level.

Christine McLaughlin: In the funding letter that we sent with the draft budget, we said to the system that we expect a real-terms increase in the existing mental health spend in order to guard against any reductions in that spend as we put more money in. We would also like to see reporting on a more regular basis. I would like to see confirmation of the budgets that are being approved for next year, so we are not waiting until a year after the event to make sure that that has happened. Of all the budget areas for 2018-19, it feels as if mental health services have been given the most protection.

Jenny Gilruth: I appreciate that. As a Fife MSP, I am concerned that, as you will know, there are five health boards nationally that did not meet the 18-week target. Will any of that funding be directed at those health boards?

Shona Robison: There is also an improvement programme through which boards that are not meeting the target are being worked with specifically. That improvement work, as well as investment, has led to some of those boards now meeting their target by doing things differently. It helps them work out what they either are not doing or need to change—for example, whether there are staffing issues, what they are and how they are to be addressed. Very detailed work is going on with the individual boards to make those improvements. That will be the case for the remaining boards that have yet to meet the target.

Jenny Gilruth: Thank you.

The Convener: How can we track the spend and the work on CAMHS and other areas—what

funding is being spent on and whether improvements are being made?

Christine McLaughlin: If we give you the consolidated information for integration authorities, mental health will be clearly included within it. That would be the easiest and clearest way to track the spend.

The Convener: The spend and the result of that spend.

Christine McLaughlin: When you say the "result of that spend", do you mean in relation to—

The Convener: People being treated—

Christine McLaughlin: —the performance target? I am sure that we can put those two together and give you regular information on that. It would be helpful to know how often you want to receive it, but I am sure that we can do that.

The Convener: We will have a think about it.

Alex Cole-Hamilton: I would like to follow up on Jenny Gilruth's line of questioning. If we accept that from the £17 million increase we will have to find the 3 per cent uplift in pay for the existing NHS mental health workforce and then the cost of the 800 additional workers, which even though it will happen over the next five years will be at least £20 million a year—if not more—how much of the £17 million will be left for CAMHS? What is the breakdown between what you expect to do to meet that 3 per cent pay obligation for existing mental health staff and recruiting the first tranche of the 800 workers, and what is then left for CAMHS?

11:15

Shona Robison: The 3 per cent pay commitment will not come out of the mental health moneys. The pay commitment is the pay commitment. I have laid out the process for that, in that we have resources within the NHS, some of which have already been allocated, and boards also have some planning assumptions with regard to pay. There is also the unknown quantity of what the independent pay review body will say and what consequentials will flow from that. However, there is a separate funding stream—it will not come out of the £17 million.

Alex Cole-Hamilton: I am sorry, cabinet secretary, but is it not up to the discretion of the boards how they spend that money?

Shona Robison: To some extent, but they will not be spending it on pay. Pay is a separate funding stream. The £17 million is an uplift for mental health services. We need to ensure that what happens next is that the resource has visibility in terms of the priorities that it goes on. As Christine McLaughlin reminded me, we set out in the letter that there was a requirement for a real-terms spending increase in mental health. We recognise that sometimes the Scottish Government's intentions for increased spending do not always find their way through to the decisions that are made locally. We have accepted that mental health is an area that we need to address, which is why the letter says that there has to be a real-terms increase.

There will be some local discretion in terms of what that money is then spent on within mental health. If a board is already meeting its CAMHS target, for example, it may prioritise other areas of mental health spend for that allocation, but if it is not meeting its CAMHS target we would expect that to be a priority for that spend. We obviously expect boards to set out clearly to us their priorities for that spend.

Christine McLaughlin: We have asked for that information as part of the plans that we will agree with boards for 2018-19, and we expect the integration authority plans to be specific on mental health. For the avoidance of doubt, we are saying clearly that we expect existing spend to continue and a 1.5 per cent real-terms increase, with the additional £17 million on top of that. If we were to fast forward to a year from now, I would expect you to be asking us whether we have seen that and what the evidence is. That is what we will be keeping track of very closely at the start of the year and as we go through the year.

Alex Cole-Hamilton: Let me come at the issue from a slightly different angle. Of the 800 new workers, how many are in place now and how many will be recruited in the next financial year?

Shona Robison: That is part of the modelling in terms of what is agreed with boards, to ensure that we define who is included within those 800 staff. Work is going on at the moment to enable us to track that, so that we can tell you and the rest of the committee about it over the rest of this session of Parliament. Work is also on-going to establish the baseline. There are already staff who have been funded and who are new, and who come within the ambit of the type of workforce that we are trying to build. We want to establish a clear baseline so that we can measure progress from here.

Christine McLaughlin: I do not have the information to hand, but I am sure that we can give you the timescales for the planned increase over the five-year period.

Shona Robison: Yes, we can provide you with that.

Alex Cole-Hamilton: I go back to my original point. When we have those 800 new mental health workers in place, they will cost at least £20 million a year in addition to what we are spending on

mental health now. If we are talking about an uplift of only £17 million, we will have to meet that commitment with an additional uplift year on year for mental health. Is that what the Government intends to do?

Shona Robison: We see the growth in mental health spend continuing in order to meet that commitment, and you would not expect it to be delivered in a one-year timeframe. It will take longer than that, so the mental health spending line will increase in order to provide the resources to deliver it.

Miles Briggs: Information Services Division figures on bank and agency staff show that £142 million was spent in 2016-17, which was up from £134.5 million—

The Convener: I am sorry, but I want to stick to mental health. I will come back to you. Does Sandra White want to come in on mental health issues?

Sandra White: Yes. My question is similar to one that I asked earlier. We have figures on mental health funding in the budget, but I think that what we are all concerned about is how that money is spent, and I want a wee bit of clarification on that. Our papers mention the community health service budget. Earlier, I raised questions about the community health service, and we heard that you are going to produce a paper in March. It is important that we get to the nub of the issue. Extra money is going into community health, but there is also the partnership aspect. Will the paper that you produce in March on community health services set out how some of the mental health budget is spent? When Margaret Thatcher was in power, we had a great yahoo about community health, but people were just flung out with no money to support them, so it is important that we look at the basics of where the money is spent.

Will the report that you produce in March mention the community aspect of the mental health budget? A lot of mental health work—most of it—is carried out in the community rather than in hospitals.

Christine McLaughlin: Part of the shift in spend involves mental health, so we would expect that to be part of the report. If you are asking for more detailed information on mental health, we perhaps should provide that as a one-off for you to understand not just the bottom line but how the money is being spent. However, we would need to collect that information. In the first report, I aim to tell you the total amount for different components rather than how it is spent. If you are asking about how it is spent, it would probably be best to do a more detailed analysis for you and provide that separately.

Sandra White: Given that so many areas are involved in health and social care integration—local government has a lot to do with it as well—it would be good to see exactly how money is spent on the ground and how it benefits the people who really need it.

Christine McLaughlin: Yes, I agree. It is one of those areas where it is relatively straightforward to get the direct spend, but identifying all the other areas might take a bit more time. If everyone agrees that it is worth doing that work, we could certainly commission that.

The Convener: We will make contact regarding that.

If Sandra White wants to follow up on alcohol and drug partnerships, she will need to be brief, because we are short of time.

Sandra White: Okay. I will try to go through this as quickly as possible.

I thank the cabinet secretary for her introductory remarks, in which she mentioned the additional £20 million for alcohol and drug partnerships. However, having looked at the evidence, although we can see that the figure will increase, we do not really know how it will be distributed to health boards—or whether it will be distributed to them. From the figures that the committee has received, the current level of spending on alcohol and drug services is not clear. I know that the Government records that spending, but there is no transparency on that for the committee or anyone else. Do you agree that the lack of transparency makes it difficult for us to see how much of the budget goes on that area? Will the Scottish Government publish the information that it has on ADP budgets?

Shona Robison: We will certainly consider what further information can be published, to be as helpful as possible. I should add that, obviously, the £20 million is in addition to the baseline funding that already goes to boards, and that boards and partnerships spend an awful lot more money on alcohol and drug services than the £20 million. It might be helpful for us to set out in a follow-up the additional spend that goes in, because it is the vast majority of the spend.

On the £20 million, we are in discussions with boards and partnerships about the priorities for that spend. We want to ensure that, as well as the fund being for the day-to-day delivery of services by ADPs, an element of it is for transformation of services, creation of new services and meeting unmet need. We are trying to ensure that resources are available to help to deliver some of the priorities that will emerge from the delivery of the refreshed substance misuse framework. The balance that we need to strike is to make sure that resources provide services for the here and now

but that there is an element for developing new services. We can follow up with further detail, if you would find that helpful.

Sandra White: Thank you very much. We need transparency. I asked about the issue because SPICe had to do a freedom of information request to get some information. From the committee's point of view, that is not great.

We know that the Government has information that it provides. I quite understand that it is not as simple as saying, "There is one budget, and here is where it is spent." There are different budgets, and the minutiae will help us to get to the nub of things.

Christine McLaughlin: That goes back to the earlier point that the funding is transferred to board baselines. In previous years, we held the budget, so we could easily tell members the total. We then transferred to the system of leaving budgets to be locally determined, and without a mechanism for getting a consolidated report we have to ask everyone what they are spending or there is an FOI request.

I do not believe that information is being withheld. We are dealing with funding in a different way. I am trying to avoid saying that consolidated reports are the answer to everything, but they would give members a much better overview of the position. If I look at any integration authority's published finance reports, I can that they cover "substance misuse"—or an equivalent term. There is a level of local transparency on spend, but there is not an easy way to pull that information together to give members a single position across the country. However, that is what members are asking for, and we will start to pull it together. Information about the way in which the £20 million will be invested will come through the refreshed frameworks, so there will be a time delay before we can give members the full information.

The Convener: A significant number of committee members are very unhappy about what happened with the alcohol and drug partnerships budget. The £20 million that is going back in is a net increase of only £4 million, if we take account of last year's reductions. The reality is that Scotland has the worst rate of deaths from drugs in Europe. We have a drugs disaster on our hands. Is this anywhere near enough to start to tackle a public health crisis on the streets, where people are dying?

Shona Robison: In her statement, Aileen Campbell, the Minister for Public Health and Sport, laid out a renewed focus on drug users who may have used drugs for many years, who are getting older and who have a multitude of chronic health conditions. The seek-and-treat approach will have a focus on proactive engagement with that community, which is where those drugs deaths have been emerging. The refreshed approach will focus on the individuals concerned to try to engage them with services to address the point that you make.

Aileen Campbell laid out in detail why and how the approach will be different. The new resources will be aligned to the refocused commitment. We are dealing with a generation of drug users who are now in their later years, which brings a challenge. Many of them do not engage with services in the way that we would like them to. A lot of work is being done to look at new ways to address their health needs. We are working with the justice department on the prison population to better support people when they come out of prison, particularly around alcohol and drugs issues. That may help to provide a better support system for people who are in that vulnerable position.

The Convener: I might follow that up personally by writing to you. A whole new generation is coming through of young people who are experiencing drugs, particularly cocaine—the streets are awash with it. They are not the older generation we have known about for some time. There is a whole new generation that I have grave concerns about. However, we are short of time so I will write to you privately on that.

Shona Robison: That is fine.

11:30

Brian Whittle (South Scotland) (Con): As a result of the committee's call for evidence for our pre-budget scrutiny, we had a few submissions from sports bodies that raised concerns about the transparency of the sports budget. The suggestion is that more detail on the sports legacy and physical activity budgets would support better scrutiny. With that in mind, what were the reasons for the change to include the sports budget within the overall health budget? Do you agree with the comments about the lack of transparency in the sports budget lines? What action could be taken to address that?

Shona Robison: We are happy to provide as much detail as possible. The rationale for trying to integrate the sports budget into the health budget was that we are trying to look at physical activity and active living as part of the health response rather than having it sit somewhere else. The budget that is allocated to sportscotland and the active programme is trying to do some of the prevention work. Sportscotland has also done a lot over the years to change its focus, so it is looking at programmes that support children and young people to be active rather than necessarily focusing on specific sports.

I should point out that sportscotland's budget will increase by £2 million to £31.7 million so that it can deliver its services and look at what more can be done. As I said in my opening remarks, we are also underwriting a fall in national lottery income for sportscotland of up to £3.4 million. I know that a lot of concern was expressed by the sports bodies about the fall in the level of income from the National Lottery. We hope that the UK Government will look at how it addresses those concerns.

The active and healthy lives budget line is new for 2018-19 and it looks at trying to ensure that we are doing the right things, particularly through early intervention, and I would be happy to provide more detail on that if the committee would find it helpful.

Brian Whittle: For clarity, the extra £2 million for the sportscotland budget brings it back up to the level that it was at two years ago. The budget has been cut a couple of times.

On transparency, sports delivery is predominantly done through councils. What links does the Government have with the programmes that sportscotland is delivering in light of the increased financial burdens that councils are under to deliver that kind of programme?

Shona Robison: Local government remains a key deliverer of sport. The decision to continue business rates relief for sport and leisure centres will help to make sure that the good work that is being done in local authorities continues. As I am sure Mr Whittle is aware, local authorities and sportscotland work closely together on developing plans to deliver more active programmes. Sportscotland does a lot of work in schools, for example, particularly around making sure that before, during and after-school programmes are delivered, as well as supporting the commitment to physical education and the minimum delivery of that.

All that is in the context of a budget that is increasing due to the tax decisions that we have made. If those tax decisions were made differently, there would be even less money for local government and the NHS. These are political decisions that each and every one of us around this table has to make when we are deciding what resources should be allocated to any part of the public sector.

Brian Whittle: To clarify, what is your understanding of the money that sportscotland has and what it should be spent on, and what the lottery funding spend is allocated for? Is there a different allocation?

Shona Robison: There will be. The National Lottery allocation will meet the requirements of the national lottery in terms of the programmes that it has agreed to fund. Sportscotland will have different funding lines for different programmes depending on what funding stream is funding what. It is not easy for sportscotland, as it is relying on different funding streams, which is why it was important to underwrite the fall in lottery income. That gives sportscotland some breathing space to look at the programmes that it is running while discussions with the UK Government on national lottery resources are on-going. I am not saying that that is an easy task, but sportscotland is required to look at the relative programmes and how they are resourced.

Brian Whittle: Does sportscotland's allocation incorporate capital spend?

Shona Robison: I think that it is all resource.

Christine McLaughlin: I think that the capital is now concluded, but I can check that for you.

Shona Robison: We will come back and clarify that.

Ivan McKee: We have come full circle to talk about performance and outcomes, having spent an hour and a half talking about the inputs. That perhaps suggests how far we have to come in terms of where the narrative generally is when we talk about the performance of the portfolio.

As I said, to my mind it is critical that we focus on the outcomes—I think that everyone agrees with that—and the relationship between them and indicators and targets. I do not want to go into that too much now, because we will talk about it when we discuss the Harry Burns report under the next agenda item. However, echoing what Harry Burns said, the landscape certainly looks confusing: there are the national performance framework indicators, local development plans and integration indicators, which all cut across each other. Alongside that, the budget report provides an assessment against 25 indicators that are allegedly health related, but, having looked at a whole bunch of them, to my mind the impact that the health budget can have on them is minimal to zero, so I am not sure why they are in there. There is a question of whether we are measuring the right things, even at the macro level, and how effective the budget report is in terms of what we are focused on.

If we drill down into the 25 indicators, we see that there are four where you are missing—actually, let us say "worsening", because there are no targets. There are four indicators where performance is worsening compared to previous years. I am looking at two of those four and do not know why they are in there. One of them relates to road deaths and the other to poverty. Correct me if I am wrong, but I would suggest that the impact that the health budget can have on those indicators is minimal.

The other two indicators that are worsening are alcohol-related admissions and the percentage of adults assessing their health as good or very good. If we were to take it at face value that the performance measurement system is robust, notwithstanding everything that has been said in the past hour and a half, those would be the only two areas where the health portfolio is falling down. I think that we would all agree that that is probably not the case. That suggests that there are major weaknesses in the way the system is set up and what we measure.

What is your reflection on that? Is the system measuring what it should be? Do you have any comments on those two specific indicators?

Shona Robison: When you lay it out like that, you make a fair point that sometimes we may overcomplicate matters. We have all the outcomes in the national performance framework. I think we should have a look at that, because the day-to-day priorities for outcomes have shifted towards the integration agenda. The focus is on preventing hospital admissions, reducing unscheduled care, tackling delayed discharge and making progress on the indicators for the early years work through the health visitor programme and so forth. In terms of what we think overall about the performance and where we focus our attention, there probably is a bit of a mismatch, so we probably need to think about that as we take the national performance framework forward.

I would just add a comment, however, on one of the indicators that you mentioned. I have always said that the health service has a big contribution to make towards tackling poverty and health inequalities but it cannot do it on its own.

If we consider the roles of health visitors and family nurse partnerships in the early years, we can see that they are making sure that children get the best start in life. Those inputs are important in ensuring that there are better outcomes for children, and we have a focus on that. I think that we should take away what you have said and have a look with our colleagues across Government at the national performance framework and whether it really reflects where we are with the priorities that are set on a day-to-day basis for the health service. We will take that away and have a look at it.

Ivan McKee: Thank you.

Miles Briggs: My question is about agency and bank staff. The ISD figures that were published show that £142 million was spent in 2016-17. That was up from £134.5 million. When I raised the matter this time last year, both the cabinet secretary and Ms McLaughlin said that, overall, they expected to see a minimum 25 per cent reduction in agency staff costs this year. What has gone wrong over the past year? Why are we seeing the costs increasing further?

Shona Robison: I am glad that you have given me an opportunity to highlight a number of things around that in the context of the budget. First, it is important to note that agency nurse spend is about 0.4 per cent of the total budget. It is very small indeed. Also, we have to be clear about the difference between bank and agency nurses. Bank nurses are NHS nurses who do extra shifts through the bank, as opposed to via an agency that takes an element of funding for its services, which raises other issues.

What are we doing around the issue? We have an increase of £16.7 million in respect of the projected increase in student intakes for 2018-19 and the student nursing and midwifery pre-registration fees and bursary budgets—of course, we have kept the bursary here in Scotland—to enable us to deliver the 2,600 additional nursing and midwifery training places over the current session of Parliament. That is important because it will lead to a substantial increase in the nursing and midwifery workforce, which will in itself help to reduce agency spend.

There has indeed been a reduction in the agency spend over the course of this year. Christine McLaughlin can say a bit more about that. We are seeing reductions in agency spend. We have been working with boards very clearly to reduce that.

We are also increasing the medical workforce through the programmes that have been laid out in the medical education package. In the budget, £4.2 million is allocated to expand medical education. All of that is about building our workforce—both in nursing and midwifery and medics—to ensure that we are able to not just reduce agency spend but mitigate the impact that Brexit is likely to have over the next few years.

In the budget, there is a substantial injection of resource into the area, to make sure that we reduce our reliance on agency spend.

The Convener: We have run very much over time, so I want to try to move on.

Shona Robison: We could write with a follow-up on the detail if that would be helpful, convener.

The Convener: Please do. I was going to suggest that.

Brian Whittle has a question on Brexit. I ask him to be very brief.

11:45

Brian Whittle: I appreciate that we are short on time, convener. How is the cabinet secretary inputting into discussions on Brexit, with regard to

its implications for health and social care in Scotland? Have her officials been, or will they be, involved in the negotiations? What methodology will she employ to hear the views of affected sectors? How does she propose to keep the committee updated?

Shona Robison: As I have said to the committee previously, Brexit is a major concern not just for the NHS but for the care sector. We are inputting into Scottish Government discussions, and Mike Russell and I meet regularly to discuss intelligence from the NHS and care services.

I also meet stakeholders regularly, in order to get feedback from them directly. For example, the British Medical Association has done a lot of work with its stakeholders to give us such information. I recently met Scottish Care and discussed with Dr Donald Macaskill some of the current pressures. He was able to tell me that, for example, recruitment agencies that operate across Europe and provide nurses for nursing homes here have essentially closed their doors in Europe, because nobody was coming through them, and that nursing homes are now feeling the impact of that. Therefore things are happening in the here and now; Brexit is not just about looking to the future.

We are looking at trialling a programme in Dumfries and Galloway in which NHS nurses will provide a locality-based response to the needs of nursing homes. There will have to be a contractual element to that, but that is an example of how we are working with Scottish Care to provide a practical and tangible solution to the fact that nursing homes are not going to be able to recruit nurses, for all the reasons that we have set out.

Therefore we are very much involved in the discussions and in providing intelligence, but also—and importantly—in mitigating what will be a very difficult impact on the NHS and our care services.

Brian Whittle: How do you propose to keep the committee updated?

Shona Robison: I am very happy to write to the committee regularly, as information emerges. As the committee knows, the situation is very fluid, as are the negotiations. If there should be times when we have something substantial to tell the committee, I will be happy to write to it with that information.

The Convener: I thank the panel for their evidence. The cabinet secretary will be staying on for our next session.

I suspend the meeting briefly, to allow for a change of panel.

11:47

Meeting suspended.

11:53

On resuming—

Health and Social Care Targets and Indicators Review

The Convener: Agenda item 2 is an evidence-taking session on the review of targets and indicators in health and social care in Scotland, and it follows our evidence session on 5 December 2017 with Sir Harry Burns.

I welcome to the committee Shona Robison, Cabinet Secretary for Health and Sport; and from the Scottish Government, Geoff Huggins, director, health and social care integration, and Dr Catherine Calderwood, chief medical officer. I invite the cabinet secretary to make an opening statement.

Shona Robison: I will be as quick as I can, convener. First, I welcome the committee's interest in the review of targets and indicators and I acknowledge the considerable work that Sir Harry Burns has done in undertaking the review and the contributions that have been made by members of the expert group.

The committee will recognise the importance of our commitment to having targets and indicators that are fit for purpose, that reflect our current priorities and which lead to the best outcomes for people. We recognise that much has changed over the past decade in our approach to health and social care. Our vision is of a Scotland where people live longer, healthier lives at home or in a homely setting and where services are integrated around the needs of the individual and are focused on prevention, early intervention and self-management. Our health and social care delivery plan, which was published over a year ago, sets out some of the actions for achieving that. It is essential that our targets and indicators are fully aligned with our work to realise that vision.

I welcome Sir Harry's report and the principles that it outlines. Like the committee, we particularly welcome his emphasis on equality of opportunity for everyone in society to enable people to be resilient and in control of their lives. I am pleased that Sir Harry recognises Scotland's highly challenging targets for public services, which have driven significant improvements in many aspects of health and social care.

Within the NHS, Sir Harry recognises that our targets have transformed waiting times for patients and have improved safety. Timely and appropriate access to treatment is important—I have already announced that our current cancer treatment and accident and emergency targets and the treatment time guarantee will remain—but Sir Harry was right to say that we should seek to understand performance across the whole journey of care instead of focusing on individual targets or indicators. I am pleased that he has acknowledged the progress of integration authorities in adopting such an approach, as it has led to better understanding of why patients are presenting at A and E in the first place, for example, and the provision of alternative community-based services to better meet people's needs.

I am mindful of the demand on emergency care services, which has been unprecedented over the festive period. We know that that is down to a number of factors, including a surge in falls and fractures, as well as people presenting with flu-like symptoms. Such exceptional circumstances mean that some patients stay longer than four hours in our emergency departments, not simply because of the pressure on the service, but because that can often be the right clinical setting for assessing their needs and deciding on the most appropriate treatment. NHS boards have responded to the demand to ensure the continued delivery of safe and effective patient care, and we are working closely with the boards to support them through the winter.

In summary, we agree with Sir Harry that further work on our targets and indicators is required, and we will take that forward to create a more balanced approach, with a broader-based assessment of the quality of care. People's wider experiences of care need to be taken into account; I am committed to doing that work with COSLA and other partners, and I welcome the committee's contribution to it.

Ivan McKee: I want to follow on from where we left off in the previous session. When I look at the debate in the health service and reflect on my experience of running performance systems in a previous life, I often find it a bit dispiriting that there seem to be two camps—the outcomes camp and the targets camp—lobbing hand grenades at each other. However, Harry Burns's report goes some way towards an understanding and a recognition that they are parts of the same thing. We need to know where we want to go, what we are trying to deliver and what our outcomes will be. After that, we need indicators to measure whether we are getting there, and then targets to assess how we are progressing. Those elements absolutely need to be co-ordinated—and, to be frank, people who suggest otherwise do not understand what we are trying to do here.

I am glad that we are moving in the right direction. The issue—the hard bit—is figuring out what we should measure, because it is very easy to come back and say that there have been unintended consequences, because of X, Y and Z. That is because the target system was not

designed correctly in the first place and the wrong stuff was measured.

A lot of thought and hard work needs to go into this, and it is clear from the report that there is a long way to go to make sure that the system is robust. Do you recognise that the current environment of multiple and overlapping indicators is cluttered and confusing and needs clarity? Where do we go next with Harry Burns's work?

Shona Robison: In the next phase of the work, I want to look at and bring more coherence to the landscape. For example, the A and E target is important not just because it measures the length of time that people wait in A and E to be seen, treated and discharged, but because it is a barometer of how the whole hospital is performing. If I were a member of the Royal College of Emergency Medicine, I would be talking about its importance in enabling all our hospital colleagues to take responsibility for what was happening at the front door of the hospital.

However, with the integration authorities—and now I am getting into the territory that you have asked about—we have taken the step before that. They are looking at indicators on reducing demand on unscheduled care in the first place and avoiding people ending up in A and E who do not need to be there through the development of local services. It is all about joining the dots, and Geoff Huggins can say a little bit more about that.

12:00

What has been quite groundbreaking is that, for the first time, chief officers and chief executives of councils are as concerned about how to reduce demand on unscheduled care as the chief executives of health boards. They see reducing demand on unscheduled care as being as much their responsibility as that of the NHS. That gets us into the right space, and the issue now is about making the whole process transparent and keeping the importance of what happens at the front door of the hospital, while considering the whole journey from what happens in the community through to a person's admission to hospital or discharge from A and E. That is the bit that we want to do more work on. We want to measure the outcomes and how successful we will be at keeping people away from the front door of the hospital when they do not need to be there.

Geoff Huggins (Scottish Government): The work that we have been doing in that area with integration authorities, which we are about a year into, has been really interesting. About this time last year, we wrote to integration authorities to set out in the context of the previous spending review the six areas in which we were looking for them to set their own objectives and make progress. I think that Sir Harry Burns's review learned quite a lot from that process. The indicators relate to unscheduled care bed days, attendances, four-hour A and E performance, delayed discharges, and the availability of palliative and end-of-life care, and within that, we are looking at a number of different dimensions that are all about the whole journey rather than particular points on that journey.

It has been an interesting process. When we look at what happened in local systems and in the setting of objectives, we see that there are perhaps four different dimensions to what went on. As the committee will know from evidence that we have previously offered, most integration authorities start from very different positions. In general, targets impose a level at which everybody must be, but our experience is that some areas will achieve many of the targets relatively easily while other areas will really struggle.

Our overall interest is in improvement. What has been quite interesting is that integration authorities have been looking at different starting points and have different levels of ambition. Some expect to make more progress over 12 months, while others expect to make less. They have different degrees of capability and support to take forward change, and some of them have a different understanding of how the world works and the impact of demography over time. All of those things will come together in how they present their objectives for the next 12 months.

We have been working with the chief officers so that they can see what other chief officers are doing and to offer through that process a degree of moderation in the context of their using that information to think about their plans for taking forward change that will give them the improved services that they are looking to achieve at a system level. That work is a very good trailblazer for the approach that Sir Harry Burns is looking for in the future, which involves looking at systems of care and the degree to which they function effectively to produce better quality as well as understanding the interactions between different services.

Early in Harry Burns's report, he identifies a challenge in how targets put a sharp focus on one component of the system, perhaps at the risk of other parts. His exhortation to us is to think more broadly, and the integration work has been very helpful in that space.

Ivan McKee: That is good to hear.

You are absolutely right that we need to start at the system level, and the system-level indicators need to be aligned with the outcome for the whole health system. It is clear that there is a hierarchy below that, and a bit is missing. A lot of stuff is

thrown in there, but it is not clear how things relate to one another. There will be a measure for the whole system, but individual parts of it will have their own sub-indicators that feed in through the hierarchy. There is absolutely no reason why different integration authorities would not have different targets; the important thing is that the framework is the same and that they measure the same stuff. It is clear that integration authorities will have different targets, depending on where they are in the journey.

Again, what you said was good to hear. Thanks very much.

Alex Cole-Hamilton: Good morning, panel, and a happy new year to you.

What struck me most when Sir Harry came to talk to the committee was what was not being measured, rather than what was, because, as the old adage says, what gets measured gets done. Sir Harry used a lot of his time to talk about the need to collect more information about adverse childhood experiences, because trauma in childhood leads to some of the most negative social outcomes that exist and there is a lot of research on that. What is the Government's response to that? Does it intend to start collecting such data and will it approach service delivery from a more trauma-informed position?

Shona Robison: There is a lot of importance to what Sir Harry has said on that area. If you track those who have had an adverse childhood experience or who have suffered trauma in childhood and marry them up with the prison population, those who have offended, those who are drug or alcohol dependent and so on, the link is clear for all to see. If that cycle can be interrupted through the collective efforts of Government and services, that will be very important.

We have had a number of cross-Government discussions to look at how we can, for example, work more closely with early years services and with education to find opportunities to interrupt the cycle. In that territory, the work of health visitors and the increase in the health visitor workforce is important, as is the family nurse partnership, the attainment fund for schools and the work between the health and justice departments that is looking at how we can get better intelligence on what has happened in people's lives and what would have helped at particular times to interrupt that cycle.

The whole of Government is keen to do something about it, and what we want to work out through the next phase is what that might look like, because it is not an easy thing to measure. How do you measure what worked in someone's life, and when, to make the difference between a good and a not-so-good outcome? We need to put some thought into that, but please be assured that that has been recognised as something that we can do more about and in a more systematic way than we are doing at the moment.

Alex Cole-Hamilton: I agree that the intent is there. However, I am not really talking about measuring what worked, although that is an important part of it. We need to get the basics right—I think that that was what Sir Harry was talking about—particularly around capturing the traumatic life events that some children experience. That includes not just the usual life events that we would expect to be traumatic, such as bereavement and loss, but things such as attachment disorder and experience of disruptive and abusive homes.

The National Society for the Prevention of Cruelty to Children produced a report called "The Right to Recover", which suggested that a very small proportion of Scottish local authorities have dedicated trauma recovery services. What Sir Harry was alluding to was that we are not getting the business end of it right. Although there is a role in mitigating the impact of childhood trauma for health visitors, the pupil attainment fund and so on, we are not addressing trauma recovery at the sharpest end of the problem, and we will not address that until we start capturing the basic statistics. Is there a commitment from the Scottish Government to answer Sir Harry's challenge and to start recording the reasons for the trauma and not just what we hope to do about it in the future?

The Convener: I appeal to all to be brief and sharp with their questions and answers.

Shona Robison: Yes, there is a commitment from the Government. Perhaps Catherine Calderwood would like to say more.

Dr Catherine Calderwood (Scottish Government): We need to learn from what has been done in Wales where, in 2016, there was a study on adverse childhood experiences that found that 47 per cent of the Welsh adult population have had one adverse childhood experience and 14 per cent have had four or more such experiences. When it got that data, the country was surprised at the prevalence.

We will add some questions on adverse childhood experiences, for adults initially, into the Scottish household survey, which you will be familiar with. As I have discussed with Mark Bellis, who wrote that report in Wales, we need to be aware that revealing past experience is sometimes traumatic for people, so we need to be careful about how we phrase the questions. We need to be prepared to provide help for people who come forward because they have recognised that they have ended up with certain outcomes because of

their childhood and that link has not been made for them before.

We want to work with the adverse childhood experiences—ACEs—hub that has been set up and which is chaired by Linda de Caestecker, who is the director of public health in Glasgow. We are talking with her about having some form of routine inquiry for every interaction with health and social care. That would need to be done very sensitively. From my point of view, it would involve taking a medical history, but there would also be some inquiry as to the child's background and the potential for adverse childhood experiences. It is much more difficult to ask children who are in that situation at the time, although it is obviously extremely important to do that, because we can then act and prevent.

We need the baseline data. You are absolutely right that we do not have that for Scotland, although it is unlikely to be very different from the Welsh experience. We intend to collect that data, and we have the ACEs hub, which already has a lot of ideas about how to take forward work in Scotland.

Jenny Gilruth: I want to follow up Alex Cole-Hamilton's line of questioning. With regard to ACEs, Harry Burns was quite critical of the getting it right for every child approach. He said:

"Well-meaning policies such as GIRFEC have arrived, but it is time that someone came up with a system to create success at school and pulled all of that together."—[*Official Report, Health and Sport Committee,* 5 December 2017; c 42-3.]

Do you agree that there is a disconnect between health and education when it comes to that agenda? Could we do more?

Shona Robison: We could always do more. A number of discussions have been taking place about what that can be and how we can work in a more joined-up way, from the support of women before they give birth through to the early years and school. We are discussing how we ensure that there is more coherence in the opportunities to support families. We have done a lot of work in the early years zone, such as the expansion of the health visitor workforce and the family nurse partnership work. That is about trying to support families who are struggling in their child's early formative years to deal with issues such as attachment issues. That is about trying to have a positive impact before the child enters the school environment. Within the school environment, we are trying to pick up any issues at an early stage. However, we could always do more. Catherine Calderwood and other colleagues are looking at how we can more closely join the dots across Government, particularly between education, health and justice.

Jenny Gilruth: On that point, one of the recommendations in the report is that

"Analysis of school attainment rates should routinely consider the effect of adverse circumstances arising from socioeconomic deprivation on attainment."

Have you had any meetings or discussions with the Cabinet Secretary for Education and Skills on that recommendation or do you plan to in the future?

Shona Robison: Yes, we have had a number of discussions about that. We have also discussed the whole area that we have just talked about of how we can more closely align our collective resources to provide better and more systematic support for the children who need it. We have had a number of discussions on that specific issue and the wider issue. We need to consider how we measure the impact of what we are doing at the moment and how we measure the impact of new services and supports that could be developed. Sir Harry's challenge to us provides a format for us in doing that.

Geoff Huggins: We should also recognise that this work is going on in parallel with the work on the national performance framework, which looks across all of Government. Some of the elements that appear in Harry Burns's report are likely to end up as part of that process of taking that more overarching approach, whereas some elements are more about the health and care system.

Brian Whittle: I want to look at the role of targets and indicators. In several committee meetings, we have asked what I thought was a fairly straightforward question about who monitors one of the indicators, which is that of significant adverse events. From NHS Ayrshire and Arran, we got nothing but waffle, and Jason Leitch's written evidence seemed to contradict his oral evidence.

12:15

However, it is quite simple. We just asked what constitutes a significant adverse event and whether that definition was universal across health boards. It is also about who at Government level monitors that and, more important, monitors whether there are any significant changes in the numbers of adverse events in a health board area. That is obviously important because, if there is a significant change, either the board has instigated practices that should be rolled out across our NHS or it has changed the way in which it records significant adverse events. If nobody at Government level is watching that, how can we learn from the targets?

Shona Robison: As Catherine Calderwood said earlier, there is improvement work to be done in that area. First, we need to know what the figures

are and try to get a proper analysis; and in that regard we can look at what has been done in Wales in terms of the population impact. Secondly, we have to create a baseline and see how we can intervene in an effective way.

I take Mr Whittle's point about the need to have more coherence. The work emanating from the review and the work that we are doing jointly across Government can help set a far clearer framework for our ambition. It is very ambitious to say that we seek to tackle adverse childhood events in a systematic way, because it is very difficult to do that. Once the work is more fully under way, I will be happy to come back to the committee to set out how we are doing it and how we will ensure that the monitoring and oversight of it is as robust as it needs to be.

Brian Whittle: Would it be your intention to present any measurement of changes in a public forum?

Shona Robison: Yes. We have work to do in terms of what we will measure and how we will do that, and on baselines. That work is at an early stage, but once it has all been pulled together in a plan, I would be happy to share that with the committee.

Brian Whittle: Thank you.

Colin Smyth: I will go back to the crux of the review, which is the big challenges that we face such as the fact that Scotland has the lowest life expectancy of the 16 western European countries mentioned and that the inequality gap is increasing, with the life expectancy of affluent Scots rising and that of those in deprived areas falling. Obviously, those inequalities are complex, but the current thinking on transformational change for wellbeing suggests adopting the life-course approach across the whole of Government and focusing on social justice, growth and wealth. That would mean that, in effect, there would be one system of indicators on health and wellbeing that would cut across every Government department. Do you support the life-course approach? From a practical point of view, how can you deliver that when departments still work very much in silos?

Shona Robison: There is huge merit in adopting a life-course approach for our priorities and measuring outcomes in a more systematic way. Some progress has been made across the Government in trying to break down the silos that you indicated. For example, the integration agenda shows that, where silos are genuinely broken down, people take on responsibilities that were previously not regarded as theirs, to be blunt. We need to see improving the life chances of the next generation—our children—as everybody's responsibility and we need to do that in a coherent way. A lot of work has been done around that, but we need to pull it together better. The direction or challenge that Sir Harry Burns has given us will provide further impetus for us to do that. However, as Colin Smyth has identified, that is not easy to do and it can be interrupted by things that are outwith our control.

Without putting too fine a point on it, let us say that the welfare reform agenda reduces a family's income, which affects the level of poverty—and everything that flows from poverty—that that family faces. That is a difficult piece of the jigsaw for us to have as part of our plan, because all we can do is mitigate the impact as much as possible, and we have done a lot of work to enable us to do that. We need to look at how, with all the levers at our disposal, we can do more and better in that respect, but we also have to recognise that some factors outwith our control have a pretty severe impact on household income and employment and so on.

Geoff Huggins: The other thing that is quite important in the review is how Sir Harry widens the scope of the issues that we consider when we look at outcomes and indicators. We are doing work in Dumfries and Galloway on dementia outcomes and indicators, based on work that we have done with the International Consortium for Health Outcomes Measurement. The ICHOM is looking at how we can measure, across systems, people's sense of control, their social connectedness and other things that are fundamental to broader health and wellbeing outcomes. We are finding that quite challenging, though, because those are not the things that we traditionally measure. We tend to measure things in particular, time-bound situations that can easily be put into a spreadsheet. However, in order to measure people's quality of experience, which affects the likelihood that they will present at accident and emergency or go to their GP for support, and understand how well we are supporting them to live the lives that they want to live, we need to look a lot more at granularity in local systems. Such questions are largely an undeveloped area in our system, and indeed in systems across the world. We have had the conversation on more than one occasion about issues to do with loneliness, and the degree to which people have good social ties and support systems around them. Those factors are not part of our measurement system, although they can be as important as, or more important than, individual clinical interventions. That is quite challenging.

That approach enables us to step into the space of realistic medicine in a different way and understand how not doing something might, on some occasions, produce a better outcome than doing something. At the moment, our system measures situations where something has

happened, but we do not have a methodology to understand the impact of something not happening. Once we bring qualitative factors into the story, we can understand people's experience and perhaps help them to understand what they might want. Sir Harry has opened up how we look at indicators and outcomes, beyond the traditional understanding of how fast or how well a system is operating. There is really quite a big challenge in that.

Colin Smyth: The big challenge will be to identify what we measure, ultimately. When Sir Harry Burns talks about the life-course approach, he says that individuals need support at various key stages, for example pre-birth and in early childhood. Specifically, he argues that early years support is key. I go back to Jenny Gilruth's point: is there scope to reinvigorate the work of the early years collaborative in the light of what Sir Harry says in the report?

Shona Robison: We need to look at all the mechanisms that we can use, and all the expertise that is available, not just in Government and its partners but among the public—people who have been through many of the experiences that we are talking about. There is something in that. The early years collaborative has done a lot of very good work, but we first need to take a step back and reassess what outcomes we want to achieve. How will we achieve those outcomes across the Government? Are the mechanisms, collaboratives and methods for delivery of those outcomes fit for purpose, or do we need to do something different? We are looking openly at where we are, and there is a commitment across Government to refocus and re-energise work in that area. We will be very happy to keep the committee informed about that work.

The Convener: Sandra White and Emma Harper want to come in on that briefly.

Sandra White: My question is about the life-course approach. Sir Harry Burns's paper is spot on: this is about holistic collaborative working. I will pick up on Mr Huggins's point about loneliness. Are we taking any data from the deep-end practices for the life-course approach? Those practices target people in the most disadvantaged areas and have shown that among older people in particular who turn up at them the issue is just loneliness—they do not necessarily need a prescription or to see a doctor.

Shona Robison: Yes we are taking such data, and the new GP contract will enable us to get a far richer seam of data coming through primary care for measurement. We will know about the populations that are served by practices as we never have before. The data will help not just practices and their partners, but all of us collectively, to consider what services need to be delivered to their area and its population. For our deep-end practices and services for the more deprived communities, the data will tell us far more than we know at the moment, and in a more detailed and local way. It is an opportunity to drill down and not just to look at data but to formulate service delivery and support based on what the data tells us.

Geoff Huggins: I will make two or three points to build on what the cabinet secretary has said. In his report, Sir Harry Burns suggests that, as part of the work to take forward the review, we should test and learn rather than simply arriving at an answer and trying to implement it. A lot of what is going in the system is that testing and learning—it is a clear objective.

Our focus is often on national indicators or targets, but there is a balance to be struck between national and local in terms of the improvement mindset. There are elements that we might expect would cascade, but there are others that we expect would be part of local system improvements and their use of data using list and source.

The third thing comes back to the cabinet secretary's point about being clear about framing and the overall aim of the system, before setting outcomes and working through indicators. That progression is how we took forward the work on dementia outcomes, and we ended up with outcomes for which initially we did not have indicators. We built the indicators to support what we were trying to achieve; the opposite is often the case.

Emma Harper: Harry Burns uses the word "flourishing" in his report, because we want to create a healthy and flourishing population. It is quite nice to have heard Dumfries and Galloway being mentioned a lot this morning. I am aware of some of the programmes that are being implemented to provide the best way forward for health and social care integration and to keep folk out of hospital. What resources or incentives are available to help local authorities to engage in plan-do-study-act cycles and to change cycles in whatever method they use, so that we can encourage the flourishing population that we seek?

Shona Robison: I ask Geoff Huggins what he knows about the improvement work and support.

Geoff Huggins: Our dementia activity work in Dumfries and Galloway is supported by the Healthcare Improvement Scotland team that supports general dementia work and has embedded that work in its broader change work. Healthcare Improvement Scotland's improvement hub—ihub—provides support to integration authorities for work on issues including falls,

admissions, delays and sleepovers. The context is that local systems are looking to make and to own change locally, but at times they require support—technical, data or analytical. There is a balance between national and local. Our primary objective is that local systems own and want positive changes and find local solutions to take them forward. NHS Dumfries and Galloway is a good example of that.

Emma Harper: I will be really quick. Obviously, some boards are a bit further ahead with change programmes than others are, so they will learn from one another what works in one area and how it can be adapted for another.

12:30

Shona Robison: Yes. Through all the improvement programmes we identify best practice and share it. Obviously, what might work in the centre of Glasgow might be a bit different from what works in a rural area, given the different resources that can be called upon in those circumstances. However, if something works well, we want to share that and help other services to develop it in their areas.

Miles Briggs: I want to discuss NHS staff empowerment. One area that I am quite keen on, and which I have raised with Harry Burns, is professional responsibility. We often set targets for NHS and social care staff. I am sure that I am not the only MSP at the table who is told by nurses that they are often asked to record information that they think is not useful. My concern is about empowering them to do their jobs. What is the panel's view on how that needs to change?

Shona Robison: I will bring in Catherine Calderwood in a second, but my instinct is that we need to listen more to what front-line staff think about what we get them to record, which takes time. We need to make sure that when we ask people to record things, we are pretty clear about its importance and the reason for it, and that staff fully buy into it and feel that what they are doing has a reason and a purpose. Ensuring the engagement of our front-line staff in all this is very important.

Dr Calderwood: I also hear doctors asking why we are measuring certain indicators at all, because they mean nothing to them clinically and will not improve patient outcomes. That recording is not something that clinical staff who have the expertise would traditionally have wanted to do—they want to see patients and they want to be at work. We need to make such work much more attractive so that staff will potentially have a greater impact by clinically advising patients based on worthwhile indicators and targets than they might by doing an extra clinic. People do not necessarily value that work, which looks at the national level.

We must also be careful about proportion and the burden of data collection on actual results. I was part of a big maternity audit in which I calculated how much time each keystroke took. I worked out that we could have employed 50 more midwives a year based on the time that was being taken to record data for the whole country. I am not sure that we consider such issues very well, either. We keep asking people to collect more data, but data collection must be proportionate to the improvement that collection will create.

Geoff Huggins: There is another component to that issue. In our work on dementia diagnosis rates, which began in 2008, the challenge that we faced included opposition from general practitioners and others to the idea that we should be doing it at all. The process that we built in response to that was clear about the benefits. We ensured that patients' and carers' voices were being heard as part of the story about what mattered to them. We made it clear how diagnosis was part of a process to enable them to move forward with their lives, and we ensured that it was not seen in the way that it had been presented by some doctors. Often, the solution is to put what we are trying to do in context.

Two other components are interesting. When people get feedback and feel the benefit of the information that they provide, they are more likely to provide information. Our system ensures that people see the value and the contextual use of the data. The link to that is the work on the digital strategy, in which the objective is to automate collection of data more so that it does not require manual entry or additional work that could be done by machines.

Of the three elements, the most important is to ensure that the value of data collection can be ascribed back to the value for patients and carers.

Shona Robison: The more current the data, the better. That is better than looking back at what happened a year ago.

Ash Denham: The only one of the existing targets that the review suggested could be removed is the 18-week referral-to-treatment target. The suggestion behind that proposal is that the target has the possible unintended consequence of interfering with clinical and possibly even patient decision making. Is there still merit in keeping that target, or are there better indicators that we could use to get the information that we need without unintended consequences?

Shona Robison: I want to interrogate that proposal and consider it in more detail. Harry Burns has made a good point, but we do not want to throw the baby out with the bath water, so in the

next phase of work we want to consider whether there is a better way of measuring without overmeasuring. Harry's point is that we already measure that part of the patient journey, so the question is whether it is a remeasurement of the patient journey in a different way. Therefore, we want to see what transpires from a closer look at that recommendation in the next phase of work.

The Convener: I have a general question about the review. It took a long time, it was delayed and it seemed to be a wee bit underwhelming when it came out. Did you expect more from it, or is it what you expected?

Shona Robison: We tasked Harry Burns with a big job. His review was in two parts. One part focused on targets and indicators and the other was about health inequality and how we make huge changes. He undertook an enormous task. Perhaps the remit was too enormous, but members know what he is like: once he gets going, he wants the freedom to consider all the areas.

What transpired from the review is a signal in a particular direction, the detail of which it is for us to take and build on. I thank Harry Burns for his work: he is a great asset to us. He is able to put his enormous experience to work in a way that might not dot every i and cross every t, but gives us the direction of travel. It is our job to take that and to apply the detail.

The Convener: The current system allows the committee and the Government to look at comparators across the UK. For example, if we look at the figures up to, I think, November, we see that the figure for the four-hour A and E target in Scotland was 94.4 per cent and, for England, it was 84.9 per cent. In cancer referrals, the figure for Scotland was 86 per cent and, for England, it was 82 per cent. However, among some of the other indicators we see that, on the referral-to-treatment time target—one of the key targets that Harry Burns wants to get rid of—we were 7.7 per cent lower than England; on diagnostic tests being performed within six weeks, our figure was 17 per cent lower than England's; and for procedures including colonoscopies being performed within six weeks, Scotland was sitting at 58 per cent and England was at 93 per cent.

We can see significant differences between us, England, Wales and Northern Ireland under the current system. If we change the measures but they do not, how can we have comparators with which to hold you to account and for you to use to make political points about what is happening elsewhere?

Shona Robison: The convener makes an important point. Those are the health systems that are most comparable to ours, although the caveat is that when we look behind data, we often find variations in how it is collected. We do not always compare apples with apples: we sometimes compare apples with pears, although it might not seem that we are. The convener's point shows why we need to proceed carefully. It is helpful for us to benchmark not only across these islands but elsewhere. However, we have to measure things in more or less the same way in order to be able to do that meaningfully, but that is often not the case. As we take the matter forward, I will be cognisant of that, because we do not want to lose our comparators, even when they challenge us on where we need to make more progress. Be assured that we will not throw the proverbial baby out with the bath water. We want to maintain an ability to compare and measure in the right way, but we also need a more sophisticated system that focuses more on the patient outcome. Often, what we measure does not give us that important bit of the picture, so that is what we want to focus on.

The Convener: I have a couple of questions that I hope Geoff Huggins can help with, in relation to the timescale for things moving on and what happens next.

Shona Robison: What will happen next is the process to take the work forward. Geoff Huggins can give you the detail on that and on the time frame.

Geoff Huggins: I would like first to pick up on the previous point. Regardless of whether the 18-week RTT was a target, the data would still be there. Even if you think that Harry Burns draws a distinction in the report between information that is available for accountability of the system and information that is there for improvement, you would still be able to make the comparison, whether or not it was a target. In a number of areas where we are making cross-UK comparisons, the information in the other systems—particularly in Wales—is not a target, it is just information, so you would not lose that ability.

There will be three or four elements in the process, going forward. First, we are doing some local testing work on the use of outcomes, such as the work that is being done in Dumfries and Galloway, in order to understand how that would work within the system, using indicators and outcomes for improvement, rather than simply applying targets to NHS boards. Our take on that is that the process of implementation is likely to be more challenging than the process of reaching agreement on what the indicators should be. We need to have those two things aligned in order to take forward the change.

We are working to develop a next-stage process. As the convener said in respect of Harry Burns's review, people have very strong views on

whether things are good or bad and what the answers should be. We need a more sophisticated process to enable us to make decisions as we crunch through from the high-level aim to the outcome and to the indicator, learning from organisations and bodies that have done that previously. We will build a process, but we will do it in parallel with testing.

We also want to build in what we have learned from the integration authorities' experience of the first 12 months of working in that different way.

The other key component is the degree to which the information systems that we will be building under the digital strategy make collection of appropriate data for improvement and accountability routine, rather than its being an add-on that is applied to the system. That will be the process.

The Convener: It has been a long meeting, so I thank you very much for coming along. This is likely to be my last time convening the committee, so I want to record my thanks to all the staff who have helped me over the past two years, and to all the committee members for their work.

12:42

Meeting continued in private until 12:48.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

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