OFFICIAL REPORT
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Health and Sport Committee

Tuesday 15 January 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 15 January 2019

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HEALTH AND SPORT COMMITTEE
1st Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
Alex Cole-Hamilton (Edinburgh Western) (LD)
David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jeane Freeman (Cabinet Secretary for Health and Sport)
Paul Gray (Scottish Government)
Richard McCallum (Scottish Government)
Anas Sarwar (Glasgow) (Lab)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 15 January 2019

[The Convener opened the meeting at 10:08]

Interests

The Convener (Lewis Macdonald): Good morning, and welcome to the first meeting of the Health and Sport Committee in 2019. I hope that everyone is thoroughly refreshed. If you can still remember Christmas and the new year, congratulations—and welcome back.

I ask everyone in the room to ensure that mobile phones are switched off or to silent, please. We have received apologies from Alex Cole-Hamilton and David Stewart. I welcome Anas Sarwar, who is a substitute for David Stewart. In accordance with section 3 of the "Code of Conduct for Members of the Scottish Parliament", I invite Anas Sarwar to declare any interests that are relevant to the committee's remit. Any declaration should be brief but sufficiently detailed to make clear the nature of any interests.

Anas Sarwar (Glasgow) (Lab): I have nothing to declare except that I am a former national health service dentist.

The Convener: Thank you very much.

Budget Scrutiny 2019-20

10:09

The Convener: The next item on our agenda is an evidence session on the draft budget for 2019-20.

The committee's approach to scrutiny of the draft budget reflects the approach that the budget process review group recommended. That approach entails addressing budget implications throughout the year and bringing that information together to inform a pre-budget report for consideration by the cabinet secretary. Members will recall that we issued our pre-budget report on 29 October. That report 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 publication of the draft budget was to enable the Scottish Government, if it chose, to endorse our recommendations and implement them in the draft budget. A response to our report was received from the cabinet secretary on 21 December.

Absolutely on cue, I welcome to the committee the Cabinet Secretary for Health and Sport, Jeane Freeman; Paul Gray, director general of health and social care in the Scottish Government and chief executive of NHS Scotland; and Richard McCallum, deputy director of health finance and infrastructure in the Scottish Government.

I invite the cabinet secretary to make an opening statement.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Good morning. I welcome the opportunity to give evidence on the budget proposals for our health and care services. The emphasis in the budget is on ensuring that resources are directed appropriately in support of our front-line services. Our outstanding health and care staff deliver those front-line services, and I want to take the opportunity to pay tribute to them, and particularly for the hard work that they have undertaken over another busy Christmas and new year period.

The budget for 2019-20 supports the medium-term financial framework and sets out the next steps in our financial plans. When I outlined the framework to Parliament back in October, I made it clear that all resource consequentials would be passed on in full. I said:

> "In finalising the financial framework, I have made the perhaps bold assumption that the UK Government will honour its commitment, deliver the consequentials as a true net benefit and not reduce the Scottish Government's funding by cuts applied elsewhere or by other measures."—[*Official Report*, 4 October 2018; c 50.]

I was therefore disappointed by and concerned about the potential impact on our spending plans when the United Kingdom autumn budget confirmed a reduction of £55 million in health consequentials for 2019-20. However, as part of our proposed budget, the Scottish Government has passed on resource consequentials in full and provided additional funding of £55 million. That reinstates the UK Government's reduction and protects the resources for our front-line services.

The Scottish budget for 2019-20 sets out total investment in excess of £14 billion for the health and sport portfolio and provides a further shift in the balance of spend towards mental health and primary, community and social care. In 2019-20, our investment in social care and integration will exceed £700 million—that is an important next step in delivering our commitment that, by the end of the session, more than half of spending will be in community health services. We will invest an additional £430 million in our front-line NHS boards—that provides an uplift of funding of 4.2 per cent in cash terms; we will continue our policy of supporting boards that are furthest from NHS Scotland resource allocation committee parity; and we will invest £23 million to ensure that no board is further than 0.8 per cent from parity in 2019-20.

We will provide funding of £392 million to improve patient outcomes. That will support our waiting times improvement plan and will lead to sustainable and substantial improvements in performance. That includes the aim that, by spring 2021, 95 per cent of out-patients and 100 per cent of in-patients will wait less than 12 weeks to be treated. Our investment in improving patient outcomes will take overall funding to £940 million to support the Scottish general practitioner contract and the reform of primary care. That will continue to support health and social care integration and allow GPs more time to spend with those who need that most.

On sport, the budget supports the people of Scotland to become more physically active as part of our efforts to prevent ill health and improve wellbeing while delivering world-class sporting performances. In 2019-20, sportscotland will receive additional funding of 3 per cent in cash terms, which will take its overall budget to £32.7 million.

We will continue to underwrite the potential shortfall in lottery funding of up to £3.4 million, and we will continue to encourage the UK Government to take the necessary actions to address lottery reductions.

10:15

In 2019-20, capital investment will amount to £336 million, which will include investment in the Baird family hospital and the Aberdeen and north centre for haematology, oncology and radiotherapy—or ANCHOR—in Aberdeen and will support increasing elective capacity across the country. Members will be aware of my intention to put a capital investment strategy before Parliament by the end of this financial year. That new strategy will create a framework for considering necessary investment over the longer term and will accompany the medium-term financial framework. It will include important investment in primary and community care projects, which will be key in delivering the emerging health and social care integration agenda and continuing to shift the balance of care from hospitals to local facilities and people's homes.

The coming year—2019-20—will be the first year of our new planning and performance cycle. In return for their efforts to deliver the reforms that are set out in the delivery plan in the financial framework, boards will be required to deliver a break-even position over a three-year period rather than annually, as is the case currently. In each year, boards will have 1 per cent flexibility in their annual resource budget, which will give them the scope to marginally underspend or overspend in that year. As members know, in order to give all our territorial boards clear ground to move forward, I will not seek to recover their outstanding brokerage. That is money that has already been spent on providing patient care, which has been accommodated within the overall health and sport portfolio budget.

In conclusion, the Scottish budget for 2019-20 passes on in full the consequentials to health and care and provides additional support to ensure that the money that it is anticipated will be received from the UK Government will be met by additional funds from the Scottish Government that go over and above that in order to protect the plans that are set out in the medium-term financial framework.

The spending plans are supported by greater flexibility to assist boards in planning beyond one year and to consider key areas of investment, such as in relation to primary care, mental health and waiting times improvement. That will support our boards, along with the integration authorities, to deliver the measures that are set out in the delivery plan and the financial framework in a safe and appropriate way, making sure that they maintain a strong focus on care and the delivery of services that are safe, effective, person centred and timely.

I commend the budget to the committee and will, of course, answer any questions that members might have.

The Convener: Thank you, cabinet secretary. That was very helpful.

Since this year's budget process began, there have been quite a number of changes in the way in which financial information is presented, including the medium-term financial framework and other innovations, which the committee has broadly welcomed.

I want to ask about something that stands out from the tables that present the level 3 spending plans: the way in which planned efficiency savings are concentrated under the "Miscellaneous Other Services" budget line. As a consequence, that line stands out as being the one area of reduced spending, as it were. The committee is keen to understand how the impact of that on other spending lines will work through over the course of the financial year. Although the efficiency savings appear to be concentrated in one place, I presume that they will be dispersed across the department. We would like to understand the likely impact of that on what are otherwise real-terms increases in some of the spending lines.

Jeane Freeman: I will ask Mr McCallum to provide an initial answer, after which I will come in.

Richard McCallum (Scottish Government): I have two or three points that it would be helpful to make on that. The first thing that the committee might find it helpful to note is that we always start the year with the level of efficiency savings that we need to make at a portfolio level—that was the same in 2018-19 as it is in 2019-20. We take that prudent approach because there can be slippage on certain programmes and the opportunity exists for savings to occur. Our approach recognises that.

If we think about the 2018-19 budget and where we have got to this year, we have made some efficiency savings on specific programmes that are under the "Departmental Allocations" line—I am talking about things such as our digital programmes, the costs associated with the non-profit-distributing model, which fluctuate and can go down, clinical negligence costs, which also tend to go down, and slippage on some of our other programmes. Having efficiency savings on a single line is the most prudent approach. We would not want to apply hard and fast savings to each budget line; that would not be proportionate. We work with each directorate and policy area taking forward those programme lines, to support them in that work.

Those are probably the key issues. The most important thing is probably that, in our core area of spend, whether that is primary care, mental health or waiting times improvement, we would not see those efficiencies being applied to those lines. We would be keen to see those move forward as we have set out in the budget.

The Convener: Essentially, you are saying that you make pessimistic assumptions about, for example, the cost of NPD and medical negligence, and look to achieve efficiency savings from the pessimism impact—that is, the impact of what comes through.

Richard McCallum: That is correct. We start with a figure that we think that it could be, and it generally is a more pessimistic scenario. Through the year, we see whether that plays out as expected.

Jeane Freeman: Of course, officials work that through based on their knowledge of how programmes have performed in previous years.

The Convener: Yes, indeed.

Emma Harper (South Scotland) (SNP): Good morning, everybody. I am interested in issues to do with spending on community health services and primary care. The cabinet secretary has described a situation in which half the budget spend will be in communities. I am aware that a lot of work is being done, especially locally in Dumfries and Galloway, to support primary care. An example is the transforming Wigtownshire programme, which is looking at better ways of providing health and social care integration and care in the community.

Spending on primary care is expected to make up 9 per cent of the budget, and there is a target for it to increase to 11 per cent in future years. That target for transferring money into the community and primary care seems reasonable, but is it ambitious enough?

Jeane Freeman: As you rightly say, our target is to reach a position in which 11 per cent of the NHS budget is allocated to primary care by the end of the current parliamentary session. Given that the figure is 9 per cent in the current draft budget, we are certainly on track to deliver that target.

I want to hold to that position in this financial year and to look at whether, in the budget for the next financial year, based on performance, we want to increase our ambition beyond the 11 per cent target. However, at this point, the prudent approach is to say that we are well on track to meet our commitment of 11 per cent. I will need to see how well we deliver improvements in areas that involve hospital-based care. I am thinking in particular about the waiting times improvement plan. If that plan is delivered against its trajectory, depending on the financial situation in 2020-21, we might want to increase that target.

Emma Harper: It is proposed that the funding for community hospitals should form part of the

community budget, which is probably reasonable. As a former NHS employee, my understanding is that many community hospitals are managed by local general practices, so it seems reasonable for community hospitals to be part of community spending and not acute care spending. Is my understanding correct?

Jeane Freeman: Absolutely. As the name suggests, community hospitals are located in the community, so they should be part of the overall shift in the balance of care. That is partly about making sure that people are in an acute setting for the period of their clinical need and no longer.

I know that there are examples of community-based hospitals being used as step-down and step-up care. Some perform a re-enablement function. There is a range of ways by which community hospitals can contribute to the shift in the balance of care from the acute setting to the community.

Emma Harper: Thank you. Could the Scottish Government commit to publishing in the budget document updates on progress towards various commitments?

Jeane Freeman: I would appreciate finding out which commitments you might be thinking of. We publish the financial position of our boards every month and the integration joint boards every quarter; the waiting times improvement plan commits us to advising Parliament—and, clearly, this committee—of progress against its milestones; and I understand that there are similar commitments with regard to our additional investment in mental health. If there are other areas in which we need to make such commitments, I am very happy to consider them.

Emma Harper: I just wanted to get it on the record that reports are being published, whether it be monthly, quarterly or as required. Thank you.

The Convener: Sandra White has a brief supplementary.

Sandra White (Glasgow Kelvin) (SNP): In your opening remarks, you talked about the shortfall in Barnett consequentials. Could there be reductions in the future as a result of that? Have you had any assurances from the UK Government in that respect? After all, we are talking about a shortfall of £55 million.

Jeane Freeman: No, we have not had any assurances from the UK Government. It made a commitment in June that was not honoured later in the year and which left us with that £55 million shortfall. The Scottish Government has committed to making that good on a recurring basis. Obviously, we will continue to press the UK Government to revisit its position, but I think that in general, whatever our position, we would all agree that, as of today, we are a bit uncertain about what the future looks like. However, we are certain that the Scottish Government will continue to meet its commitment with regard to the shortfall.

Sandra White: Thank you.

George Adam (Paisley) (SNP): Good morning, cabinet secretary. Following on from Sandra White's question about the Barnett consequentials, it was good to hear you say that you would put all that resource straight into the NHS, but it is disappointing that we have what is, in effect, a £55 million black hole. As you know, I like to keep things simple, and it is almost as though the Westminster Government has picked the pocket of the health service to the tune of £55 million a year. I am glad that the Scottish Government is covering that £55 million, but as I read about that over the weekend, the question that kept coming into my head was this: what would have been the impact on the health service if the Scottish Government had not made sure that that £55 million a year was available?

Jeane Freeman: If we look at the additional moneys that are going into front-line spending, we see that, in 2019-20, there is additional funding for our work to meet the elective targets. That is an example of the difficult decisions that would have had to be made. I also point out the commitment with regard to mental health. Those are significant areas of additional spend. We should also remember the reform of primary care, the transfer of funds to change the balance of care towards community care, the additional resource of around £120 million that is going from the health budget into local government for integrated health and social care, the £30 million for implementing Frank's law in the widest sense to everyone under 65, and so on. There are a number of examples that show that, if the shortfall had not been made good by the Scottish Government, the decisions that we have to make would have been more difficult.

On the other hand, given that the Scottish Government's budget has been significantly reduced, making good that shortfall from the overall Scottish budget puts pressure on other areas. The money has to come from somewhere. It should have come from the UK Government, because it made the commitment, but it did not honour it. The Scottish Government has worked to make good that shortfall, but that puts on pressure elsewhere in the Scottish budget, which is already significantly reduced as a consequence of UK Government decisions.

10:30

George Adam: Many of the issues and services that you mentioned in your first answer concern

stuff that we all support, regardless of the political party that we belong to. In effect, is it not the case that anyone who votes against the budget is going against not only the £55 million extra that is being put into the NHS from the Scottish Government, but measures such as Frank's law and other measures that people have campaigned for? Is it not the case that you have taken a pragmatic view in order to push things forward?

The Convener: Cabinet secretary, as we are not here to discuss the votes for or against the budget, you can use your discretion with regard to how far you can go down the road of answering that question. We want to know about the evidence that you can bring forward in support of your budget proposal.

Jeane Freeman: I appreciate that, convener. However, the simple fact is that, at the end of the day, the committee will have views that it wants to express on this part of the draft budget and Parliament as a whole will make decisions on the overall budget. What I am saying clearly is that, if the health and sport portfolio has less money than is currently in the draft budget, difficult decisions will have to be made, and those will be around areas in which there is a significant level of spend, whether that is on mental health, addiction or Frank's law.

I am sure that every member of the committee is cognisant of the fact that there is no money hidden anywhere; the money that is available is in the budget. If the budget is not supported, difficult decisions will have to be made about what cannot be afforded.

George Adam: I have a final question on the back of what you said in answer to Sandra White. She asked whether you had any guarantees from the Westminster Government about the Barnett consequentials—it could find other ways to make sure that we do not get them, which raises the possibility of further cuts. Has any guarantee been given that the Westminster Government will not continue to go down this route of finding further ways in which to attack Scotland's health service?

Jeane Freeman: With regard to the overall funding that comes from the UK Government as a result of consequentials, there is no guarantee beyond where we are in this current year. Of course, there may well be a subsequent UK budget, depending on how decisions play out with respect to Brexit. As the Chancellor of the Exchequer said, he might have to come back and introduce another UK budget. We cannot be sure about that, so there are no guarantees; nor can we be sure of how the position might change, if it changes at all.

The Convener: The medium-term health and social care financial framework, which was published last year, is very helpful. Can you lay out for us the level of savings that will be expected in 2019-20 from health boards and integration authorities?

Jeane Freeman: I will try to find that in my papers. I have read my briefing, but members can see that finding exactly the bit that I need is not always straightforward.

The financial framework indicates health demand pressures of up to 4 per cent above inflation. The level of savings that is required from the boards in this current financial year is not in the papers in front of me. Do you have that information, Richard?

Richard McCallum: We are still working through the matter with health boards. They will have received the budget and they will now be working through their financial plans for next year. We expect the savings that boards will require to make to be similar to those in 2017-18 and 2018-19. We will work through that with boards over the course of the next couple of months.

The Convener: Can you give us a ballpark figure so that we can understand the territory that you are talking about? What is the level of savings that you expect to be made in the current year? To what extent do you expect that to be increased or repeated?

Richard McCallum: Health boards are making about 4.5 per cent savings in 2018-19.

The Convener: Do you anticipate that the savings in the coming year will be in that sort of territory?

Richard McCallum: Yes.

Jeane Freeman: A point that is often misunderstood because we talk about savings is that the boards hold that money and use it to reinvest. I know from my experience at the Golden Jubilee national hospital that when a board makes efficiency savings or other savings in the delivery of its work, that resource is applied to another area of the board's activity. It is not money that comes back to central Government.

The Convener: That is understood. However, in your financial framework you laid out an expectation that £1.7 billion in savings would be achieved by 2023-24. How far does the budget keep the Government on track for that medium-term target?

Jeane Freeman: It keeps us on track. The budget has been devised and negotiated with the Cabinet Secretary for Finance, Economy and Fair Work in order to align with the medium-term financial framework. The finance secretary and his officials contributed to that medium-term financial framework when we pulled it together.

The Convener: The financial framework suggested that, even in that context, there might still be a funding gap of some £159 million.

Jeane Freeman: Yes.

The Convener: What is your expectation when it comes to addressing or filling that gap?

Jeane Freeman: That work is under way. It requires considerable consultation between us and major groups of clinicians, boards and our local authorities to consider two things: first, how effective we are in the coming period in continuing the reform of delivery, both in shifting the balance of care from the acute to the community setting and in the delivery in the acute setting; and secondly, our anticipated level of spend, in light of the reforms in delivery that do not in any way diminish either the patient experience or patient outcomes, against the level of demand and where we think that there are ways in which we need to make some difficult decisions in the longer term or to secure additional resources in order to meet the shortfall.

My feeling at this point—I stress that it is only a feeling—is that, over the period of the medium-term financial framework, there will be a mixture of a reprioritisation of our existing resources, some additional resources and some deliverables in terms of better use of resources when we fully reform the process.

Sandra White: Good morning, cabinet secretary, Mr Gray and Mr McCallum. You will be aware that, on previous occasions, the committee has expressed concern about reliance on in-year allocations to health board budgets. I note that the national boards have received an increase and that other boards' budgets will be topped up by other departments offering in-year allocations. Would not it be better for the health boards to get the moneys at the beginning of the year, rather than through in-year allocations? Could boards budget better if they had the money earlier rather than later? Does the cabinet secretary agree with the committee—we have previously raised the issue—that reliance on in-year allocations hampers boards' ability to plan for the longer term?

Jeane Freeman: I understand the question. In the draft budget, 90 per cent of what boards will receive is in their baseline funding. That is a significant amount of money. We have accepted that prudent financial planning should span a longer timeframe than a year, which is why we have set a three-year financial planning framework for boards, beginning in 2019-20. However, a balance is needed. Boards know what money they have with which to deliver their services, and can plan for that. That includes being able to meet commitments on workforce pay, planned maintenance and other matters.

However, where we have set specific work as a priority, I am keen that we fund to results. I am thinking, for example, of our significant resource-backed commitments on waiting times and mental health. By "fund to results", I do not mean that health boards must deliver the result and then we will give them the money; rather, if a board is receiving £2 million to reduce waiting times, I want to know exactly what its impact will be on how many patients and in what specialisms.

There needs to be a mix. Boards have significant certainty about the funding that they are working to—the 90 per cent—but we should also rigorously manage performance on the additional resources that go towards delivering services for patients against anticipated outcomes. We flex resources across the piece.

For example, not every board is in the same place with regard to meeting waiting times targets in specific specialisms: a board might be successful in some areas but not in others. There is not a consistent picture across the country. I want to use the additional resource in a targeted way in order that we consistently meet the targets throughout the country.

Boards know that there is additional resource to support them in meeting waiting times targets and delivering on mental health commitments, for example. They can therefore anticipate that that resource will be available to them, provided that they have in place propositions that evidence what they will additionally do and, therefore, additionally deliver.

Sandra White: Thank you. You mentioned that particular issue in your opening remarks: I wanted to get a wee bit more information with regard to 2019-2020. In other words, you have listened to the committee as well as putting forward the idea that the extra 10 per cent is needed to ensure that priority commitments of the Scottish Government—whatever its make-up—can also be fulfilled.

What funding will be made available for the new body, public health Scotland? If there is extra funding for public health Scotland, will that reduce budgets elsewhere in the health portfolio?

Jeane Freeman: Public health Scotland is due to come into being in the next financial year. It is based on public standards and objectives that have been shared and agreed with the Convention of Scottish Local Authorities. We are in the middle of appointing to it. Public health Scotland will take on a significant role in helping us to deliver in areas that are already in the budget—for example, the diet and healthy weight strategy and parts of the work on addiction. It will have a responsibility

to assist the Government in delivery of commitments in those areas.

The resource that public health Scotland will require is set out in budget information that the committee already has. That aside, it will be considered to be a national board and will receive some core funding. However, I do not anticipate that its core funding will be seen at level 3 in the budget.

Paul Gray (Scottish Government): As the cabinet secretary said, the new body will bring together work that is currently done in a number of places, including in NHS Health Scotland and NHS National Services Scotland.

The answer to the specific question whether funding is being taken from other places to fund public health Scotland is no, because we are using money that currently exists.

However, the co-ordination that the new public health body will provide and the ability to work much more effectively with our partners, including local authorities, will produce better outcomes in public health and overall population health.

Sandra White: Thank you. That completely clarifies the issue.

10:45

Anas Sarwar: I want to focus on service reform and capital spend. One of Audit Scotland's findings was that there is a severe backlog in the capital investment and maintenance that is needed for our hospital buildings, such that we are going further into the danger zone. How does that tie in with a reduction in capital investment? What priorities will be set in the strategy that is to be published later this year?

Jeane Freeman: As Anas Sarwar has rightly noticed, our capital spend allocation is limited. It will cover areas that I set out earlier. The allocation is £5 million down on the previous year. There is £188 million in core capital, and £52 million of that is for elective centres.

The level of backlog maintenance has come down between 2015 and 2017, which is the year for which we have the most recent figure. However, it remains a significant area in which we need to work with our health boards. Although we have made some commitments on new capital spend, we need to work with health boards on backlog maintenance and the risk profile in relation to that—about 10 per cent is considered to be high risk. That is an area of significant focus in which we are undertaking work with the boards.

Anas Sarwar: My guess is that, given that you will want to expand capital expenditure in some areas, the allocation of capital investment in the budget will not address the high risk that has been identified. Do you expect all the high-risk maintenance backlog to be cleared in this financial year? If not, when do you expect it to be cleared?

Jeane Freeman: The core element of the capital budget covers maintenance, and the priority is to address high-risk maintenance areas. We expect such areas to be addressed in this financial year, and we will work with boards to ensure that that is the case.

We then move down the priority list to significant-risk areas. Once we have completed the discussions with boards, we will understand better what proportion of that significant-risk maintenance backlog we will be able to address in this financial year. That will give us the trajectory.

Anas Sarwar: For clarification, do you expect the high-risk maintenance backlog to be cleared by the next financial year's report, based on the capital investment commitments that are made in the budget?

Jeane Freeman: I expect the high-risk areas to be cleared.

Anas Sarwar: Excellent.

An issue that comes up constantly in my exchanges with Mr Gray in the Public Audit and Post-legislative Scrutiny Committee is organisational reform, as does service reform. I will focus on organisational reform for a moment. There is a direct link between how the organisation is run and its delivery in terms of budgets and maintenance. Lack of leader figures and the lack of adequately skilled individuals to run, or be chief executives of, health boards comes up regularly. What action is the Scottish Government taking to improve leadership in NHS Scotland health boards? How much of that is to do with greater integration?

Jeane Freeman: Let me deal with the last question first, before I ask Mr Gray to speak a bit more about the specific programmes that are under way, and about our discussions with COSLA on leadership in integration joint boards, which is, as you will know, an area that Audit Scotland's report touched on.

On integration, my primary focus at this point is to ensure that our health service delivers on the commitments that we have made—on mental health and waiting times, in particular—and that the service remains safe, effective and person centred.

I know—as does Anas Sarwar—that in embarking on major organisational restructuring, people inevitably take their eye off a particular ball in order to worry about and position themselves in the new world. I do not have time for them to do that. My focus in the current session of Parliament

is on delivery. What a future Parliament and Government might do will be for them to decide. They might want to build on the regional working that has long existed in NHS Scotland. That is currently part of our look at reforming delivery of services to get the best clinical outcomes. They might want to build on that or they might not. However, right now, in this session, I have no intention of reorganising the structures of our health boards, because I need everyone to be focused on delivery.

Anas Sarwar: I agree with that. I think we would all agree that the focus has to be on delivery.

We accept that there are challenges around leadership and getting adequate numbers of people to fill the roles that are required. Do you envisage more shared roles across health boards—more shared financial officers, for example—and more skills training for individual health boards in how to manage their budgets—on looking at brokerage issues, for example?

Jeane Freeman: We already have some of that work under way. Mr Gray will talk about where that is taking place and what we are learning from it. There may be an opportunity to increase that work or scale it up, but that is about using the resource that we have effectively so that everyone keeps their eye on the delivery ball. I will let Mr Gray pursue that issue.

Paul Gray: Let me deal first with the point about adequate numbers. The cabinet secretary has just appointed chairs to NHS Grampian, NHS Western Isles and NHS Dumfries and Galloway. When people have said that they are leaving, we have gone through the appropriate processes and new people have been appointed. We have just appointed a chief executive to NHS Highland, who will start at the beginning of February. The board has an interim chief executive for one month. As I tried to do when I previously appeared before the committee, I want to make it clear to you that, with the cabinet secretary, we plan ahead for what is coming, and with those appointments we are showing that those plans bear fruit.

On leadership at the executive level, the committee will doubtless know from documentation that we have provided elsewhere that, for example, Alan Gray, the finance director at NHS Grampian, is also providing support to NHS Tayside. It is entirely appropriate that one of our most senior and experienced finance directors should assist another board that needs support.

As we look ahead, there is definitely opportunity for some joint appointments. There are already joint appointments with local government in Orkney—at finance director level, I believe—and similar appointments are being considered in Shetland. When a joint appointment is appropriate, it is considered. When it is efficient and makes sense, and when the experience is valuable, we make it.

I will not go into too much detail about leadership development today. I can send the committee details of project lift, our leadership development programme, which has recently been implemented to ensure that we develop not only the leaders who are currently in post but those who may take up more senior positions. The Scottish leaders forum takes collaborative leadership very seriously as a core component of the learning of leaders in the public sector for precisely the reasons that the cabinet secretary mentioned. This is not all about structure; it is about how people lead and how they can lead across boundaries.

The ministerial steering group, which is co-chaired by the cabinet secretary and the COSLA lead for health and social care, will meet shortly and will consider the recommendations that are being made to it on the further development of integration. Leadership will be considered within that area—again, that is about joint leadership. If we take our eye off the delivery ball at this stage, we are backing away from what we think is most important, which is the delivery for citizens. We would also backing be away from the importance that we attach to collaborative leadership, which is fundamental to delivering what we need.

Jeane Freeman: I will add a couple of points. We would be happy to send the committee information in addition to what Mr Gray has said about the various leadership programmes that are under way. There are other examples of joint roles—the nurse director of NHS Dumfries and Galloway is also the nurse director of NHS 24, and the finance director at the Golden Jubilee national hospital has a joint role with one of our other national boards. We will make sure that the committee is aware of where sensible joint working is under way. Of course, as that joint working is demonstrated to be effective, there is an opportunity to widen the approach.

Anas Sarwar: Let me turn the focus back to delivery of service reform. How ambitious do you want to be, how ambitious will you be allowed to be and how ambitious do you intend to be when it comes to service reform?

Jeane Freeman: That is a suitably open-ended question, Mr Sarwar—thank you very much. I think that I am pretty ambitious. You ask how ambitious I will be allowed to be—I am not sure who might stop me, unless Parliament disagreed with what I wanted to do.

Members will be familiar with the idea of collaboratives and quality improvement and how we undertake that work. Something that has struck

me, which will not be news to anyone, is that, across the piece, not just in health—I think that it is a 20-year-old tradition in this place—we have an overfondness for pilots, which I do not share. We have some excellent examples of good reform in the delivery of services—reform that is led from the ground up by clinicians, medical staff and others working in our health service. I can even think of examples of reforms having been driven by our reception, porter and other staff. The reform works very well and we then cast out an optimistic hope that good practice will be shared. My intention is that good practice will be applied and we will not simply hope that someone shares it.

In the waiting times improvement plan, for example, there are a number of measures to reduce the current long waits in a sustainable way so that we do not return to a similar situation in the future. We have brought into that plan the work headed up by Jason Leitch on our quality improvement programmes and the number of individuals across our health boards who have led service improvement and reform, to make sure that we can upscale that work.

We have a really good track record in that area—for example, in the Scottish patient safety programme—and I want to see that being replicated in service reform in the health service and in work with local government in relation to the IJBs. I have begun some initial discussions with Councillor Currie, who is the COSLA lead in this area, on how we might do that using some of COSLA's experience in working with Government on the children and young people improvement collaborative, for example.

The Convener: There is some good stuff here, but we need to move on after one final question from Anas Sarwar.

Anas Sarwar: Let me say—in a friendly way, cabinet secretary—that we know that you are ambitious. We also know that you are ambitious for the national health service.

Do you intend to come to Parliament with a service reform programme and try to get the support of Parliament to build public support for a reform agenda that helps service delivery? A lot of the challenges that we face are around workforce issues rather than budgetary issues. If we are to have a service that meets our workforce needs as well as our ambitions for delivering healthcare, it requires fundamental reform. Do you intend to come to Parliament with a radical reform agenda for our NHS and our health and social care services?

11:00

Jeane Freeman: At this point, the sensible thing for me is not to commit to doing that until I have continued the important discussions that need to happen with, for example, the royal colleges as well as with boards and other colleagues. I am not saying no to doing it, but it would be foolish to commit to that until I was sure that we could have a radical reform plan, in this parliamentary session, that I was confident had the support of key deliverers. I would want to bring the issue to the Parliament to have that wider discussion. There will be the recommendations on health and social care that Mr Gray touched on, and I will inform the Parliament about how we and COSLA intend to deliver on those recommendations. That is one part, but not necessarily the totality, of what we are talking about.

Brian Whittle (South Scotland) (Con): We are moving to a three-year financial planning framework. What practical changes will the move entail? When do you expect boards to be provided with indicative allocations over the three-year financial timescale?

Jeane Freeman: The practical improvement that the approach brings is that it will allow boards to look over the horizon of three years and, in some of the areas of delivery reform that Mr Sarwar and I have talked about, plan improvements in delivery and service redesign—that might not be as easy to do within a 12-month timeframe as it is to do within a 15 or 20-month timeframe—and anticipate their resourcing accordingly.

Boards can reasonably anticipate that their core funding will, at the very least, remain stable. As you know, the Scottish Government does annual budgeting, so I cannot give boards figures for anything beyond 2019-20. However, boards can reasonably anticipate where they might go in 2020-21 and so on.

On the practical improvements that I expect to see at board level, I think that, by extending to boards the flexibility for which they have asked—which will match the flexibility that IJBs have, because IJBs benefit from local authority arrangements in relation to reserves and flexibility—there can be better integrated and forward planning.

On practical changes for the Government, the approach allows for the more detailed conversations about service redesign that we have touched on. I expect to see a scaling up of improvement. The waiting times plan is a 30-month plan, so boards will be able to plan what they need to do over that 30-month period to deliver the results that I require of them.

Our financial and performance monitoring arrangements will be flexed so that we work with boards to ensure that they reach a balance at the

end of the three-year period and use the flexibility that they have in-year as judiciously as possible.

Brian Whittle: We are moving to a three-year financial planning framework. If you are unable to give health boards indicative finances with which to work, how can there be three-year financial planning? How can boards plan if they do not know how much money they will be allocated over the three-year period?

Jeane Freeman: Mr Whittle, I do not know what the Scottish Government's budget will be in 2020-21. I do not know that because the UK Government does not work to those longer terms, so we do not know what the Barnett consequentials will be or where the Scottish Government's starting point will be. The Scottish Government cannot do three-year financial planning, so, as I said, I cannot give boards figures for 2020-21 and 2021-22.

What we can say to boards is that they should anticipate that their baseline funding in 2019-20 will not be reduced when we get to 2020-21. I am certain that boards have a degree of common sense and the financial expertise that will allow them to do that.

Brian Whittle: I presume that, with the UK Government moving to multiyear financial planning, you will be able to tie things down a bit tighter.

Jeane Freeman: Even if it did so, it would be for Mr Mackay to decide how he wanted the Scottish budget to move forward.

Brian Whittle: I note that the Scottish Government has underwritten—for want of a better expression—brokerage of £151.6 million across four boards. You have said that you are looking for a break-even position over three years, but how confident are you of achieving that outcome? Moreover, for purposes of clarification, are you seeking a break-even position in each of the three years or at the end of year 3? Does that make sense? If you are looking for a break-even position over a three-year period, does that mean that you expect a loss in the first couple of years and the shortfall being made up in year 3, or are you looking for break-even by year 3?

Jeane Freeman: I am looking for break-even by year 3.

Brian Whittle: NHS Ayrshire and Arran has indicated that it will require brokerage over the next three years, which suggests that it will not reach a break-even position in three years. Will the Scottish Government underwrite that brokerage, too?

Jeane Freeman: The brokerage that it has said it requires over the next three years is a continuation of the brokerage that it has required this year. I have told it that it is not required to repay that money after this year; in other words, from 2019-20, the brokerage that boards have been given will not be required to be repaid to the Scottish Government. They will therefore start with a clean slate.

Brian Whittle: I understand that, cabinet secretary, but I also understand from what Ayrshire and Arran has said that, even if it starts with a clean slate, it will require brokerage for the next three years.

Jeane Freeman: That is not my understanding from NHS Ayrshire and Arran. My understanding is that its requirement for brokerage over the next three years takes account of the fact that it needs the money this year. When it said that, it was anticipating having to pay the money back over the next three years, but that situation has now changed.

Brian Whittle: I suggest that you and I have different information and that we might need to clarify the issue.

Jeane Freeman: We might indeed.

The Convener: We are familiar with the decision that has been made on brokerage, but what do you expect to be the financial position of the boards that have not received it? Are you confident that all of those boards will continue to be able to break even on a year-by-year basis?

Jeane Freeman: Yes, I am.

The Convener: An additional related point is about monthly reports, which you mentioned earlier. My understanding is that there have been no such reports since September. Is that the current position?

Jeane Freeman: No. A monthly report was published for November, and the one for December is due to be published. What might have happened is that the website URL—as I think it is called—has changed; however, the old website directs you to the new one, where you will find the November report.

The Convener: That is great. Thank you very much.

With regard to the board performance escalation framework, one board that is not currently in receipt of brokerage but which has been identified as potentially being in an escalating position is NHS Forth Valley. Given that five boards are at stages 3, 4 or 5 in the escalation process, what steps are being taken by those boards to ensure that they reach break even within three years?

Jeane Freeman: We are due to give the committee clarity about the escalation levels—we will send that this week. Before I ask Mr Gray to respond in more detail to your question, I point out

that a board could be at a particular escalation level because of one aspect of its performance, and that aspect might not always be financial. However, we will set that out for the committee when we formally write to it.

Paul Gray: The committee will be aware from the published data that NHS Forth Valley has struggled for some time to improve its emergency department performance. On that basis, we have put a support team into the department. The cabinet secretary covered that at the annual review in December, and the chair and the chief executive are fully sighted on what needs to be done. I visited the emergency department over Christmas and new year to meet the staff and the support team that is being provided, to ensure that the arrangement is working well. It is on that basis that NHS Forth Valley is at level 3—it is not so much connected with its financial position.

The Convener: I welcome what the cabinet secretary said about letting the committee know the position in relation to escalation. Can that be included in the monthly monitoring reports in the future? Can that be accommodated?

Jeane Freeman: Do you mean including what level a board may be at in the monthly financial monitoring report?

The Convener: Yes.

Jeane Freeman: That would be sensible only if the board was at a particular level because of its financial performance. That would allow you to look at financial performance and whether the board was at a particular level. Would that make sense?

The Convener: The committee is keen to understand the position in relation to financial performance.

Jeane Freeman: Yes.

Miles Briggs (Lothian) (Con): I want to look at NRAC targets and NRAC funding of health boards. Why have the cabinet secretary and the finance secretary not used the fact that our NHS is receiving record additional consequential funding as an opportunity to finally end the underfunding of some of our health boards?

Jeane Freeman: Although we have received additional consequential funding—and this Government has made up the shortfall—there are still difficult decisions to make. As I said, we will award £23 million—if I recall correctly—to ensure that no board is further than 0.8 per cent away from NRAC parity. At this point next year, we will be continuing to look at what further improvements we can make, but I think that that is a reasonable position for us to take this year.

Miles Briggs: The percentage increase that is being delivered to boards by the budget is under the percentage increase in the overall budget. In my Lothian region, that equates to £11.6 million less to deliver the same level of services. The cabinet secretary and I have had a number of conversations about services that are delivered in Lothian, including in relation to delayed discharge, with 40 per cent of all delayed discharges in Scotland occurring in NHS Lothian. What is the impact of underfunding NHS Lothian by £11.6 million on the health board's ability to meet the targets that the cabinet secretary has set?

Jeane Freeman: I do not recognise the numbers that you are talking about at all. For the current year, the increase to boards for front-line services was 3.7 per cent, and in 2019-20 it will be 4.2 per cent. In addition, as I have set out, significant additional funds are going into the waiting times improvement plan and mental health, and an additional £120 million is being transferred from the health budget to integrated services, in addition to the money that health already puts into such services. Addressing the issues that you rightly identify, which need to be addressed in Lothian as they do elsewhere, will be supported by the additional resource. Delayed discharge in particular is an area in which the work of IJBs is critical. My understanding is that the Edinburgh IJB's work in that area has shown significant recent improvement in reducing the level of delayed discharge. I am happy to send you that information if it would be helpful.

I think that both the local authority and the health board recognise that there is a particular additional pressure in Edinburgh, due to the Edinburgh economy and the level and attractiveness of the wages that are available. The health board and the local authority provided additional funds in order to be more competitive in the local labour market, which is precisely the kind of flexibility that integration should permit and that we should see realised, in order to address particular local pressures.

As you will understand, I am not in any sense making light of the particular pressures that are faced in Lothian or those that are faced elsewhere across the country. There is a core of issues that are the same, and there are some differences from one area to another. However, my starting point is that I do not recognise the figures that you have used.

11:15

Miles Briggs: The figures are from the Government and are in our briefing document, which points out that NHS Lothian's funding is £11.6 million distant from parity with other boards. NHS Lothian is being asked to deliver the same

level of services and is home to a number of national services, so there are additional pressures. Specifically on NRAC targets, is the Government still committed to delivering the parity that you have outlined? Given that Lothian provides national services, that creates additional pressures. NRAC funding also takes into account student numbers, and we have growing numbers of students in Lothian, which is welcome. Is NRAC fit for purpose for NHS Lothian in the future? Given that the board has the highest percentage difference from parity, with an effect of £11.6 million, will you look at the issue again so that NHS Lothian can receive fair funding?

Jeane Freeman: NHS Lothian received, under NRAC, an adjustment of plus £7.7 million.

On the overall question of the NRAC formula, a number of parts of the country would argue that it does not particularly work for them in every respect. I am certainly open to discussion about the formula and whether it continues to be as fit for purpose as we need it to be. Like all formulas, even if we look to make it as good as we can make it and to take account of all the differing demands, from Shetland to Lothian to Dumfries and Galloway, some boards will nonetheless feel that it works better for them than others. We should not set about the discussion thinking that we will find a way of reviewing and revising the NRAC formula so that everyone will be happy at the end of the process. However, I accept that more work needs to be done.

Miles Briggs: I welcome that, and I hope that the committee will be able to look at the issue further.

I want to give you an opportunity to outline how preventative spend in your budget will be developed in the coming year. Specifically, will additional funds be made available for the development of the respiratory action plan? The Government has said that it will be published later this year, but there has been no financial commitment to that.

Jeane Freeman: Where we have made commitments to publish plans, such as with the respiratory action plan, if there are financial requirements as part of the plan, those will be funded. There is no point in producing an action plan if you do not produce the resources to deliver on it.

The Convener: When do you expect the review of integration that is being undertaken by your ministerial strategic group for health and community care to be completed? Will the review be made public?

Jeane Freeman: Mr Gray is probably best placed to answer the question about the timeline, given that he and Sally Loudon from the Convention of Scottish Local Authorities are the joint chairs of that review.

Paul Gray: The ministerial strategic group will meet towards the end of this month—I will provide the exact date later, so that I do not get it wrong. At that meeting, Sally Loudon and I will present to the group the recommendations that have come from the review that we have carried out. As far as I am aware, the paperwork for the ministerial group is in the public domain, so there would be no difficulty whatsoever in sharing with the committee not only the recommendations but the views of the MSG in early course.

Jeane Freeman: That should mean that, at some point—I anticipate that it will be before the February recess, which is about the middle of February—we will be able to provide you with the review's recommendations and the views of the ministerial strategic group on how we intend to follow that through and implement the recommendations.

The Convener: Excellent—thank you. When do you expect the integration authorities' budgets for the coming financial year to be finalised?

Jeane Freeman: We expect that to be done in March.

The Convener: You will know that one of the things that our pre-budget report focused on was the requirement for integration authorities to report budgets against outcomes. I know that you shared some of the concerns that the committee expressed. Do you expect any development on that front in the coming financial year?

Jeane Freeman: Mr McCallum might want to say a bit more about that. Our senior finance officials are working with the IJB finance officers to look in a bit more detail at how that might be implemented.

Richard McCallum: IJBs publish annual performance reports, including a financial report. They need to be published within three months of the end of the financial year.

On the basis of the 2018-19 financial year, we are keen to see what progress has been made against some of the outcomes that we have talked about, whether in mental health, primary care or alcohol and drug partnerships, where we are starting to see some things being delivered. Those annual performance reports will be crucial in the coming years.

We also have a finance development group, which is looking at some of the more complex finance issues in integration. We will use that group to get into how we can budget more effectively so that we can see some of those outcomes being delivered. There is scope for more of that.

The Convener: That is helpful. We are still awaiting the financial information from quarter 2 of 2018-19.

Richard McCallum: I think that the problem might be similar to the one with the health board information. The information has been published and is available.

Emma Harper: I am interested in set-aside budgets. I have asked questions and sought clarification on the purpose of set-aside budgets previously at committee. They are sometimes referred to as unscheduled care budgets or budgets that are retained by NHS boards for larger hospital sites that provide both integrated and non-integrated services.

The committee took oral and written evidence that set-aside budgets are not quite working as intended and might even be hindering some integration. Could any action be taken, or is there any intention to take action, on set-aside budgets? Do you agree that they might be hindering integration? Are management changes to the set-aside approach required?

Jeane Freeman: I am familiar with that concern. Councillor Currie from COSLA has raised it with me, and he and I need to consider a number of areas of the operation of IJBs in relation to their financial position. We have begun to do some of that consideration, which includes looking at what are referred to as set-aside budgets.

Set-aside budgets come under the IJBs' remit, but I appreciate that, in some circumstances, some IJBs do not feel that they have the degree of commissioning authority over the funds that they should have. The picture is disparate across the country, as it is on other integration matters. The Audit Scotland report is a helpful starting point because it talks about where there is good leadership—to return to Mr Sarwar's point. When leadership works well, we do not see some of the issues around which budget is where; instead, we see a strong focus on the quality and appropriateness of the service and how it is delivered in a way that achieves the best outcomes for individuals.

We have begun to work with our chief officers and COSLA to help all IJBs get to the position that the better ones have reached with outcomes and the approach that they use. Part of that work will involve looking at whether there are mechanisms that we might usefully tweak, in terms of not only set-aside budgets but the outcomes that we expect to be delivered from the funds that go from health, directly or via local government, into IJBs. Some IJBs have significant reserves that are not earmarked, which they have been carrying for some time, so we will also consider what the most appropriate use of that additional resource might be. That discussion, which was initially between Councillor Currie and me, will continue, and we will look to reach a resolution before the start of the 2019-20 financial year.

David Torrance (Kirkcaldy) (SNP): The committee has heard concerns about the operation of regional planning boards and the way in which the boards interact with NHS boards. When will the regional delivery plans be made available? Are the lines of accountability considered to be working effectively in the context of integration of health and social care and regionalisation?

Jeane Freeman: The draft regional plans are currently being discussed with local stakeholders. When that exercise is complete, the plans will be returned to me with comments on any adjustments that are required, and I will review the plans. I expect to be able to publish the plans in this financial year, so that people are clear about where we are going in the next financial year.

There might be concerns or confusion, but accountability is clear: health boards and IJBs are accountable for what they deliver. The idea of regional working is not new in our health service, and the aim of the regional plans is to see where we can build on the experience of regional working in previous services in order to improve the quality of outcomes for patients, either in those services or in other areas. If boards or chief officers require further clarity on accountability, I will be very happy to provide it—although I think that the issue is pretty clear.

David Torrance: What will be the benefit to the NHS of the £700 million investment in health and social care integration?

Jeane Freeman: In Parliament, it is widely agreed that use of the acute hospital setting is absolutely appropriate when there is a clinical need for it. The majority of people in Scotland—me included—want healthcare and social care and support in their own homes or the most homely possible setting. The right direction of travel is to shift the balance of care and to integrate health and social care. The additional resources that we are putting into that are designed to support integration further and to drive its pace.

That is significantly enhanced by the work that is under way in primary care, a core component of which is the new GP contract and the proposition on GP clusters. Our general practitioners will be recognised and given the status that they should have as the expert clinical generalists working with a team of multidisciplinary professionals to provide appropriate care for individuals based on their particular health needs. That is a core element of the reform in primary care and is, in itself, a significant driver of integration.

At the end of the day, as we touched on earlier, one of the fundamental principles behind integration is that the individual who requires, is entitled to and should expect high-quality health or social care should not be troubled about whose budget pays for that care: they should simply receive the care that we have set out as being what we want to deliver. Questions about accountability, governance and budget are important, but they are important in that they underpin delivery. Of course we should pay attention to those questions, but the bottom line is that people should get the care and support that they need, and which we have committed to delivering.

11:30

Emma Harper: I have a supplementary question that will pick up on David Torrance's question on social care. In the draft budget, how much has been allocated to free personal care for the under-65s? I am interested to get that figure out there.

Jeane Freeman: We have, in the draft budget, committed £30 million, which is clearly vital to delivery of care for under-65s. We decided on that amount in consultation with COSLA, based on our estimated figures, which included an estimate for implementation of extension of support.

Miles Briggs: I want to talk about the national picture on delayed discharge. When the cabinet secretary was appointed she said that she wanted to address the issue, but figures that have come out today show a 4 per cent increase in delayed discharges in November 2018 over November 2017. Given where we currently are in integration of health and social care, are you confident about how you are addressing that and that you will achieve your target in the next two years?

Jeane Freeman: Yes, I am.

Miles Briggs: Is that the case even given the 4 per cent increase on the figure for November 2017?

Jeane Freeman: I have been in post only for 6 months.

Miles Briggs: I am not blaming the increase just on you, cabinet secretary, but on your party's 11 years of government.

Jeane Freeman: In the grand scheme of things, I am just starting. I share your concern about delayed discharge because there is potentially a significant impact on the individual who is delayed—a frail elderly or other person. I know that we share that focus. I am very concerned about delayed discharge because I see that there is in some parts of our country little, if any, delayed discharge.

That takes me back to the point that was mentioned earlier, which is that we should stop just talking about sharing good practice and start applying it. In relation to IJBs, that takes me back to the very productive conversations that I have had with Councillor Currie and his colleagues in COSLA about how we can use Scottish Government and local authority good practice, which produced significant improvements for the children and young people's collaborative, for example. We must use the approach, skills and learning that already exist in the health service and local authorities and apply that good practice, rather than simply talking about it.

I accept that there are different local pressures for IJBs in different parts of the country—we touched on that earlier with specific reference to Edinburgh—but I do not accept that there are significant differences in individuals' or patients' needs that would account for differences in delayed discharge rates, or that there are significant differences in funding demands, requirements or allocations that would account for the differences. I have little patience in relation to the disparities in delayed discharge figures across Scotland.

Integration is a joint venture with local authorities, so I need to work with Councillor Currie—we are already doing that very productively—and with councils' chief officers. There was a large meeting of chief officers at the latter end of 2018, at which I made that position very clear. They all applauded, so I presume that they agree with me that, two years in, what we need to do is apply good practice. There is a minimum that should be required: that is my direction of travel.

Miles Briggs: You might need to listen more to those who do not agree with you. Where we try to move forward with health and social care is really important. There is political consensus that the direction of travel is right, but a 4 per cent increase two and a half years in is not where we all want to go. I hope that, during the next two years, in the time that the Government has left, we can see where there are opportunities to reform health and social care, and that you will listen to voices and ideas that parties from across the Parliament have been bringing forward to tackle the issue.

I totally agree with what the cabinet secretary said at the beginning. We are talking about people's lives and we are talking about people's parents and grandparents being in hospital when they should not be there. That must change.

Jeane Freeman: You have my absolute assurance that I will listen to ideas, regardless of where they come from. I think that I have demonstrated that in the past two years. I am not averse to good idea: when they can be evidenced

and we can show improvement as a consequence, I am happy to take them on board.

Miles Briggs is right that it is always worth while to listen to people with whom we disagree and to understand the nature of those disagreements. Sometimes disagreements are hyped up as proxies for something else: sometimes it is about fear of change or protection of personal status. I understand all that, but the fact that we have such widespread political consensus that this is the right direction of travel gives us good ground to stand on.

The work that COSLA is doing with social care providers is another important area in which we are looking at a new national contract. Discussions that we have started with social care providers and others about provision of residential care are equally important. We need to look at it all in the round.

Sandra White: I want to pick up on what was said earlier. I hate to see the NHS being used as a political tool; that is wrong. I agree with integration of health and social care.

David Torrance talked about £700 million that is being put into integration. That is good news, and I hope that everybody agrees. For me, and I think for most members here, when we have to deal with cases of delayed discharge, we see that there are not enough care homes to take the number of elderly people who are being discharged. That is why integration of health and social care is so important.

That was probably a statement. I am sorry about that, but I get angry when we are constantly being attacked. We are moving in that direction and all members said that they agree with that.

I know that it is a long-term issue, but do you see improvements in the delayed discharge situation, in particular with £700 million being put into integration of health and social care? That is the absolute nub of the situation.

Jeane Freeman: I absolutely expect to see improvement from that level of investment. One of Sandra White's earlier questions was about the balance of allocation to health boards, what were described as in-year allocations, and why I think that the balance is right. It is, to put it in simple terms, important to focus on what the money buys and what effect additional resources will have. That is how the budget is framed, if you like.

The whole matter of social care homes and care at home is interesting. Some evidenced work from social care points to changing use of residential care for the elderly, with less long-term care, more respite, more short-term step-down work from hospitals, and so on. There are other ways in which the care home sector is changing, although we require to work with it on those changes.

Elsewhere in my portfolio, a major piece of work is under way on reform of adult social care. It is looking less at what we are talking about today and more at adult care more widely. It is looking at and individuals who have complex health and social needs and who require lifetime packages that are of high intensity, resourcing for that, and how we might work with local authorities to support those packages and improve their availability through a different approach to resourcing. A lot of work is being done in the area. Adult social care deserves a lot of our attention.

The Convener: Almost finally, I have a question about Food Standards Scotland, from which we heard in December about the costs that it faces in dealing with preparation for Brexit, which it estimates for the current financial year will be in the region of £1.3 million.

The budget includes uplifts from the Scottish Government and UK finance expenditure for Food Standards Scotland. Do those increases provide sufficient support for further preparations for Brexit that FSS might be required to make in the next financial year?

Jeane Freeman: The detail behind those increases is in the level 4 information. I ask Richard McCallum to talk through what the increases are for, and I will come back on the potential costs of Brexit.

Richard McCallum: There is a £0.7 million funding uplift for Food Standards Scotland for 2019-20. There are two elements to that uplift. The first is a technical accounting adjustment. FSS gets funding for impairments and provisions, which takes up about half the increase. The other half is for specific work that Food Standards Scotland is doing on animal feed. There is a budget uplift for FSS, but it is having a wider discussion with the Scottish Government about Brexit and preparations for it.

Jeane Freeman: As members will know from Mr Russell's recent statement in Parliament, the Scottish Government's resilience group is working every week. It includes key ministers—me, Fergus Ewing and others—and it is chaired by the Deputy First Minister. It also includes a large number of officials.

The group is considering the preparations that will be required in the event of a no-deal Brexit and Brexit with a deal. For my portfolio, it is looking at preparations in respect of supply of medicines and medical devices and other matters. As we work through the detail of that and what we anticipate will happen, additional costs might be identified for this or the coming financial year, so we are working with Derek Mackay so that we take

as many precautions and make as many anticipatory planning decisions as we can.

The Convener: Thank you, cabinet secretary. There are important policy areas that time has not permitted us to address this morning—sport, alcohol and drugs, and mental health, among others. We might drop you a line with those questions: it would be helpful if you could respond to them before the Parliament debate in two weeks.

Jeane Freeman: Yes—of course.

The Convener: Thank you.

11:43

Meeting continued in private until 12:00.

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