The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 9 June 2015

Session 4

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HEALTH AND SPORT COMMITTEE
19th Meeting 2015, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Mike MacKenzie (Highlands and Islands) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Dennis Robertson (Aberdeenshire West) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Lindsay Bedford (NHS Tayside)
Dr James Cant (British Lung Foundation Scotland)
Sheila Duffy (ASH Scotland)
Marion Fordham (NHS Western Isles)
Celia Gardiner (NHS Health Scotland)
Katy Lewis (NHS Dumfries and Galloway)
Derek Lindsay (NHS Ayrshire and Arran)
David McColgan (British Heart Foundation Scotland)
Mark White (NHS Greater Glasgow and Clyde)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

The Mary Fairfax Somerville Room (CR2)

Scottish Parliament

Health and Sport Committee

Tuesday 9 June 2015

[The Convener opened the meeting at 09:54]

NHS Boards Budget Scrutiny

The Convener (Duncan McNeil): Good morning and welcome to the 19th meeting in 2015 of the Health and Sport Committee. I ask everyone to switch off mobile phones, as they can interfere with our sound system. People may notice that some committee members are using tablet devices instead of hard copies of the papers.

The first agenda item is an evidence session with directors of finance from five national health service boards, as part of our NHS boards budget scrutiny. We have with us this morning Mark White, director of finance for NHS Greater Glasgow and Clyde; Derek Lindsay, director of finance for NHS Ayrshire and Arran; Lindsay Bedford, interim director of finance for NHS Tayside; Katy Lewis, director of finance for NHS Dumfries and Galloway; and Marion Fordham, director of finance for NHS Western Isles. You are all welcome. We appreciate your attendance.

We delayed you a bit this morning because we were having a pre-meeting briefing. We struggled with our papers over the weekend, because there seem to be such a lot of performance targets and data—we struggle with that, but you deal with it on a daily basis. You may be able to help us with what we tried to understand during our brief discussion this morning by giving an evaluation of how that data drives improvement, what is useful and what is less useful.

The papers and questionnaires that we have been studying show that there seems to be a lot of data collection and performance targets, some of which are important because they drive the way health boards act—not always in the interests of a business plan, it would seem, because you could be driven in directions that take you away from your business plan.

After all that, my question is: how important are performance targets, which ones are not important, what drives health boards' performance, what drives improvement, and is the data that is collected useful to health boards, to the general public and to politicians such as us, who are trying to establish what is going on in the service?

Does anyone want to take those 15 questions? I would appreciate it. Derek Lindsay blinked first.

Derek Lindsay (NHS Ayrshire and Arran): There are a number of performance targets. The main ones that boards are measured against and on which our local delivery plan is based are what used to be called HEAT—health improvement, efficiency and governance, access and treatment—targets, of which there is a limited number. Those targets drive the investment that is required, at least to an extent.

For example, in Ayrshire and Arran we invested an additional sum of about £1.8 million in the treatment time guarantee, which was introduced a couple of years ago. We invested in orthopaedics, for example, because that was the main area where the treatment time guarantee was being breached for patients. A target can therefore drive performance. More recently, the four-hour target for accident and emergency has led to significant investment. There is increasing demand, and we have had to invest to manage it. I would say that performance targets have a direct relationship with some areas of investment for boards.

Mark White (NHS Greater Glasgow and Clyde): In answering your main question, convener, which was whether the performance targets are useful, I would add to Derek Lindsay's comments by saying that they absolutely are. You touched on the fact that there is a huge range of them, so invariably some of them will be more important than others, and we base the business investment decisions that affect our day-to-day operations on the targets that are deemed to be more important. As Derek Lindsay said, over the past several years, those have tended to be the targets that relate to the treatment time guarantee, A and E waiting times, delayed discharge and so on.

My answer to the question is yes, the performance targets are useful: they are useful to the public and they are useful to us in making our investment decisions and in the day-to-day running of our operations.

10:00

The Convener: I have another question—it is not necessarily directed at Mark White. Do targets dictate your investment decisions in a reactive way or in a planned way? That is what we are trying to get at.

We are part of the problem with A and E: if boards miss a target, there is pressure from the public and from politicians. As politicians, we know that we need to reduce the demand that is going into the hospital and to speed up the stuff that is coming out. We are talking about community investment, which would reduce some of the demand on your hospitals. Are your decisions reactive? Does continuing in that way meet the

needs of the business plan over a longer period of time?

Derek Lindsay: Can I come in on that?

The Convener: Certainly. I am happy to give the other witnesses an opportunity to come in, too.

Derek Lindsay: Most of the targets that I have mentioned tend to focus on acute services, so shifting the balance of care may not be the major focus there. There is an issue with how tight the targets are and whether there is flexibility in them. The law of diminishing returns applies: in order to get to 100 per cent, we would have to invest a disproportionate amount.

One such example is waiting list initiatives. Our normal workforce capacity is able to deliver on the targets—we are, I hope, staffed at a level at which we would normally expect to be able to deliver on them. However, if we have unusual levels of staff sickness or operational difficulties, we have to invest a disproportionate amount to catch up again through things such as waiting list initiatives.

Having flexibility around some of the targets—either so that we do not need to meet them all the time, or so that the target that we are aiming at is only 90 per cent rather than 100 per cent—means that we do not have to invest at a premium rate to catch up in some areas.

Marion Fordham (NHS Western Isles): When one is considering the benefits of doing something new or differently, it gains added impetus if there is a benefit in terms of achieving one of the national HEAT targets. That can lend weight to the argument for doing something, but it is not necessarily the only driver.

In the Western Isles, we are often affected by another point to do with the targets: because we deal with such low numbers, it does not take many variations to make a big percentage difference. We then look like an outlier when really only one or two patients are involved.

The Convener: I saw that you made that point in your submission.

Katy Lewis (NHS Dumfries and Galloway): I want to reflect on the position in Dumfries and Galloway. Although the targets affect some of our investment decisions, particularly—as Derek Lindsay said—the TTG and our unscheduled care pathways in the emergency division, we have endeavoured to get a balanced acute system to ensure that demand and capacity are managed and that we do not experience peaks and troughs in demand.

Some of the investments that we have made are about seeking to get that level of sustainability in the system. The ambition of an acute system should be to get the balance right between managing demand downwards to some extent while ensuring that we have the capacity to meet demand.

Lindsay Bedford (NHS Tayside): As Derek Lindsay said, flexibility is important, rather than boards having to achieve the targets 100 per cent of the time. We all recognise the pressures that boards face over the winter period, which puts additional pressure on their ability to deliver and sustain the treatment time guarantees during that period.

The Convener: I want to put one question to you all on an area that the committee is interested in. Derek Lindsay mentioned that disproportionate investment was needed to meet targets. What does it cost boards to get from 90 to 95 per cent, and from 95 to 100 per cent?

I sometimes ask myself what the difference in cost is when someone gets an elective procedure done on a Friday rather than on the following Monday. The committee would like to get some idea of the impact in terms of cost, as we do not always hear about that when we talk about targets.

Derek Lindsay: Consultants are generally paid about three times the usual rate to do a waiting list initiative, so if we ask a consultant who works a normal working pattern to come in and do a waiting list initiative, we pay them three times their usual rate. Using the private sector to increase our capacity is also more expensive than having our own in-house provision. I do not have figures to show how much it would cost to move from 90 to 95 or 100 per cent, but as a general rule that is the scale of difference in salary costs.

The Convener: As financial directors, you must know what it costs you and your board to meet those demands.

Derek Lindsay: In Ayrshire and Arran, over the past few years, we have spent about £3 million per annum on waiting list initiatives. Some of that will not necessarily be spent on orthopaedics; it could be spent on radiology capacity, because we have vacancies there, but we are spending roughly £3 million a year on waiting list initiatives.

Mark White: We have been focused on our A and E waiting times. It is difficult to give a direct answer to the question of how much it has cost to move the percentages, but to give an example, we spent an extra £5 million over the winter to give ourselves that breathing space while trying to meet the target. It is not always a case of being able to split the cost down. To achieve an improvement in A and E waiting times, we have to have support beds, staff and a whole range of things in place, so it is complicated to work out exactly how much it costs to meet the target, because it is part of a wider picture.

As Derek Lindsay said, you can break the costs down into particular initiatives, and you can put sums on particular areas where there has been a specific drive, and for Glasgow there was an extra £5 million just to get us through the winter.

Marion Fordham: If we look as if we are going to breach the TTG, for instance, the incremental costs for us can be enormous. We might end up having to send patients away to another board where we do not have a contract, which we could pay quite a lot for.

The Convener: I suppose that it comes back to the original question. If you do not understand that detailed cost now, it makes it difficult for you to argue for the flexibility that would allow you to make savings that could be invested in the community, which would prevent the same issues from arising next winter. If some of that money was diverted to reduce the demand, you would not have to pay as much. Could Mark White repeat the figure that he gave?

Mark White: It was about £5 million specifically for last winter, and I have planned for a similar amount next winter.

The Convener: Is that additional? Is it on top of other costs?

Mark White: It is on top of my day-to-day spend. As I said, the money is predominantly focused on A and E waiting times in Glasgow. It is very challenging: it is a demand-led service and it is hard to predict what the pattern of attendance will be. In Glasgow, we have been more successful in meeting the TTG target, but it is difficult to put a range on our spend on our A and E waiting time targets, although we can allocate some money to them and we hope that it will have an impact.

Mike MacKenzie (Highlands and Islands) (SNP): It strikes me when I look overall that, with some exceptions, there seems to be a remarkable convergence of the data for the targets and some of the health outcomes—so much so that the scale of some graphs in our papers has had to be expanded in order to amplify the differences. In deciding on allocations within your budgets, have finance directors seen that particular areas are doing well, against the Scottish average, and therefore reduced expenditure on those areas and put it into other areas that are not doing so well? If so, has that driven that remarkable convergence over a long period, despite the fact that in some areas—for example, the Western Isles—there is a huge amount of fuel poverty, the health effects of which we know about? This is just a general question, but is that driving a race to the bottom—to the lowest common denominator—rather than a race to the top, in which health boards that do particularly well in certain areas set a standard that the others strive to reach? Is the average the lowest common denominator?

The Convener: Are the data comparable across the health boards? If not, why not?

Derek Lindsay: We all have the same targets, which is the first thing that would drive us all towards being similar. If we did not meet those targets, the Scottish Government, which manages our performance, would want to know why and would provide support teams to help with that. There is also sharing of best practice; if one health board is able to deliver good performance in an area through innovation, we try to share its practice. I hope that there is a drive towards best practice and learning, rather than there being a race to the bottom.

Katy Lewis: Over the past year, NHS Dumfries and Galloway has performed strongly in its emergency department and its A and E waiting times. The fact that we have exceeded the 95 per cent target is partly down to our having ensured that we have a sustainable system. We have reduced our emergency department waiting times and we are trying to establish a system in which the situation is fixed not just for today but for the future. The move towards a target of 98 per cent will be challenging, but it is right that we, in conjunction with clinical teams, patients and so on, set a standard to which we all aspire. We cannot set the standard too low—we would not want to move back from the target of four-hour waits for patients in our system.

Lindsay Bedford: NHS Tayside has been a front runner in accident and emergency waiting times, and we have probably regularly achieved the 98 per cent level, not the 95 per cent target, over the years. We have had a significant number of visits from other boards to look at the model that we have in Tayside. We invested in the accident and emergency service two or three years ago, but we still have challenges around treatment time guarantees, so we are looking at what other boards are doing in order to see how we can improve our performance.

Mike MacKenzie: Perhaps I did not articulate my question as well as I might have done. I am not talking solely about targets; I am also talking about outcomes. The committee's inquiry and the questions to which you have responded in your written submissions touch on outcomes as well as targets. I am struggling to come to terms with the fact that, although you all deal with different social demographics and social economics—matters that are often largely outwith your control, and that drive different health problems in different areas—there is a remarkable convergence when we look at outcomes and the achievement of targets. How do you feel about the general approach? Is it

contriving to create a situation in which the good becomes the enemy of the best?

Derek Lindsay: One of the three outcomes that you picked is emergency admissions: the survey report contains a graph that shows among boards in the west of Scotland a trend of there being more emergency admissions per 100,000 of the population than happen in boards elsewhere. That is partly about socioeconomics, deprivation and patterns of presentation at A and E departments. There is also something about the model and how we deal with patients and respond to demand. As Lindsay Bedford mentioned in relation to NHS Tayside, their general practitioner assessment model is being followed and copied by a number of health boards, including NHS Ayrshire and Arran.

10:15

Mike MacKenzie: That takes me neatly on to my last question, which concerns the wider approach to health problems that is indicated by the integration joint boards. I notice that there has been a huge range of percentage contributions from health boards to the integration joint boards. On what basis do you calculate what proportion of your budgets you put into the integration joint boards? There is a big spread in the range of contributions from health boards.

Marion Fordham: We are quite different from some of the other boards in the approach that we have taken. NHS Western Isles decided that it wished to put the minimum that it could into the integration joint board. However, the figures that the committee received in the response have now changed. Following feedback on the integration scheme we have included more services. Our percentage contribution is now comparable with that of some of the bigger health boards, although it is not as much as boards such as NHS Dumfries and Galloway.

Mike MacKenzie: On what basis did you make the initial decision, and on what basis did you change your mind?

Marion Fordham: There was apprehension about losing control of some of the acute services that we manage.

Katy Lewis: In NHS Dumfries and Galloway the entirety of the acute services and a range of other clinical services are included within the integration joint board. That is everything that currently sits under our chief operating officer within health, who is also the chief officer designate for integration. One reason why is that our being coterminous with our local authority allows us to do that. Not all health boards are able to do that because of the way that partnerships are created.

We were keen to maximise integration across the whole patient pathway, and not to break down acute services into unscheduled care and the like; we were concerned about getting the greatest benefit out of integration by having full integration. As Marion Fordham said, that is a bolder decision than other health board areas have chosen to take. We took that decision through discussions within the health board and within the local partnership about what would be the right thing to do, remembering that the focus of integration is improvement of services to patients.

Derek Lindsay: Both NHS Tayside and NHS Ayrshire and Arran have three health and social care partnerships within their areas, and Glasgow has five or six. Something about the synergies of acute services means that it would not be appropriate to split the whole of the services three ways in those boards —there are synergies in how they are delivered.

It is perfectly understandable that NHS Dumfries and Galloway has looked at its acute services in totality; however, the local authority boundaries in other health board areas make doing that more difficult because we would have to consider splitting them up. NHS Ayrshire and Arran has two district general hospitals in our three council areas. We have devolved the whole of mental health services, primary care and all our community hospitals to the integration joint boards, but the main district general hospitals are retained within the health board, with the exception of some of the emergency services that they provide. The emergency services are in what is called the set-aside budget and are subject to the strategic plans that are prepared by the integration joint boards. Those allow some movement of money between hospital and community.

Lindsay Bedford: NHS Tayside is in a similar position to NHS Ayrshire and Arran. The report that the committee received shows that the percentage of NHS Ayrshire and Arran's overall budget is 52 per cent—it is 54 per cent for Tayside. We have three local authorities in NHS Tayside, and we are dealing with the shadow integrated joint boards.

For exactly the same reasons as those Derek Lindsay highlighted, at this stage, given the complexities of acute services at the Ninewells and Perth royal infirmary sites in particular, we have focused on delegating down the older people and adults budgets, which sit within our current community health partnerships. That brings in mental health, as well as the community hospitals.

Mark White: I return to your initial question. We are still finalising our budget. I, too, have been examining the percentage splits in order to find out where NHS Greater Glasgow and Clyde sits. In

direct answer to your question, it is very much to do with the mix and range of services that boards delegate to the IJB, which varies for each board.

In primary care, the complexity is largely to do with acute services; the challenge is in determining the range and boundaries of the spectrum of services to which boards allocate. It is difficult to compare like with like; there are common themes, but it is a difficult situation. That is accentuated in Glasgow, where we are dealing with six partnerships. I understand the question, and that is the broad answer as to why things are so different.

The Convener: I will go back to a matter that we discussed earlier. Your approach is understandably cautious, because you have to deliver all the acute services and to worry about all that, but we have a policy that is, I think, generally accepted by the committee. The 2020 vision is that more people will be treated at home, closer to home or within the community. Is the cautious approach that you are demonstrating consistent with a plan that will mean that the healthcare of more and more people will be delivered in community settings, rather than in acute hospital settings? What type of planning is in place to get us there in five years or beyond? Are you just working year to year?

Derek Lindsay: Strategic plans are being prepared by each of the three integration joint boards in NHS Ayrshire and Arran, in consultation with the health board. The IJBs do not just focus on community services; they also deal with the emergency and elderly services that are delivered in the acute hospitals, so there is an opportunity for the integration joint board to propose a shift in the balance of resources.

The three chief officers from the health and social care partnerships sit on our corporate management team and input significantly to our discussions. They reflect on the demands on our acute hospitals, which are increasing because of demographics. Although, initially, the thinking was that we would be able to take money out of acute services and transfer it to community services, we have to prevent people from going into acute services, which are demand driven at the moment. A balance has to be struck between investment in the community and the increasing demand on acute services.

Mark White: The question is a timely one. As Derek Lindsay mentioned, the strategic plans for each of the IJBs are drafted; to answer the convener's question, they very much focus on the themes of the 2020 vision: early intervention and treating people at home or in the right community setting. That is very much exercising the process at the moment.

As Derek Lindsay said, moving funds from acute care and elective and emergency surgeries to more preventative action is complex, but that is very much the purpose of IJBs and is where the focus is at the moment. The challenge will come in how we will measure outcomes from the IJBs. That work is in train, so that we will have a suite of performance indicators and so that, in however many years' time, we can look back and determine what the flow has been and whether the allocation of resources has been working.

Lindsay Bedford: The forerunner to the process was the integrated resource framework, which is about developing the datasets that will at least allow local communities and areas to understand the resources that they consume. Although the framework has been around for a few years, there is still an issue about understanding the data and how each individual area uses the health resource, which varies across the piece. Clearly, NHS Tayside covers an urban area and a rural area, so the population's use of health resources varies significantly across the area.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Convener, that leads on to my question.

The Convener: I will let you in, but Katy Lewis and Marion Fordham might want to respond first.

Marion Fordham: I am happy to do so. Notwithstanding the integration process, we do quite a lot of joint work to try to keep people out of hospital and to keep them as close to home as we can. For instance, we have a project under way on Barra to try to reprovide the services at St Brendan's hospital and care home in an innovative and joint way. We can point to a lot of joint working that is designed to keep people at home, but at the moment that almost runs in parallel with the integration process.

The Convener: The issue goes back to the targets and what drives the service. We heard earlier that, if someone is breathing down your neck and wants waiting times at A and E to go down, you will not get on to some of that preventive stuff.

Dr Simpson: I am interested in the integrated resource framework, which has been around since 2009. Tayside's Perth and Kinross division is the most advanced, in terms of what the framework is delivering. We have been at that for six years now. In my view, refining the data is critical to integration. The data ranges across the field, from data on general practice prescribing to SPARRA—Scottish patients at risk of readmission and admission—data and figures on the amount of care home use. Those are all fundamental if we are to look at the variations.

I am sorry to concentrate on Lindsay Bedford but, in Tayside, Perth and Kinross is furthest

ahead on the IRF whereas, interestingly, Angus has one of the highest levels of care home provision. That shows the variation. Understanding that and the costs that are involved is fundamental to the integration process. Are the health boards using the IRF? Do the boards and their local authority partners really understand what that is about? What effort is being made to ensure that the data is available? Unless we get the data right, we will not be able to understand the variations. Those variations might be justifiable, but we need to understand them.

Katy Lewis: Derek Lindsay talked a bit about the strategic plans that are being developed as we move to integration. Within that, there are locality plans. In Dumfries and Galloway, we have four localities. Supporting the strategic plans we have a wealth of data through the strategic needs assessment and the financial plan. That is one of the main areas in which I envisage our using the IRF to influence decisions, particularly at locality level. Over the years, we have been challenged on that. The IRF has been around for a while, and the quality of the information that we get through it has improved significantly over that period.

In Dumfries and Galloway, we have been thinking about how we involve the localities and how we get strong locality management so that they are empowered to make some of the decisions as we move forward. You are absolutely right that the localities need to understand the resources that they have, whether those are people, hospitals or money, and to have an influence on that. That is certainly one of the principles of the integration model that we have set up in Dumfries and Galloway. It is fair to say that we are still in the early days, so we are still working that through, but it is one of the work strands in our implementation of integration through the shadow year.

10:30

Lindsay Bedford: In Perth and Kinross, highland Perthshire was the pilot for the integrated resource framework. We spent a significant amount of time collating and refining the data over that period. We started to have discussions not only with general practitioners so that they could help us understand the resource profile but with the community, too.

Katy Lewis has touched on this already, but there is one area where we have always suffered. Although significant amounts of data are held nationally for in-patients and new out-patients down to individual patient level, we have at times struggled with the community data. To understand what the full resource consumption is, we need to understand the community spend at a more granular level. That is the bit that has, in part, always challenged us, although we are continuing to take forward work on that. Similarly, social work is not used to collating data in the way that we have looked to manage and corral it, and we have used the Perth and Kinross experience as a learning curve.

We can certainly transfer that knowledge to Angus. Certainly, we have significant amounts of health data from the Information Services Division database and we can provide and demonstrate the data in however many ways we wish, but we still need to think about how we take that discussion to the clinical fraternity in primary care as well as the public. Taking such a significant amount of data and helping people to understand it will be a challenge.

Derek Lindsay: For a long time now, Ayrshire and Arran has had prescribing budgets down to GP practices, and there is good visibility of all that. The IRF brought visibility to the spend on acute services for the populations within the three local authority areas. Having identified that spend and compared it to the NHS Scotland resource allocation committee share—NRAC is flexible and detailed enough to take things down to that level—we found that there appeared to be overuse by some parts of the population and underuse by others. That led to some debate on the issue, and it was a useful starting point in the move towards integrating health and social care.

The Information Services Division of National Services Scotland is now dedicating data analysts to each of the partnerships to help support the use of data, and we want to use those analysts to examine what we call high-resource-use individuals, or the relatively small number of people who have frequent admissions to hospital. If we can identify the best way of supporting those people in not being admitted and in staying in their own homes, we think that that will help with the demands on the hospital sector.

Dr Simpson: My other question is on general practice, because I am very concerned about what is happening in that area at the moment. I do not know whether the boards around the table this morning have any particular problems, but in my health board area, Forth Valley, there are three practices serving 23,000 patients that have no GP partners any more and the likelihood of at least one more practice going the same way. We know that 26 practices in Lothian—in Edinburgh, anyway—have closed their lists to new registrations, and all except one practice in Stirling have closed their lists. It seems to me that, with this shift to integration, continuing to shift things to general practice when it is clearly struggling is a major difficulty.

The share of money going into primary care has also been reduced; indeed, the colleges and the

British Medical Association bang on about that all the time. Given that, how in the integration process are you going to tackle what is a serious developing problem in general practice? Indeed, do you recognise that as the reality, or am I wrongly extrapolating from a couple of areas that I know about to conclude that the same thing is happening elsewhere?

Katy Lewis: On the facts that Richard Simpson just outlined, the position in Dumfries and Galloway is that we have around 11 vacancies in GP practices. We know that about 10 per cent of our GPs are planning to retire within the next 18 months. Our management team and our board have had considerable discussions about the options, not just for daytime general practice provision but for out-of-hours provision. If GPs are struggling to meet their commitments in daytime provision, the out-of-hours provision will inevitably suffer. We have had to invest significant amounts in locum costs to provide support.

In addition, we are not able to recruit the numbers that we would like to our GP training posts. The latest position is that we have recruited four out of 14.

There are no easy solutions. We have looked at different models of provision involving advanced nurse practitioners and other professionals supporting provision. We have a good and committed GP community in Dumfries and Galloway. The reality hits us when we see that those committed and enthusiastic individuals are being challenged. They are critical to the sustainability of the system, given the impact that they have on emergency admissions and their ability to manage people in the community.

The key thing that we have been doing in D and G, aside from looking at different models, is having almost a fundamental review of our services, particularly out-of-hours services, and looking at the national work that is on-going. We have been looking at our medical recruitment process and supporting GPs with it, which includes looking at how we advertise and how we maximise the intake that we can get locally and even looking at international candidates. Given that we are a rural area, a key thing is ensuring that we work with local partners to find jobs for candidates' spouses or partners.

I do not have a final answer for you, because this is one of the challenges that we face. We need to think about how we take things forward.

Derek Lindsay: Dr Simpson asked about the overall picture in Scotland. Forth Valley is a particular hotspot in terms of vacancies for GPs. There may be particular issues in rural areas. Ayrshire and Arran does not have as many vacancies as Forth Valley, but our age profile shows that we have a large number of GPs who are over 55 and will therefore retire in the not-too-distant future, so we are making provision for that.

In 2015-16, there is a £100 million increase in the integrated care fund, £40 million of which is identified for primary care. Therefore, that area has been recognised as a national issue for investment.

Dr Simpson: So those two funds are not separate. There is £100 million, and £40 million of it is for general practice.

Derek Lindsay: No. There is £100 million that has gone to boards for integrated care, which is prioritised by the integration joint boards. In addition, £73 million was retained by the Scottish Government, of which £40 million is for primary care. There is a total of £173 million.

I was going to give one example of where there is significant pressure on GP out-of-hours provision in Ayrshire and Arran. We had issues getting a GP for the Isle of Cumbrae, particularly if the GP then has to do out-of-hours work. We are using a team of advanced nurse practitioners. They are not just based in Cumbrae but rotate between Crosshouse hospital and Cumbrae so that their skills and experience are kept up. We visited either Orkney or Shetland—I cannot remember which—to look at its model for using advanced nurse practitioners. We even took members of the public from Cumbrae up to see that so that they would be satisfied that the service that they would get would be appropriate. The service in Cumbrae has now been working for over a year.

The Convener: Can we broaden out the responses a wee bit? Who is responsible for the overall workforce planning for health and social care? Workforce arrangements always seem to be local and in the moment to make up for a shortage of cover for out-of-hours care—such as flying people in from South Africa, as happened in my neck of the woods. Given the context that we are talking about this morning—the planning and the spending—whose responsibility is it and who is driving the thinking about workforce planning and what the workforce will look like so that it can deliver more healthcare closer to home and in the community? Who decides whether it is 50 nurses or 100 home carers? Is any of that going on?

Derek Lindsay: Each board produces a workforce plan, I think by the end of June. All the plans go to the Scottish Government, so there is a consolidation. The issue with workforce planning is that it can take five or 10 years to train a workforce to meet a future need, so a crystal ball would be required for us to know exactly what will be required in 10 years' time. Therefore, there are national workforce planning arrangements for

things such as the medical workforce, involving deans of colleges and so forth. The inputs into the education system that are required to produce the outputs of qualified staff at the end can take a long time.

The Convener: We put in our leaflets commitments to things such as 1,000 more nurses, but that might not meet our requirements in future. We are still recruiting for hospitals and a clinical workforce, but is there any workforce planning that looks at the value of workers right down to care workers or physiotherapists, who can bring about some prevention and reduce admissions? Who is doing that?

Mark White: As Derek Lindsay said, workforce planning just now is done by the health boards. It will contain both acute and primary care staffing quotas. In many ways, that will involve what we have in the current primary care system; it is all about improving that system and its efficiency. In answer to your question, it is sitting with the health boards just now. Social work will also be doing its planning. When the IJBs are up and running next year, that will become a joint process.

The Convener: I am just drawing it out. You are dealing with the demands that you have to deal with. I am looking for a wider approach to workforce planning.

Dr Simpson: You moved swiftly on to my question, convener, which was partly about general practice. The response has been to use advanced nurse practitioners, and physician assistants are being considered as well. That is great. However, we have had quite a substantial cut in nursing student intake, which has been going on for seven years now. The midwifery student intake has also been reduced. The FY01 levels for doctors were cut, and specialist training grades were going to be cut by 40 per cent. All that happened around 2011-12. The numbers in the health service dipped—we had 2,500 fewer nurses. Those were proportionally far greater cuts than occurred in England. Then, within two years, we are back up.

I look at that and think, "Where is the workforce planning in that?" As Derek Lindsay said, we have to plan years ahead. Was the plan in 2011 to have a smaller workforce five or six years later? What was happening? How could the workforce plans that feed in locally possibly lead to the situation that we have now?

You cannot just create specialist nurses who can keep people in the community—not just advanced nurse practitioners but specialist nurses in neurology, heart failure, chronic obstructive pulmonary disease and so forth—and not have more nurses coming in at the other end to do the general nursing or nursing in general practice. How on earth can we say that we have a workforce planning system that is anything like functional?

10:45

The Convener: I do not think that anybody has said that.

Derek Lindsay: You mentioned what happened in 2011 or thereabouts. You will recall that, with austerity and the budget projections that we had, although health was protected and had a real-terms increase, we were looking at straitened times with funding uplifts of 2 per cent or thereabouts. We have seen expenditure on drugs increasing significantly in the past few years and our other main cost is staffing. We have to strike a balance between the costs that we know are going to go up and pretty static funding.

The years of austerity that were lying ahead of us were probably the driver for any reduction in the intake for professional qualifications. Other issues to do with the introduction of the nursing workforce tool, the patient safety focus and staffing levels on wards have resulted in a significant increase in staffing, certainly in Ayrshire and Arran. Those factors might have contributed to the dip and the subsequent increase that we have seen in recent years.

Lindsay Bedford: In Tayside, we have talked about growing our own workforce, perhaps not for primary care in the community but for the theatre environment. We recognise that we struggle to recruit band 5 nurses so we have looked at opportunities to develop support roles and expand the labour market. We are looking for a workforce with a completely different profile and at giving those in bands 2 and 3 the opportunity to become assistant practitioners through education and the opening up of new potential employment markets.

We recognise that there are challenges in particular areas, but we have had to think differently and recognise that we could not sustain the position that we were in.

Bob Doris (Glasgow) (SNP): In the context of workforce planning and nurse and midwife numbers, it is worth remembering that the Government announced last week record levels of NHS staff, including nurses and midwives. I put that on the record. We can scrutinise and have a well-rounded discussion about some of the figures that others have cited this morning a bit more robustly at another time and place.

I will look at budget scrutiny, which is the principal issue this morning. I apologise to Mr White, because I have concentrated on NHS Greater Glasgow and Clyde's submission. I have done a bit of comparing. For example, accident

and emergency admissions show that NHS Ayrshire and Arran has significant challenges, as does Glasgow, although some others are faring a bit better. I take on board the demography and ageing population issues.

I will refer to some of the answers that we have received. For example, when Glasgow was asked:

"What factors can help to explain any observed differences in performance?",

the answer was:

"Key factors are likely to be an aging population and levels of deprivation across NHSGGC."

The other health boards, including NHS Ayrshire and Arran, identified routes for improvement. I will not list them, because they are all in the evidence. Glasgow did not do that. More information on that would be helpful.

The question was also asked:

"How does performance against this indicator influence budget decisions?"

Glasgow's answer was:

"This is an important performance indicator and significant recurring and non recurring investment in this area has been made in 2014/15 and 2015/16."

However, there are no numbers behind that. I say to Mr White that we got numbers behind other evidence that we received.

The final response that I will refer to was to the question:

"What programmes or services are specifically aimed at improving performance against this indicator? Please provide details for the three main areas".

The response was:

"It is not really possible to give a meaningful response as it could be argued that significant elements of community services expenditure eg District Nursing, Rehabilitation etc are geared to achieving this."

The responses to that question from the other health boards had more detail. For example, NHS Dumfries and Galloway said that the issue was complex, provided two pages of information and identified budgets and budget increases in three areas, as did every other board apart from Greater Glasgow and Clyde.

I know that good things are happening in Greater Glasgow and Clyde, but I feel that it has not given us enough information to enable me, as a Glasgow MSP and deputy convener of the committee, to interrogate its figures. Maybe this is an opportunity for Mr White to say something about what Greater Glasgow and Clyde is doing to align its budget to improve its performance on emergency admissions, which is challenging. Perhaps some of the other witnesses, too, can talk about how they have prioritised budgets to meet the emergency admissions target.

I am sorry for going on at length, but we are undertaking budget scrutiny and have been given significant amounts of information by some witnesses but not very much by others. I am trying to scrutinise and compare the information that is before us. It is over to you, Mr White.

Mark White: I can answer in two parts. First, I point out that I have been in post for just under two months and that our response was submitted before I started. I have read it over the past few weeks and I would have put far more detail in it had I been in post earlier, so I appreciate Mr Doris's comment. I promise that our submission next time will be far more comprehensive.

As I said at the start, emergency admissions are an extremely challenging issue that Greater Glasgow and Clyde has struggled with. However, it is not all bad news, because we have achieved emergency admission targets in the Royal hospital for sick children and our emergency care centres at the Victoria and Stobhill hospitals, so we have pockets of good achievement.

We have significantly invested in every other part of our service. We have a number of initiatives going on, particularly at the Royal Alexandra hospital, where we have had an issue. The Scottish Government support team has visited that hospital and a number of other sites, and we have taken on board the team's comments. We have allocated directors to sites to support managers who deal with emergency care. We have just spent money at the Western general and the Royal Alexandra on discharge lounges, so we are taking steps around that. We also have a new surgical assessment area at the Royal Alexandra that we hope will help us to achieve the targets.

In the overall Glasgow picture, we have the new Southern general hospital, which has just opened. That has involved significant investment, as I am sure everyone is aware. We are looking to improve our performance significantly, particularly on emergency admissions, with the opening of the new hospital. We have a number of cutting-edge initiatives and ways of working in the new hospital that we are confident will bring our figures up and address the challenges.

I do not have specific numbers, but I am happy to provide them, if that is the committee's request. To answer Mr Doris's question, we have taken heed of the emergency admissions problem and we are spending significant money and giving it huge amounts of attention in order to resolve it.

Bob Doris: I just wanted you to have the opportunity to put that on the record. I have a habit of being grumpy on a Tuesday morning, but I am

genuinely trying to scrutinise the information that is available to us.

I mentioned challenges that Mr Lindsay's board has, but it has been quite proactive in tackling them head on.

Derek Lindsay: Yes. I want to put on the record a point about the way in which I completed the section on investment in the committee's questionnaire. I showed additional investment each year, but the questionnaire appeared to show a reducing level, although there was in fact investment in year 1, further investment in year 2 and further investment in year 3.

The "Report on the survey of 2015-16 NHS Board budget plans" that the committee received notes that for most boards there is a planned increase in expenditure but for

"Ayrshire and Arran, the reduction reflects lower spending on local unscheduled care action plans".

That is not the case. In 2014-15, we invested about £1.7 million to provide things such as GP assessment. We learned from the Tayside model, which I mentioned previously. We also introduced combined assessment—a clinical decisions unit—to allow a flow of patients through accident and emergency. There was therefore significant investment in 2014-15.

In 2015-16, we are investing another £700,000 and, in 2016-17, a further £2 million. Most of that relates to new builds of combined assessment units at the front doors of Ayr hospital and Crosshouse hospital. The capital spend on that is about £27 million. The Crosshouse unit will open in February or March next year and there is additional staffing resource as well as the facilities cost there. Therefore, NHS Ayrshire and Arran's increase in spend on unscheduled care over those three years is about £4.4 million.

Bob Doris: I am interested to know about that because, although Mr White did not have it in his submission, the two pieces of evidence that we have heard on emergency admissions show that your budgets are aligning to a strategy to reduce such admissions. Do the other three witnesses have specific budget alignment to achieve progress on that?

Katy Lewis: In Dumfries and Galloway, we have spent not only resource but a lot of time on redesigning our systems to improve our resilience over the winter because, if a system is going to be fragile or break, that is when that will happen. We have developed our local unscheduled care action plan in partnership with our local authority.

We had higher levels of admissions over the winter, but we sustained our A and E performance. Although we had an increase in emergency admissions, it was lower than the Scottish average.

Our delayed discharges have also reduced, particularly over recent months, so we have invested the money that came through the Scottish Government towards the end of the year for delayed discharge and the additional resource in year to manage some of the challenges that we have had locally. Those include challenges that relate to care home closures.

I do not have specific figures other than what is in the return, but we have invested money over and above what is included in the information that the committee has received.

Lindsay Bedford: In Tayside, we had the enhanced community care pilot, which was an attempt to stop the flow into accident and emergency and medical admissions beds. Using our unscheduled care moneys, we started a pilot over the winter—not in the previous financial year but in the one before. It demonstrated a 17 per cent reduction in admissions to wards for the four practices that were involved in the pilot as well as a reduction in the length of stay for patients.

We continued with those four pilots last winter and have now extended the approach to two areas: to Arbroath in our Angus South locality and to an area in Perthshire. We continue to believe that that will benefit not only patients but the flow into the acute hospitals and we are looking to invest further resource in that.

Marion Fordham: In the Western Isles, we have done a lot of work on a much smaller scale. This is not particularly new, but we have an initiative with the Scottish Ambulance Service in which our GPs have trained paramedics so that they can assess patients more at scenes and decide whether to admit them. We are also working with nurse practitioners to take some of the pressure away from GPs. However, investment is caught up a little in other areas of work, so teasing it out would be reasonably difficult. I do not have the figures with me, but I can try to provide the information for Mr Doris, if he wishes.

For us, the issue is more the pressures that we face—Richard Simpson referred to them—in relation to GPs and supporting the out-of-hours service, as well as the pressure that delayed discharges create. Those pressures all converge to provide a focus on working to reduce A and E admissions in any way that we can. That is more a matter of service redesign within the resources that we have than it is of additional investment.

11:00

Bob Doris: Thank you for all that, which gives us a sense of what is going on across the country.

We can prevent emergency admissions through the slips, trips and falls strategy for frail older people at home and that kind of thing, but do we count among emergency admissions someone who was in hospital for social care needs rather than for medical needs? Would emergency admissions statistics count someone if they came to A and E and it was felt that they should be admitted to hospital as a place of safety? If the emergency was a social care crisis rather than a medical one, would that count in the emergency admissions statistics? If such admissions were counted, would that help to inform health and social care integration boards in redirecting funds to integration?

Derek Lindsay: I understand that, if someone was admitted to a hospital bed from A and E for whatever reason, that would be included in the statistics. As you said, admissions can sometimes be made for social reasons. In Ayrshire, we had the frail elderly pathway, whereby we had a geriatrician at the front door, supported by social work, who tried to redirect people. We have also involved the Red Cross, which has taken elderly people to buy milk, bread or whatever they have needed to ensure that they could be resettled in their homes and could leave A and E without being admitted to hospital. It is crucial that we work with voluntary organisations and social work to reduce emergency admissions.

Another issue relates to the seniority of the medical staff who review the condition of people when they arrive at A and E. Often, we admit someone in order to carry out tests and decide whether it is safe to allow them to go home. However, if we had a senior clinician at the front door who tolerated taking a bit of risk—that would be the opposite of a defensive practice—they could judge whether, with the appropriate support, the person could go home rather than be admitted to hospital for their safety.

Bob Doris: Does anyone else have anything to add?

Mark White: I understand that the people that you are referring to would be included in the statistics. Part of the acute function is being transferred to IJBs so that people can be dealt with properly.

I will reiterate a point that Derek Lindsay made. At our new hospital, we will take big steps to have a joint medical and surgical assessment at the point of admission to get our turnaround and discharge rates up to about 40 per cent. Preventing such admissions while still ensuring patient safety and the quality of the service is a big focus for us.

Lindsay Bedford: I will add a couple of statistics. The initial pilot that we carried out saw a 17 per cent reduction in unscheduled admissions. Of the referrals to the enhanced community support service, 24 per cent were to do with falls and 26 per cent were to do with infection. That ties in with the strategy that we are following on slips, trips and falls.

Dennis Robertson (Aberdeenshire West) (SNP): We are hearing that setting budgets is a complex issue. Clinicians probably look for the outcomes for patient care, but are you driven by finance rather than other aspects? Can you divorce yourselves from the direct outcomes for patient care and look at the budgets in isolation? If so, how do you prioritise?

Derek Lindsay: The director of finance has an important role in bringing their professional judgment to bear on the value for money of different aspects. We spend about 66 per cent of our budget on staffing, about 22 per cent on drugs and about 12 per cent on other things. Is that the right balance? Can we evaluate the outcomes that are associated with any of that expenditure?

We are assisted in that by people such as health economists and by some of the research work, which shows that, by investing additionally in a certain area, we can get a better outcome. As I mentioned at the beginning, we are also influenced by the need to achieve the targets that have been set and the demand that comes from population and demographic changes.

The finance director's role is primarily about looking after the budget, but it is also about how best to achieve value for money and the right balance of spend.

Lindsay Bedford: The Academy of Medical Royal Colleges published a report in November, which was the first time that I had seen clinicians getting involved in the debate about how we use our resources effectively. The report says that 20 per cent of mainstream clinical practice provides no benefit to patient outcome, given the excess amounts of tests and diagnostic investigations. That was the first time that I had seen a report that allows us to have a better dialogue with the clinical environment, not only in secondary care but in primary care—we have talked about referral levels. To me, that report is a route to helping the clinical side and us as directors of finance to understand how the resources are being consumed and whether they can be consumed more effectively.

Dennis Robertson: You are working with directors of finance in local authorities on integration and joint care. Are you setting out

together a five or 10-year plan with regard to that integration? Also, given the efficiencies that you have to make, be they in prescribed drugs or staffing, are you working with those other directors to see where you can both make efficiency savings while protecting the levels of care for patients and for people in the community through social care?

Derek Lindsay: We have those discussions with local authority directors of finance. I have been meeting them monthly for at least a year or a year and a half in preparation for the integration joint boards and the shadow arrangements that we had in place last year. The strategic plan that I mentioned, which was prepared by the integration joint board, has a financial strategy attached to it with projections for spend, and we have inherited efficiency savings programmes from the council and the health perspective that have to be reflected in that strategic plan. We meet, and we reflect that in the strategic plan.

I hope that some synergies will emerge from the integration joint arrangements rather than our having to look after our own interests. There might be opportunities through which, by working together, we can do things more efficiently.

Mark White: I have had conversations with each of my five partner directors of finance about a number of issues related to the IJBs. We are trying to get people in posts and to work out the strategic plans and our accountancy and control framework. A range of consultation and negotiation is going on.

As Derek Lindsay said, the focus has been on working out how we can do things better. There is no denying that both parties are in a period of real restraint and will always have their own savings initiatives, but the crux is that the focus has to be on efficiencies, improvements and being able to drive the processes through to end outcomes to ensure that the IJBs achieve what they have set out to do. The focus is on improvements and efficiencies as much as on joint savings.

Dennis Robertson: Given that it is an integration process, are you looking at it year on year or are you projecting into a five or 10-year plan? It seems to me that it would be more sensible to have a long-term view. Are you taking such a view or are you just basing it on a year-on-year budget?

Mark White: We are probably looking at a five-year plan. That is based on year-to-year budgets, but we have to look at the long term, because there are longer-term goals for the IJBs. It will take time, so that is the timescale that we are probably going to base our strategic plans on, although they are still in draft at the moment.

The Convener: Is it common to have five-year plans with year-to-year budgeting?

Katy Lewis: Our local delivery plans are five-year plans. We will develop plans with that sort of timeframe. We will assess the opportunities from integrating budgets, recognising that there will be challenges and risks around that.

The Convener: How public are those plans and discussions? Is the information about the objectives and finances in the public domain?

Katy Lewis: Derek Lindsay reflected on the strategic plan and the financial plan that will go alongside that. NHS Dumfries and Galloway is still developing its plan, so it is not in the public domain yet, but those objectives and the finances will form part of the strategic plan that will be consulted on widely within partnerships.

Marion Fordham: That is what I was going to say.

The Convener: That is the common approach.

Dennis Robertson: Do you prioritise that in accordance with Government guidance or is it something that you are just doing in your localities?

Derek Lindsay: The timing issue is partly down to when the integration joint boards go live. NHS Ayrshire and Arran's schemes of establishment were approved around the beginning of April. The first meeting of the integration joint board happened in April, and it considered the strategic plan. I think that the Ayrshire strategic plans are now in the public domain. Other boards are at different stages and will have their schemes of establishment approved through the parliamentary process in 2015-16. The first thing that makes the integration joint boards live is the approval of their strategic plans. All boards will go through that process this year, on a staged basis.

Katy Lewis: I see the process as iterative. We are developing strategic plans and at the same time developing locality plans, so there will be a bit of a bottom-up process on the developments that localities might want to take forward, the things that they think might impact on service areas or any service changes that they want to implement. The same applies from a partnership perspective, with the things that we want to commission or that we think are the right things to do.

We are in the first year of integration, and the plans will evolve in the coming two to three years as we develop as a partnership and know a bit more about what we want to do and where we want to get to. We recognise that there is a performance framework that sits around integration and that there needs to be linkage with some of the performance outcomes that are expected as a result.

Dennis Robertson: Is the priority to keep more people in the community rather than have them go into acute services, which will give you efficiency savings and so might not necessarily mean a reduction in staffing?

Katy Lewis: Absolutely. We know that the models of care that we adopt in future can be sustained only by having resilience in the community. A lot of the work that we have done so far through the resources that partnerships have received from the change fund in the past three to four years has involved consideration of what those models might be and how we can develop sustainable solutions at local level.

Nanette Milne (North East Scotland) (Con): My question follows on from Dennis Robertson's questions. With regard to the last six months of care as people near the end of their lives, I was particularly interested in Tayside's approach to the rotational scheme for nurses, which involves having them work in the acute sector and in the community setting so that they get a grasp of the whole picture. That is quite innovative and is the sort of thing that will probably have to happen in all areas as the population gets older. Could Lindsay Bedford tell us what drove Tayside to start using that strategy? What challenges have you met? Have you worked out the cost benefit?

11:15

Lindsay Bedford: I am probably not in a position to respond to that question. That response came from the clinician who has been directly involved in driving forward our palliative care strategy. Clearly, we believe that it has had significant benefits for patients. No cost benefit analysis has been done yet, but I can ask about that.

Nanette Milne: It is an interesting approach and I would love to hear a bit more about it in times to come. Does anyone else have comments on that?

Mark White: The statistic on end-of-life care is interesting on its own, but it has to be looked at more broadly. We need to ensure that people are in the right setting rather than just look at the statistic itself. It is about making sure that people have a choice.

That takes us back to our initial discussions about how useful some of the performance indicators are and how much we use them. That is a perfect example of an indicator where we have to look more broadly at some of the underlying issues and factors that dictate the statistics to make sure that we are doing it right.

Nanette Milne: NHS Tayside felt that there is not really any indication of quality of care in the statistics that are being looked at. Do people have any comments on that? Is there an alternative approach that allows quality of care to be judged?

The Convener: How do we measure that?

Katy Lewis: In our submission, we mentioned our putting you first programme, which was the change programme that we developed through our previous integration resource. As part of that, we had a full qualitative assessment done to look at how the patient experience had been impacted by the initiatives that we took forward. That was much broader than the end-of-life care example that was mentioned. However, the approach has to be around understanding the patient experience and the family experience of the care that is received and being able to measure that, understand it and do something about it.

In Dumfries and Galloway, we have focused much more on acknowledging the impact that the interactions of teams with the patients that they are working with can have on the quality of care that patients receive. Ken Donaldson, our acute medical director, has been taking forward that work across the organisation and it has had a measurable impact on what we do.

Nanette Milne: My feeling is that that sort of qualitative assessment will be important as integration beds in, so that we can see whether integration is working in the interests of patients. I am sure that you will agree that we have to look at the outcomes for patients from the whole integration process—that is why we are doing it.

Katy Lewis: That is reflected in the outcomes that are set for integration and it will be measured as part of the process. It is not just about the hard numbers and facts.

The Convener: I am happy to take some supplementaries on the issue of end-of-life and palliative care, because the committee plans to do some work on that and our briefing indicates that boards have different approaches to using hospice services and how they are funded. The funding model is that local government and the NHS boards should meet about 25 per cent of the costs. Some areas are achieving that, with about 12.5 per cent of hospice funding coming from boards, but some areas are not. As regards CHAS—the Children's Hospice Association Scotland—there are the children's services that it provides and its particular responsibilities.

I do not know whether we can explore any of that. I am happy to take brief supplementaries from members over the next five or 10 minutes on the topic.

Derek Lindsay: On the funding, there is complete consistency in regard to the children's hospice because the funding is done on behalf of all boards through NHS Tayside and, as you say,

the contribution is about 12.5 per cent. The target for local hospices is 50 per cent and most boards are close to that level.

On the quality of services, given their person-centredness and small scale, local hospices offer a high standard of care to patients. Joint working with the voluntary sector is also important in palliative care. For Macmillan nurses and hospices in local areas, working with the voluntary sector adds real value.

Lindsay Bedford: We provided a table that shows the contribution to CHAS from territorial boards as well as the Scottish Government's contribution through the Diana nurses fund.

The figure that we obtain from CHAS is for its total charitable activities, and our contribution is a percentage of that. From CHAS's perspective, charitable activities means hospices, care-at-home services and outreach facilities. On health boards' current contribution, if we go back to about 2009-10, a fairly detailed piece of work used to be undertaken each year to reach an agreement on the level of funding for hospices. That was quite a bureaucratic process, which took CHAS a significant time.

At that time, both parties agreed that we were looking for a more pragmatic solution and that any baseline uplift received by health boards would flow directly to CHAS. That gave CHAS certainty about the planning cycle and the level of budget that was going to be available to it. No efficiency savings measures have ever been applied to the resource that goes to CHAS.

It is now recognised that CHAS has a significantly expanded service. With medical advances, children and young people now need much more complex clinical care, which has led to CHAS having to employ more specialist medical and nursing staff.

In 2009-10, the CHAS at-home service was a support-worker-led service, but it is now a very different model—it is a nurse-led service, which is integral to palliative care services. Many of the roles that CHAS staff undertake are not in hospices, as they go out into the community. We recognise that, with that significantly expanding service, we probably need to revisit the baseline. We might not do it every year but, perhaps every three or five years, it is appropriate to reset the baseline so that we can agree on the level of hospice funding.

In my initial discussions with CHAS's chief executive and its director of finance and administration, they have agreed to that outline proposal. I will be looking to work with the senior officials of CHAS this year to revisit the baseline and confirm the agreed hospice running costs.

Dennis Robertson: The majority of palliative care is for older people. CHAS has a conference on palliative care services this Friday in Aberdeen. Should you all be looking not just at hospices but at the community support that is there? Can you work out how much the specialist and general services cost each board? Tayside was considering a 0.7 per cent reduction in its palliative care services, which seems extraordinary, given that we are looking at expanding palliative care.

The Convener: I think that Rhoda Grant has another supplementary on this issue. I will ask the panel to respond to both questions together.

Rhoda Grant (Highlands and Islands) (Lab): My question is more about how we grow palliative care. Everyone to whom the committee has spoken has said that those in receipt of palliative care have good outcomes and have no complaints whatsoever. However, we seem to encounter problems where there is a lack of palliative care. Third sector bodies and charities seem to provide most palliative care—through CHAS hospices and the like—but we need to look at mainstreaming that provision, and in particular to have it close to home and in the community. Are there plans to do that? What would it cost, and how would it impact on budgets? Would good-quality palliative care provide savings? A lot of people at the end of life are admitted to hospital needlessly, which creates a stressful situation for them and their families.

The Convener: I have a supplementary of my own on that point. Some of the health boards were unable to give us any information about the costs of the general palliative care that they provide. Is it feasible to ask for that information? Could it be provided? Reference was made earlier to the fact that the broad information set that shows that more people are dying at home does not give us any sense of quality or an indication of whether that happened by accident or choice. Those are the issues that we are exploring.

Derek Lindsay: We have worked with local care homes on that. In the past, if somebody was nearing death, there was a tendency for them to be taken to A and E and admitted to hospital. However, we want to upskill the care home staff by providing them with training on how to support people who are dying in a way that allows them to die with dignity. We have done that in Ayrshire and Arran in an effort to minimise the number of admissions to hospital and to avoid taking people out of their homely environment and putting them into an acute environment.

Outreach services were mentioned. The Ayrshire Hospice has outreach workers who work in the community, and we fund 50 per cent of that outreach service. It is not just about people coming into the hospice to die; they can be supported well before that, and they may also

come into the hospice on a day-case basis. Joint working goes on with third sector organisations.

Lindsay Bedford: I would like to respond Dennis Robertson's point on palliative care resources in Tayside. The recurring budgets for palliative care services in both 2014-15 and 2015-16 do not show any differential. Tayside has invested in palliative care services over the past few years and the differential that Dennis Robertson referred to relates to the actual expenditure that was incurred from April 2014 to March 2015, which took into account some of the operational challenges that I am guessing were around supplementary staffing. That is why there is a differential between that figure and the recurring budget figures. There is no reduction in the recurring budget that is available to the service.

Katy Lewis: I would like to comment on the specific question on how we cost, and understand the cost of, palliative care services. We have included in the Dumfries and Galloway return the specialist services that we provide—specifically, the in-patient facility in the infirmary, which operates as our hospice, and the services that we commission through Marie Curie Cancer Care to supplement community support. You will find that an element of the role of all our community teams and district nursing teams is to support individuals who are at the end of life. However, it is difficult to say how much of the day those teams spend on that.

Similarly, we deal with individuals not just in our community hospitals but in our main acute hospitals, and it is really difficult to disaggregate that cost. We can have a discussion about the issue and take it away, but I suppose that most of us have struggled to pull that information together because we do not count activity in exactly that way.

11:30

The Convener: The follow-on question would be whether that work would be worth while. Would it be worth the effort to establish the cost of palliative care in a hospital setting? Would it drive any other initiatives outside the clinical setting and ensure more of a focus on the end of life?

Mark White: With the move to IJBs and joint working, it might be helpful to try to put a cost to that. We might end up with some disparities and questions about accuracy, but I think that such an exercise would be valid, and if the committee wants to make such a request, I am certainly happy to take it away with me.

The Convener: Okay.

Rhoda Grant: An issue that was flagged up last week was the impact on budgets for patients travelling to hospital. The costs of patients travelling certain distances to hospital used to be paid centrally through the Scottish Government, but I note that that is no longer happening. Indeed, NHS Highland has made huge cuts to the patient travel budget; a patient now needs to drive for about 70 miles before they get any of their costs met, and the money that they get for any mile that they drive above 70 miles is about half the amount that Her Majesty's Revenue and Customs suggests for mileage. The health board has also told people coming in from the islands to take ferries rather than flights. Do the same concerns arise in other health board areas? How has the patient travel budget been devolved, and how is it funded?

Marion Fordham: NHS Western Isles is the biggest recipient of patient travel funding—we are getting something like £3.2 million in 2015-16—and it is now transferred to our earmarked recurring baseline. However, we are quite concerned about the budget's volatility and the significant vulnerabilities around it. For example, we can find ourselves suddenly having to take cohorts of patients to the mainland to meet TTG targets and so on.

Our efficiency plans this year include a small reduction to the budget of something like £25,000 as a contribution to our total savings target. At the moment, I do not imagine that we will make the same swathe of reductions that Highland is making, but I cannot rule that out, because we are struggling to identify the rest of the efficiency savings to meet our target.

This is a real issue that we are very worried about, but the most important point to make is that those who live on the islands tend to expect all their travel to be funded. There are questions to be raised about equality in that regard, given that people who live on the mainland are expected to make their own way to their appointments, and their journeys can be equally as difficult.

Derek Lindsay: The Highlands and Islands travel scheme applied to only four boards. Although NHS Ayrshire and Arran includes Arran and Cumbrae, we did not actually receive any funding from the scheme.

Richard Lyle (Central Scotland) (SNP): Good morning. Most of the questions that I was going to ask have already been answered, but with regard to cost pressures and efficiency savings, we all know that most of the costs relate to staff, energy costs and drugs. I note that, according to a table in the survey report entitled "Hospital drugs: anticipated price and volume changes 2015-16", the figures for assumed price uplift and assumed volume uplift in Ayrshire and Arran are 2 per cent

and 22 per cent; in Dumfries and Galloway, they are 8.7 per cent and 2.5 per cent; and in Tayside, they are 3 per cent and 5.7 per cent. The assumed volume uplift figure for Ayrshire and Arran, for example, is not the highest, but it is quite high.

Further on, the report comes to efficiency savings, which is where I cannot quite square what you are saying. The report says:

"Ayrshire and Arran, Dumfries and Galloway and Tayside are planning to achieve around a quarter of their savings from drugs and prescribing".

You tell us that you will have volume and price uplifts but, in the next breath, you say that you will achieve financial savings by reducing drugs consumption. Can you explain that? One factor could be that drugs are coming off patent. You might want to pin your colours to the mast on that. How do we square the two issues? You say that the volume and price figures are going up but that you are going to save by reducing drugs consumption.

The Convener: I think that Katy Lewis has an answer.

Katy Lewis: I will explain a little bit about how we establish budgets. We establish a drugs budget in conjunction with our clinical team and pharmacists at the local level. The gross cost is reflected in the budget. For Dumfries and Galloway, the price uplift of 8.7 per cent will have been built up from our previous experience of volumes and our knowledge of new drugs that have been or will be approved through the Scottish Medicines Consortium, and it takes account of any local investments or developments that we have made on drugs. We reflect that gross cost in our financial plans and budgets.

At the same time, we are looking at how the board can deliver efficiencies. As part of that same piece of work, we look at a range of areas where we can make efficiencies. For example, although we have had significant increases in volume year on year, that does not mean that we will not target that as an area in which we want to make efficiencies. In Dumfries, as part of the efficiencies that we are looking to deliver in year, we will try to reduce the uplift in volume from 2.5 per cent. That is not an unreasonable approach. At the same time, we are considering drugs that are coming off patent and the normal drug switches, as well as doing anything else that we can do to reduce our drugs budget. The principle in Dumfries and Galloway is about maximising the efficiencies that we can make from drugs and procurement, without having an impact on staff.

When I spoke to my chief pharmacist earlier in the week, we discussed the fact that, two or three years ago, we were looking at efficiency savings from a list of about a dozen drugs, but we are now considering 70 to 100 drugs that are coming off patent and for switches. We are looking at different ways of delivering that. The environment has become much more complex. Although we are still targeting the area for savings, we know that the level of savings that we can deliver from it will reduce in future years.

Derek Lindsay: Richard Lyle mentioned the high figure for Ayrshire and Arran. I just flag up that the table that he referred to relates specifically to hospital drugs. Our statutory annual accounts show that, on primary care prescribing, over the past two years, Ayrshire and Arran's cost increases have averaged about 4 per cent per annum. However, in the past two years, the average increase in other drug costs, which are mainly in hospital, has been about 15 per cent per annum. New drugs for conditions such as hepatitis C are expensive and are being used more, and there has been a policy initiative to increase access to end-of-life drugs and drugs for ultra-orphan and orphan conditions, which are also expensive. We know that our costs for that category of drugs are likely to go up by about 20 per cent in the next year.

The split between price uplift and volume uplift is a bit subjective. For example, there is a relatively new drug for hepatitis C and there will be increasing numbers of patients using that drug. We have categorised that as volume, rather than price, whereas if the cost of a hepatitis C drug went from £50,000 per year to £60,000 per year we would say that that was a price increase. That is the reason for the discrepancy.

Lindsay Bedford: In relation to hospital drugs, we focus on uplift associated with established agents, as well as the new medicines that are likely to come to the fore during the year—we are advised of them through the forward look submission from SMC. We work extremely closely with our clinical pharmacists. This is not the finance department coming up with figures—the figures come from our clinical pharmacists.

In the past, secondary care drugs were never looked at in terms of driving efficiency unless there was a drug that was coming off patent. Over the past couple of years, through the hospital medicines utilisation database that has now been developed, we all have the opportunity to compare our secondary care spend. We were not able to do that before, except at a single-line level. The database allows us to look at variation in secondary care prescribing. We believe that there are potential efficiencies to be pursued there.

Primary care will always be a focus; in NHS Tayside, we spend £77 million to £78 million on primary care drugs. As ever, we will continue to look at driving first-line formula compliance, and at the waste, harm and variation of our practices. We

look to drive down costs through the locality pharmacists that we have in each practice.

Richard Lyle: I have one more question. During the general election campaign, politicians were talking about a seven-day service in hospitals. In a comment earlier it was said that, if a surgeon was brought in at the weekend to perform an operation, they would be paid three times their normal rate. Most workforces have had their days of working amended over the years and most people now work at the weekend as part of a normal week of working. Conditions have changed in the last 20 years.

A truly seven-day service would be one in which people can have an operation or receive other care on a Saturday or Sunday that was not provided at weekends before. I realise that many decisions would be down to hospital managers, but from your end of things—the costs and so on—what discussions have you had with any of your chief executives about how differently things would be done in the health service to provide a seven-day service?

Derek Lindsay: There is a national group that is chaired by the director of human resources from the Scottish Government. My chief executive sits on that group. It has been meeting for about six months to look at seven-day services. It has produced an interim report but the work is on-going.

Nursing staff already work seven days a week, because they are looking after patients in wards all the time. The main impact is likely to be on medical staffing and the change in working patterns for them. We have already introduced some changes, such as ward rounds that happen at weekends. The main cost associated with the seven-day service will be related to changing the working patterns of doctors to a seven-day pattern.

Katy Lewis: I will mention one other thing that we have done in NHS Dumfries and Galloway to date. Because we know that Mondays are always high-activity days, particularly in the winter, we have been piloting the enhancement of support from allied health professionals over the weekend period, particularly physiotherapists and occupational therapists. That has had an impact on how busy Mondays are: when we start the week, particularly during the winter when there is reduced bed capacity, there has been an impact on services.

We are thoughtful about what that approach might look like in future, particularly as we need to be clear about what our vision of a seven-day service looks like. We might not necessarily do everything that we do during the week at the weekends; it is a matter of managing some activity a bit better over the week so that a patient who is admitted on a Friday afternoon will not automatically have to stay until the Monday.

We really need to explore and develop that area of work, while awaiting what comes out of the national review, considering how best we can implement it at local level and what fits each local system.

11:45

The Convener: My final question—I do not know whether anyone else has further questions—takes us almost full circle, on priorities and targets being set outwith the boards. In our 2014 report to the Finance Committee, we suggested that we needed to place more attention on analysing the performance of targets that are more urgent for change, leaving a longer period of time—I think we said—for revision to targets that have a lower priority.

Do you have any views on that type of approach and on analysing outcomes and priorities in that way, deinvesting in or pulling back on some of them and concentrating on others? Do you already adopt that approach, with some targets having a lower priority than others? Does that process take place? Do you agree with the committee's view that we need to analyse outcomes and to prioritise efficiently, having the flexibility to draw back?

Derek Lindsay: I will reflect comments that I have heard from clinicians about targets—waiting times targets in particular. Clinicians would always prioritise the greatest clinical need as what should come first. Sometimes, they feel frustrated that someone with a relatively minor need has to be treated within 12 weeks from being seen or within the 18-week referral-to-treatment time, while someone with greater need has to wait the full 12 weeks or the full 18 weeks.

There is something in differentiating between the urgency and clinical need as identified by clinicians and having a blanket requirement for everybody to be treated within the same time.

The Convener: We assume that that happens, but has any analysis been done on that?

Derek Lindsay: Clinicians make assessments on a case-by-case basis. If someone needs to be treated urgently or to have routine treatment, clinicians do a degree of prioritisation. I am not aware of things being done on a national basis; it tends to be more anecdotal and individual.

The Convener: Is any work on that being done locally, at board level?

Mark White: As Derek Lindsay mentioned earlier, in any organisation there is a suite of performance targets and some of them will be

more important than others. Some of them will take up more of people's attention and a larger part of the resources.

The question whether we should deinvest or divert resources from certain targets on to others is a boardwide question rather than a director of finance question. We follow our clinical strategies and our local development plans, which set out a whole range of targets to which we allocate resources. There may be an argument for such an approach, but it would have to go wider than a decision made by the director of finance.

The Convener: Some boards suggested in evidence that guidance and priorities should be developed. What is the justification for that? Is it that you, as financial people, are not best placed to set the guidance and priorities? Is that what you are saying? Should there be guidance?

Who was it who mentioned that in their evidence? We received some evidence about needing to have some guidance. Katy Lewis?

Katy Lewis: I am not sure whether it was me who said that, but from my perspective we must ensure that the targets that we focus on are the right ones. We spoke earlier about flexibility in relation to some of the targets and, as I reflected, if we use access targets and TTGs we must ensure a sustainable and balanced demand and capacity model for all health systems. Sometimes targets can skew that approach a wee bit in terms of the flexibility that there is.

We have some of the focus right, and particularly at partnership level we are looking at delayed discharges and things that have a bigger impact on the whole system, not just our acute system. We have spoken about focusing not just on what we can measure but on the whole system. As we move into that integrated world and the more sophisticated performance targets that come with it, we must also be thoughtful about the basket of targets that we use to measure overall broad performance. As has been said, as individuals we are probably not best placed to say exactly what those targets should be, but we need to think about how we take the issue forward.

The Convener: None of those ideas appears in your efficiency target, unless it is in the savings from productivity that we hope to achieve. We have talked about flexibility and how savings can be made, but none of that thinking or flexibility seems to appear when we get to the stage of proposing efficiencies. Is that a no-go area?

Derek Lindsay: For some time we have received advice from clinicians or public health bodies on low-value procedures such as adenoids and grommets, saying that we should be doing fewer of them. We can monitor that situation, and it may progress to the point at which we issue advice to ear, nose and throat consultants that we should not be prescribing any more grommets, although there will always be exceptions. We have implemented some clinical advice over a number of years in those areas.

The Convener: I do not think there are any further questions, so I thank all members of the committee and witnesses for their attendance and for the time they have taken to submit written evidence. We will continue next week with the director general of health and social care in NHS Scotland, Paul Gray. I thank everybody for their time today.

11:52

Meeting suspended.

11:59

On resuming—

Smoking Prohibition (Children in Motor Vehicles) (Scotland) Bill: Stage 1

The Convener: We resume our meeting and move to agenda item 2. I apologise to our witnesses for the delay. We had a long session earlier.

I welcome our first panel of witnesses to give evidence to the committee on the Smoking Prohibition (Children in Motor Vehicles) (Scotland) Bill. With us are Dr James Cant, who is the head of British Lung Foundation Scotland and Northern Ireland; Sheila Duffy, who is chief executive of ASH Scotland; and David McColgan, who is the policy and public affairs manager at the British Heart Foundation Scotland. All of them are members of the Scottish coalition on tobacco. I also welcome Celia Gardiner, who is the health improvement programme manager for tobacco at NHS Health Scotland.

We move immediately to questions. The first is from Richard Lyle.

Richard Lyle: I have an admission to make. I am a smoker, and I smoke in my car.

The Convener: Ooh!

Richard Lyle: It may not be the done thing now, but if we go back 20 or 30 years, it was common. I smoked in my car when my kids were in the back. They are grown up now; my daughter and son do not smoke. My wife does not smoke either, now.

As far as some people are concerned, the bill will invade their privacy by affecting their ability to sit in their car smoking. However, I am leaning towards supporting the bill. I do not smoke in my car when my grandson or granddaughter is in it.

What effect will the bill have that will help children? What effects are there on children at present? What would you say to the person who says, "It's my car. I'll just put the windows down. The air will blow through and the smoke will go out the window"? One of the submissions—I think that it is the one from the British Lung Foundation Scotland—says that convertibles could be exempted. If there should be no smoking at all when children are in cars, why should there be an exemption for convertibles or whatever?

Dr James Cant (British Lung Foundation Scotland): I begin by declaring an interest for the record. Neither I nor my organisation has had any contacts, financial or in kind, with the tobacco industry or any similar vested interests.

What I am about to tell you might surprise you: I have been in post at the British Lung Foundation for five and a half years and I have not yet told a single smoker to stop smoking, and I never will. It is not my job to judge in any way, shape or form. Had it not been for a slight twist of fortune as a teenager, I would probably be smoking in my car, as well.

This is very much a case of working together with adults, whether they smoke or not. It is absolutely not an attack on smokers. Again, it might surprise you to hear that I have, on a personal and organisational basis, defended the rights of people to smoke within the confines of their own environment. You have an absolute pledge from our organisation that although we want to work together to protect the next generation's lungs, we are also always there to support, without prejudice or judgment, people whose lungs have been damaged for whatever reason.

You might be surprised by how much esoteric thinking went into whether there should be a ban on smoking in convertibles. I like to think that the approach that the BLF is proposing is pragmatic. We are trying to produce something that is seen to be enforceable and sensible; one thing that encourages us in that regard is that the most recent figures show that 85 per cent of the adult population are in favour of such a control and that, crucially, 72 per cent of people who smoke are in favour of it. We do not want to lose that level of support and consensus by being seen to be dogmatic when it comes to convertibles, for example.

It is absolutely crucial to differentiate between the impact of second-hand smoke—or the lack of it—in a convertible and the impact of second-hand smoke in a car even when the windows are wound down. Nowadays, we are in the fortunate position of being able to measure precisely the level of $PM_{2.5}$—fine particulate matter—in a specific environment. Dr Sean Semple and his colleagues at the University of Aberdeen are world leaders in that. Their long-term studies have shown that, even with the windows wound down, any passenger in the car would encounter levels 10 times the World Health Organization's stated safe level of $PM_{2.5}$ exposure.

A crucial point that I want to get across before I finish is that there is no safe level of exposure to second-hand smoke, given the number of toxins in the chemicals.

Sheila Duffy (ASH Scotland): For the record, I make the same declaration of interests as Dr Cant. We are not anti-smoker, but we believe that the bill is proportionate and needed because of the damage that tobacco smoke does, particularly to

children. There is excellent substantive evidence of that.

Earlier this year, we commissioned YouGov to do some fieldwork among adults in Scotland—it carried out that work in late February and early March—and it found that 85 per cent of Scottish adults overall and 72 per cent of smokers support the introduction of legislation to end smoking in cars in which there are children under 18. The research shows that there are very high levels of tobacco smoke in cars in which people are smoking and that the smoke builds up very quickly. We also know, from other research, that short-term rapid exposure causes a disproportionate amount of heavy damage and that—as Dr Cant said—winding down a window or putting on the air conditioning to blast air through the car does not prevent that damage.

In our written submission, we suggest that any car that is 50 per cent or more open could be exempt, because that would be in line with the principles that were put in place for the ban on smoking in enclosed public spaces.

David McColgan (British Heart Foundation Scotland): I echo Dr Cant's initial declaration.

Richard Lyle asked about the effect on children. A number of studies on that have been conducted with a focus on cardiovascular disease. A systematic review in 2011 showed that children who had been exposed to second-hand smoke had altered cholesterol profiles and had lower levels of high-density lipoprotein cholesterol, which is a protective cholesterol. A study of 11-year-olds who had been exposed to second-hand smoke showed that they had endothelial dysfunction, which affects the lining of the blood vessels and leads to atherosclerosis, which is a thickening of the blood vessel walls that ultimately leads to coronary artery disease and heart attack. There is clear evidence that exposing children to second-hand smoke leads to cardiovascular disease, and that study of 11-year-olds showed that that was already occurring in kids who had had only moderate to small exposure to second-hand smoke. That clearly shows—I echo Dr Cant's comment—that there is no such thing as a safe level of tobacco smoke.

Celia Gardiner (NHS Health Scotland): I echo my colleagues' statements about not having any links to the tobacco industry.

The important thing about the bill is that it is about protecting children; as my colleagues have said, it is not about getting at smokers. A car is a confined space, and when children are in a car in which someone is smoking they breathe faster. Because they have smaller airways, they absorb the smoke much more quickly than an adult does. There is a general misconception among the public that winding down a window makes smoking in a car safe because there is fresh air coming in. However, we know that the danger is in the chemicals that are in second-hand smoke. As others have said, there is no safe level of second-hand smoke.

It is important that we put legislation in place in order to protect our children. It is not about having any baggage with smokers; we need it to protect our children. Second-hand smoke in cars can build up rapidly and reach very high concentrations, so we must not expose children to it.

Mike MacKenzie: I am a former smoker; I now use e-cigarettes, and I am very pleased that I have been able to encourage a few colleagues to take the same route out of smoking. I am also very pleased that, like Richard Lyle's children, my children, who have long since become adults, do not smoke.

Although I am in favour of the bill's general principles, I wonder whether you will allow me to play devil's advocate for a moment and ask: is this not the thin end of the wedge? Given your comment that there are no safe limits for smoking, is the logical next step for legislation to move from cars, which are enclosed spaces, to another enclosed space—the home—and then to what would pretty much be a complete ban? I am not so sure that I would be absolutely against that, but is this not, as I have said, the thin end of the wedge?

The Convener: I caught Sheila Duffy shaking her head, so she will be first up this time.

Sheila Duffy: I am not aware of anyone calling for legislation for domestic settings. This bill is about legislation for vehicles to which other forms of legislation including legislation on wearing seat belts and installation of child car seats, and a ban on mobile phone use while driving, apply. We are used to legislation that applies to vehicles. Moreover, the bill is aimed at protecting children in a very enclosed and concentrated environment, and it is warranted because of the large amount of evidence about the harm that is caused by tobacco smoke.

Dr Cant: Members will know better than I do that politics is the art of the possible—and this proposal is possible and achievable and already has significant support. I can assure you that, as Sheila Duffy has suggested, no organisation that I have worked with—and certainly no one in my organisation—imagines a ban on smoking in domestic properties to be conceivable or feasible. From a civil liberties point of view, it would not be feasible and, indeed, would not be supportable.

The moment any one of us gets into a car, we immediately place ourselves under quite a significant list of restrictions and expectations in order to keep other road users and our

passengers safe. Scotland has set a phenomenally ambitious target of being smoke free by 2034—that is defined as a smoking rate of 5 per cent or less—and to achieve that we will need a mixed suite of activities. The vast majority of the approach will be about changing behavioural norms; there are very few situations in which specific discrete legislation cannot encourage such behaviour change and—crucially, as Sheila Duffy said—provide protection.

I am glad that Mr MacKenzie has raised what I think is a very important issue, but I assure the committee that I do not see this in any way as part of a creeping legislative approach. This is a specific, carefully targeted and measured piece of legislation, and it should be seen in that light and against the wider campaigns that are being run in partnership between us, the Scottish Government and NHS Scotland to increase awareness of smoking in the home. The take it right outside campaign is an excellent example. We are not telling people not to smoke; instead, we are telling them that if they want to smoke, they should do so in a place where they can keep their family safe.

Mike MacKenzie: As a non-smoker, I am something of a zealot and an enthusiast for this cause, but you will forgive me if I point out a logical inconsistency. The damage that is done to our lungs through smoking comes down to the size of the enclosed space and the amount of time that we spend in that space, and the logical inconsistency is that your position on having an outright ban on smoking in homes, for instance, is scientifically and logically unsustainable. There is another argument to be made about public opinion, civil liberties, freedom and so on, and I think that by pretending that that argument does not exist you are doing your cause an injustice. You are not exploring the issue fully and in the round, and I have to say that I have been disappointed by the answers that you have given. Perhaps you might want to reflect on that and add to what you have already said.

12:15

Sheila Duffy: I will add to what has been said. One of the benefits of having this debate and having this bill up for consideration is that it will raise public awareness that tobacco smoke is, in itself, a harmful and damaging substance. We have evidence from other countries that people have voluntarily introduced additional restrictions when they have got that message. We know from the refresh work that ASH Scotland did with the University of Edinburgh and the University of Aberdeen that parents and carers want to protect their children but that they do not always know what is effective in that regard.

As James Cant said, the overall objective is to put tobacco out of sight, out of fashion and out of mind for the next generation. We would like to raise awareness of the harmfulness of tobacco smoke—it is always harmful. The bill is timely and the change is possible. The Republic of Ireland has introduced the offence and England and Wales are on track to introduce it in October. It is on the table here, so we are supporting this legislation.

Colin Keir (Edinburgh Western) (SNP): Since we are all owning up, I should say that I am not a smoker. I never have been and, personally, I hate the things. That said, there is something in what Mike MacKenzie said. To play devil's advocate, in a situation in which a child grows up in a home with two heavy-smoking parents, how could you measure the damage that is done to that child only during the time when they are in a car with their parents who are smoking? How can we justify taking the action that is proposed? What sort of measurements would you envisage? How would we measure the outcomes?

David McColgan: From a cardiovascular disease point of view, the figures are fairly stark. Exposure to second-hand smoke increases someone's chance of stroke by 25 per cent and chance of coronary heart disease by 30 per cent. The message is very much a child protection one. It is about ensuring that children are protected during car journeys.

I understand the devil's advocate arguments, and the suggestion that the next step might concern what happens in the house. The British Heart Foundation Scotland, like ASH Scotland and BLF Scotland, would respond to that by saying that we are here today to talk about cars, as that is what the bill that is on the table is about. We equally supported the Scottish Government's take it right outside campaign, but someone once said to me that, although it is easy to take it outside in the home, it is difficult to do so in a car. That is a valid point. On long—or short—car journeys, someone who lights up a cigarette cannot take it outside. Everyone is trapped in that confined space and has to breathe that second-hand smoke.

The interesting point about the take it right outside campaign was that it challenged the conception that you can hang out the window and have a cigarette or smoke in the kitchen with the window open. That does not work in a home, and simply opening the window in a car does not work, either. That is why we support this bill.

Colin Keir: My question remains, though. If the child is living in that environment and the parents are not going into the back garden or—if they are living in a flat or something—going right outside to smoke, which means that damage is being done in

the house, how can you measure the benefits of banning smoking in a car? What makes that so much more dangerous than living in the environment that I have described?

David McColgan: To measure the exposure in the car versus the exposure in the house would be challenging. My argument would be that banning smoking in cars would at least give that child a break, and would mean that they were not exposed to such high levels of smoke when they were in a confined space. From the point of view of the British Heart Foundation, it is the status of such exposure that means that people should not smoke in cars. As Sheila Duffy said, it also gives us another opportunity to educate people on the harm of second-hand smoke, which is part of what the take it right outside campaign was trying to do.

In this context, we are not telling people that they should stop smoking completely. Much like the British Lung Foundation, we are saying that they should not expose others to second-hand smoke. Quite often, that is the challenge. People know that, if they smoke, they are consuming the smoke and the chemicals that it contains, but they need to understand that the people around them are also being exposed. An adult would have the respect of the driver and be able to ask someone in a car not to smoke, but a child might just sit there during the journey. The child needs to be protected in that space.

It is hard to differentiate between smoking at home and smoking in a car, if a child is going between the two and is having the same experience. We need to look at where children are protected and educate people who smoke in the car that second-hand smoke is bad. It does not matter whether the window is cranked down a little bit. Others might have views on that, too.

Sheila Duffy: Two recent studies from New Zealand showed an increase in voluntary restrictions in the home following smoke-free legislation and some evidence of protection for children from that legislation. In terms of the bill, you could listen to what children say, because there is documented evidence that children say that they feel choked and nauseous in the car. Many of them would like to ask people not to smoke in the car but far fewer have felt able to do so.

Dr Cant: The bill should be seen as complementary to the on-going take it right outside advertising campaign. The beauty of the narrative of that advert was that the parent was trying to do the right thing. She was at the back kitchen window and she shooed her husband to shut the door when he came in because she thought that she was doing the right thing to protect her child.

That helped to convey two critical things. More than 85 per cent of second-hand smoke is invisible and has no smell. That is because it is caused by particles that are one twentieth the size of a grain of sand. A huge education programme must take place as part of this process, which would provide a wonderful opportunity to dovetail those messages.

There is a very good chance that the child who you describe in your scenario would have to attend the local sick kids hospital. Figures from the Royal College of Physicians of Edinburgh indicate that more than 4,000 new cases of asthma, wheeze, glue ear and the like will appear in Scotland every year, almost certainly as a result of second-hand smoke. For ethical reasons, we cannot differentiate to what extent the smoking took place in the home or in a car. However, we have an opportunity to make a clear statement.

I envisage that, in a couple of years' time—or even sooner—people will look at the issue in the same way that we look at putting a child in their car seat. You have to put the seat belt on because that is what you do to keep the child or young person safe on that journey.

As Sheila Duffy says, the emerging evidence—particularly from Australia, which is pioneering on this—is that there is a positive knock-on effect. To come back to the devil's advocate question, the allegation that we face most often is that we want to help you to develop a nanny state. That is not what this is about. It is about engaging with adults in Scotland today to ensure that the next generation is able to break the chain in the way in which Richard Lyle's family has done.

Colin Keir: Sheila Duffy talked about cars that are 50 per cent or more open. We all know what a cabriolet is, for example, but how is "open" defined? How would you expect it to be defined for the purposes of practical enforcement?

Sheila Duffy: It was just a rule of thumb, which was to bring the law into line with the rules that have been put in place for enclosed public spaces. We know that opening car windows and turning on the air conditioning will not sort the problem of tobacco smoke. It is still there in sufficient quantities to be considered harmful.

Colin Keir: I just say that because a normal cabriolet would have a fold-down roof. You then have something like an old 2CV that has windows on the front and the sides and a roll-down roof. There must be a difference in the air circulation in those cars, too. That sounds mundane, but the fact is that different designs exist.

Sheila Duffy: I liked the simplicity of the guidance on smoke-free enclosed public spaces. It was very clear and simple, although working out what fitted and what did not was perhaps less

clear. What is proposed is in line with the existing legislation.

The Convener: I presume that there is no support from the panel for including exemptions for convertibles in the bill.

Sheila Duffy: If they are 50 per cent or more open.

Dr Cant: I confess that we are relatively relaxed about whether the eventual legislation contains cabriolets. My experience of going through Easterhouse in our recent summer weather has not indicated that there are many 2CVs or cabriolets—certainly not with their roofs down. That is a relatively minor detail for us. We are much more focused on the more significant message. The BLF would certainly defer to the committee's wisdom on the cabriolet question.

Colin Keir: I was just thinking about enforcement. Identification is not easy.

The Convener: Is it just a problem for the poor?

Dr Cant: Exposure to second-hand smoke will increasingly have a social and economic element, because we have seen with the smoking rates that Scotland is doing very well in encouraging the reduction of smoking in the more affluent communities. The issue is absolutely an inequality one, as well.

The Convener: How have their opinions on the bill been reflected? Do they view it as they view recent legislation on smoking in public places?

Dr Cant: That is a critical element. A lot of our work has been geared to working with children in some of Scotland's most deprived communities. We have done some work in Easterhouse to develop messages. Sheila Duffy mentioned previously that children very often feel disempowered; they feel that they do not have the authority or the voice to be able to speak in such a way. We have done extensive work in some of Glasgow's more deprived areas, and we are currently doing work in Forth Valley as well, because it is crucial for us that children are given a voice and that entire communities are taken along in that way.

You are right to highlight the danger that many people feel that health is done to them rather than with them.

The Convener: That is certainly the case with the smoking ban, is it not? We see evidence of that every time we walk along the street outside pubs and clubs. It is exclusion from their point of view. How do we know that the group of people you state the bill would directly impact on are in favour of it? Has any work—quantitative surveys, for example—been done with the group of people we are targeting?

Celia Gardiner: Quite a lot of work was done with the take it right outside campaign last year. There was a lot of promotional activity that was targeted at parents in more deprived communities. That work was done outside Lidl and other such supermarkets. Basically, it was educational work. It was reported back that many parents said that they had not realised that there were all these chemicals in second-hand smoke. There is the perception that there is no harm if there is ventilation or windows are open and smoke cannot be seen, but we are talking about something in the atmosphere that is invisible to the eye and which people breathe in.

The committee will have received submissions from the University of Aberdeen. It has done work with Dylos meters, which can measure the amount of smoke in the air. James Cant and the BLF have done a lot of work on that in deprived communities.

We know that there is a real educational need and a misunderstanding about what the harm is from second-hand smoke. If the bill is passed, it will be important to build on that education and ensure that parents are aware of how harmful smoking is for their children and what they can do to protect them. Most parents want the best for their children—they do not want to knowingly harm them. There is a gap in knowledge, and we are working at breaking that down. Once it is generally better understood that harm lingers in the wake of smoke that can no longer be seen and dissipates very quickly through the house, we will make progress.

12:30

The Convener: We have to accept that that message has not got through to that group, and that takes us to enforcement. People are not listening or they do not understand, so we are legislating. How do we enforce the legislation?

Celia Gardiner: I still think that there is a big need for education.

The Convener: But we have failed in many respects. I know that there needs to be a change in behaviour. That group is still the one that has the greatest number of smokers. That will be related to socioeconomic problems. Someone who is living a sad life is not going to go for an extra five years of that life, and they are not receiving the educational message. Many of them are still smoking; they are smoking when they are pregnant, with their children around at home, and with children in cars. That is the target group.

Celia Gardiner: There are several different issues in there. We are not targeting an educational message about stopping smoking; the message is about protecting children. The

message is different from the one about giving up smoking; it is about doing the best for your child, and I think that people are open to hearing it.

The Convener: Perhaps I am not up to speed on the issue but, in hard-to-reach communities, we are struggling to reduce the prevalence of smoking among pregnant women.

Celia Gardiner: I know that.

The Convener: I would think that that would be when they would be more responsive to the message about protection and the health impacts on their child, not when the child is in the back of the car. The message will not necessarily have an impact on the community that I am talking about.

Dr Cant: I would be happy to invite you to come and see some of our community work. I think that you would be heartened at the impact that the messages have on young people, the parents' generation and, crucially, the grandparents' generation. As we all know, grandparents have huge influence with children and practical significance because they provide childcare. When we go to work, we go into the community, but we also seek to work with families across the generations.

As Celia Gardiner highlighted, this is not about us trying to stop people smoking. We are talking about the protection of the next generation. Your point about smoking during pregnancy is hugely important, and it increases the importance of the priority that should be given to this particular piece of legislation.

It also increases the importance of making sure that we get across key messages. For example, many of those in deprived communities who smoke while they are pregnant might have a sense of fatalism or despair. The critical message to get across is that, if someone smokes during the first trimester, the stats tell us that their baby should be born unaffected by the impact. There is therefore an imperative to give up within the first trimester. The messaging is critical.

The work that we have done in communities is encouraging. If Scotland is going to achieve its ambition by 2034, society needs to take it on. We need to see it as something empowering and recognise that, if each member of a couple smokes a pack of 20 a day, by the time their child reaches the age of 18 or 21, they could have given £100,000 to that child. That is how Scotland needs to address the wider issues.

To come back to the specifics of the bill, we support it and it attracts us because we see it as having immediate and long-term impacts by safeguarding children's lung health, and it has significant support from the population as a whole as well as from those people who smoke.

The Convener: The bill is about enforcing legislation. If everything had been wonderful, we would not be at the stage of legislating and enforcing. As well as the legislation, there is the hope of the educational message refining our public message and targeting the people who we are talking about. The point was made earlier that we are not talking about the wider population, and I agree with that.

We are talking about legislation and enforcement. We anticipate that some people will not listen to the message, so how do we ensure that the bill is enforced effectively?

Sheila Duffy: You are right to flag up enforcement. We believe that because the police are routinely out checking vehicles and enforcing other legislation, they would be best placed to monitor and be part of the enforcement. The Royal Environmental Health Institute of Scotland has said that it would be happy to work with the police to enforce the measure properly.

I previously mentioned two pieces of research that were done in New Zealand following the implementation of smoke-free legislation. The research concluded that smoke-free legislation for vehicles resulted in a drop in the likelihood of children going on to take up smoking, independent of smoking in the home and other areas. For me, the bill looks like an investment in the next generation.

The Convener: Do you believe that you will have the support of hard-pressed communities if scarce police resources are used to enforce smoking legislation in cars rather than to tackle moneylenders, violence and drug dealers on the streets? Would enforcing a ban on smoking in cars divert police away from those things?

Sheila Duffy: We hope that it can be done as part of the police's regular traffic duties, rather than being an additional significant burden.

Dr Cant: The closest parallel is seat belts. When legislation on seat belts was introduced, it gave priority and significance to parental or grandparental safety that might not otherwise have been given. Such initiatives also allow an opportunity for advertising campaigns, which really get the message across. We do not for a moment anticipate the diversion of police officers because of the legislation. I agree with Sheila Duffy that the measure should be part of police activities regarding road traffic offences.

The Convener: Do you accept that the number of police officers or others who could carry out similar work is finite?

Dr Cant: Were it not for the fact that smoking in cars has a permanent and sometimes fatal impact

on children in Scotland on a daily basis, I would not be pushing for the legislation.

The Convener: I accept your position, but many specific campaigns on drink driving, seat belts or mobile phones are conducted at Christmas, in the summer or on particular roads and those initiatives are usually information led. Perhaps you are saying that this is just an add-on and that there will be no specific campaign but that, if the police are doing a road check, or campaigning on seat belts or drink-driving, the measure would be added on. Is that what you are suggesting for police enforcement?

David McColgan: The British Heart Foundation Scotland does not have a position on how the measure should be enforced, but I suspect that Police Scotland or whoever runs the campaigns will decide when to do them. Drink-driving campaigns take place around Christmas, but I am sure that when we first imposed drink-driving legislation, people did not think that it would be a Christmas campaign. There is no reason why Police Scotland might not decide to take a week at the beginning of the summer holidays to crack down on smoking in cars.

James Cant's point is valid. The bill gives us the opportunity to raise the profile of the issue and educate through legislation. All the things that you mentioned—mobile phones, seat belts and drink driving—are legislated for, and we have come up with ways of enforcing the legislation. Sheila Duffy's point about it being part of the police's regular road traffic duties is sensible.

The Convener: But if we give the police more responsibilities, they will require more resources.

Sheila Duffy: We could, for example, decide that tobacco and alcohol should be dealt with at the same time.

The Convener: That would be one way of doing it.

Dennis Robertson: I will try to be brief. I should declare that I am the convener of the cross-party group on heart disease and stroke, for which the BHF is part of the secretariat.

I have no qualms about the evidence on second-hand smoke. I sometimes think that when we talk about smoke we assume that, once the smoke has dissipated, there are no smoke chemicals left, so part of the problem is in getting the correct information across. In the short space of time that we have been talking this morning, I have heard all the witnesses mention education and awareness several times. Do we require legislation, or is it all about education and awareness?

Dr Cant: I contend that we do need legislation. The most recent Scottish schools adolescent lifestyle and substance use survey statistics, which are based on interviews with 13 and 15-year-olds in Scotland, indicate that 22 per cent of them often or regularly travel in a car in which smoking is taking place. Sheila Duffy has already indicated that there is a sense of powerlessness. As an adult who just needed a lift to work, I have felt powerless myself, but children and young people are certainly powerless to intervene to protect themselves in that situation. When I put that statistic alongside the scale of the immediate and long-term medical threat that smoking causes to children and young people, my conclusion is that there is an imperative to legislate.

Dennis Robertson: As I said, I have no qualms about the evidence and the medical effects and impacts. I think that they are a given, to be perfectly honest. I am taking up the convener's point about enforcement but I am still asking whether it is about education and awareness. Governments and Parliaments are sometimes accused of passing legislation that is not necessary when they should take a different approach. I just wonder whether we need to be smarter about education and awareness. For example, every time a car is sold, should it have a no smoking sticker attached to the handbook to remind people not to smoke if there are children in the car? Should a sensor be built into the car, so that when someone lights up it goes off, like the sensor that goes off if you are not wearing a seatbelt? Are there other things that we should be doing rather than taking forward legislation?

Sheila Duffy: Generally, you have to do a number of things, and do them repeatedly, to raise awareness and change practice. I saw the public attitude to tobacco smoke revolutionise itself during the six years of the debate on smoke-free public places. If Scotland had unlimited resources, we might be able to provide the sustained level of education and awareness raising that would be required to change culture, but my experience suggests that there would be significant media interest in the legislation and that that would give you free education and awareness raising that would cost a lot of public funds if done in any other way.

David McColgan: The British Heart Foundation has looked at international examples in places such as Australia and Canada where bans were introduced through legislation, and the impact was a substantial reduction in children going on car journeys. James Cant alluded to the 60,000 journeys a day that are currently being made. The scale of the problem and its impact on health prompt us to ask why we have not already done it in Scotland. We have a history of being progressive on issues such as smoking in public places, and the time has come for Scotland to act on smoking in cars. We are not talking about five

or six kids a day; we are talking about 60,000 journeys. One is too many, but that number is massive and we should be acting on it.

Dennis Robertson: I am not against passing legislation; I just ask whether it is necessary.

Before you bring in Richard Simpson, convener, I have another point about the adult age limit being 18, although the panel might not have a particular view. Someone can hold a driving licence at 17. If a young person of 16 is smoking in a car and there is no adult there, the legislation does not cover that. The age limit at 18 seems peculiar. Do the witnesses have a view on that?

12:45

Sheila Duffy: My understanding is that 18 is generally and internationally the accepted age for child protection. With regard to children's rights such as the right to learn to drive or whatever, the age of 16 tends to be preferred.

Dennis Robertson: In Scotland, we have legislation with different provisions relating to the age of children with regard to transitions, duty of care and so on. I just wonder whether the issue needs to be looked at.

Sheila Duffy: That is all about supporting children and about children's independence and rights. The age of 18 is, I think, internationally accepted as the age for child protection.

Dr Cant: Because of the complexity that has been mentioned, the BLF could not come to a view on a clear or definitive correct age, and our organisation is quite relaxed about what is felt in the legislation to be the most sensible cut-off point.

The Convener: Does Sheila Duffy want to come back on that?

Sheila Duffy: I suppose that, with regard to underage sales and so on, having a higher age limit and making the cut-off age 18 rather than 16 makes it easier to distinguish children who are younger than the limit.

Celia Gardiner: That was the very point that I was going to make. People are legally allowed to purchase cigarettes at the age of 18 so, technically, 16-year-olds should not really be sitting smoking in a car—although, in reality, they probably are.

Dr Simpson: On a slightly different issue, I understand that the level of accidents that occur in cars with drivers who smoke is higher than it is for cars with non-smoking drivers. Is that the case?

Sheila Duffy: It has been noted as a factor in road traffic accidents; indeed, it is probably significantly underreported as a cause of accidents. The issue might be covered by existing motoring restrictions.

Dr Simpson: As Mike MacKenzie suggested right at the start of the session, we might be on a slippery slope here—although, in this case, it slopes upwards. Why do we not just ban smoking in cars completely, given that the level of accidents that are caused by such circumstances is higher? After all, it is not good to do anything with your hands while driving apart from having them on the steering wheel, and smoking really is unnecessary. Why do we not just ban smoking in cars completely instead of taking the more reasonable route of protecting children?

Sheila Duffy: For us, the bill is about protecting children, and we want to see that aim secured.

The Convener: I should point out that the bill does not propose to do anything other than that.

Dr Simpson: I know, convener.

The Convener: Would e-cigarettes be covered by the bill?

Sheila Duffy: That proposal is not on the table, and there is not the same level of established evidence of harm that there is for tobacco smoke. That evidence is irrefutable, although I would be surprised if some of the tobacco industry representatives do not challenge it.

The Convener: As members have no more questions, I thank the witnesses for their attendance. We look forward to taking this journey with you over the next few weeks and seeing what further evidence we receive.

That concludes our business for today.

Meeting closed at 12:48.

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