HEALTH AND SPORT COMMITTEE

Wednesday 29 October 2008

Session 3

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HEALTH AND SPORT COMMITTEE
25th Meeting 2008, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Jackie Baillie (Dumbarton) (Lab)
*Helen Eadie (Dunfermline East) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Mr Frank McAveety (Glasgow Shettleston) (Lab)
Jamie McGrigor (Highlands and Islands) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

John Matheson (Scottish Government Health Finance Directorate)
Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health and Wellbeing)
Dr Kevin Woods (Director General Health and Chief Executive NHS Scotland)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Slater

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Wednesday 29 October 2008

[THE CONVENER *opened the meeting at 10:18*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning. I welcome everyone to the 25th meeting this year of the Health and Sport Committee. I remind everyone to switch their mobile phones off—I have done it myself, this time.

No apologies have been received.

The committee is invited to agree to take items 3 and 4 in private, in line with usual practice. Item 3 is consideration of a draft report to the Finance Committee; item 4 is consideration of a draft response to the health inequalities inquiry. Are we agreed?

Members *indicated agreement*.

Budget Process 2009-10

10:18

The Convener: For item 2, I welcome Nicola Sturgeon, the Cabinet Secretary for Health and Wellbeing, to give evidence on the Scottish Government's draft budget for 2009-10. The minister is accompanied by John Matheson, the director of the Scottish Government's health finance directorate, and Dr Kevin Woods, the director general of the Scottish Government's health department and the chief executive of NHS Scotland. I invite the cabinet secretary to make some opening remarks before we move on to questions from members.

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): Thank you, convener. I will be brief. I remind the committee that when I came here to speak to you last year, the context of the Government's spending plans was a very tight spending review settlement that determined that we would face a period of lower growth in public spending than in previous years. That remains the context this year. In addition, we face a dramatically changed economic climate. In response to that, in my portfolio we have significantly accelerated expenditure from future spending plans on affordable housing by up to £100 million. We have also decided to invest an extra £10 million in central heating programmes in the current financial year. The continuing impact of global economic conditions will obviously continue to be a key consideration in our overall spending plans, for the remainder of the current spending review period and beyond.

That said, despite the developing economic climate, the tough spending review settlement and the range of competing priorities on which we are committed to delivering, the Government is increasing spending on health by, on average, 4.2 per cent a year over the spending review period. That is broadly in line with the average increase in the overall Scottish budget.

Since I last gave evidence on the budget to the committee, I have published "Better Health, Better Care", our action plan for health in Scotland. Improving the health of Scotland, especially in our most disadvantaged communities, is a top priority to which we are fully committed. We also want to ensure better, more local and faster access to health care. We will continue to use the resources that are available to us to achieve those overarching objectives.

The policies and programmes that we have put in place will continue to be developed to support the achievement of those objectives, and we will

continue to place a high priority on actions to improve health and prevent illness. For example, to increase healthy life expectancy we will reduce the harm that is done by the misuse of alcohol and tobacco, immunise against cervical cancer, enhance national screening programmes, target anticipatory treatment, and help people—particularly children—to tackle obesity through diet and physical activity strategies. To improve services, we will achieve a maximum wait of 18 weeks from general practitioner referral to hospital treatment by 2011, we will screen for MRSA in hospital patients, we will develop and embed a quality improvement and patient safety culture, and we will improve specialist children's services, including cancer care and high-dependency facilities.

I turn to the detail of our spending plans as set out in the 2007 spending review, which was published last November. The draft budget for 2009-10 refreshes those plans, with minor updates since the 2007 publication. My portfolio accounts for public spending of £11.7 billion in 2009-10—£2,281 for every person living in Scotland—which will rise to £12.1 billion in 2010-11. In 2009-10, £11.1 billion will be spent on health, rising to £11.5 billion in 2010-11. In 2009-10, £53.9 million—rising to £54.9 million in 2010-11—will be spent on sport. The remainder of the money will be spent on housing and regeneration, wellbeing and the Food Standards Agency Scotland.

Despite the tight spending settlement, the difficult economic climate and the range of competing priorities on which the Government is committed to delivering, we are making progress and increasing spending on health in Scotland by an average of 4.2 per cent a year. Improving our health service is a top priority for the Government, and we remain committed to it through our spending plans and all the action that we take.

I am more than happy to answer the committee's questions.

Ross Finnie (West of Scotland) (LD): For 2009-10, as with the current year, the inflation and efficiency savings projections in the revenue budget are a material element in getting a handle on where we are. Before I ask specifically about 2009-10, can you help us by indicating to the committee your understanding of the rate of inflation that is being experienced in the health service in the current year? In your experience, and to your knowledge, how far is the health service delivering on the 2 per cent savings that you set it for last year?

Nicola Sturgeon: The inflation allowance in the health budget is 2.7 per cent. Like every other area of the public sector, and the private sector and private individuals, the health service is struggling with increased inflation. That is having an impact on every aspect of life in Scotland, and we all hope that the economic experts who predict that inflation has peaked and will start to come down are correct.

Obviously, health boards have to plan for inflation within their allocated budgets. We increased the allocations to individual health boards by an average of 3.3 per cent this year and we estimate that we will increase those allocations by 3.2 per cent over the next two years. In addition to those allocations, we have allocated slightly more to boards that are below their Arbuthnott allocation and that are predicted to be below their NHS Scotland resource allocation committee parity allocation, to help them to make progress more quickly.

On efficiency savings, the first point is an important one. Every single penny of the efficiency savings that national health service boards make will be reallocated to front-line patient care. The efficiency savings target that we set for NHS boards is in the interests of everybody who uses the NHS in Scotland.

I am pleased to say that boards' performance in meeting their efficiency savings targets is strong. I do not underestimate for one second the challenge that meeting the efficiency savings poses for health boards and other parts of the public sector, but I believe that it is right to get as much of our taxpayer spend to front-line services as possible.

Over the three years of the comprehensive spending review period, £645.6 million of savings are targeted on the health and wellbeing portfolio. The forecast savings for 2008-09 are estimated at £277.08 million, which would result in a potential overachievement of more than £60 million. By 2009-10, total savings of £423 million are forecast.

The NHS and, indeed, the whole health and wellbeing portfolio is performing strongly against what we all recognise are challenging efficiency savings targets, but they are necessary if we are to ensure that as much of the money that we spend on health as possible is targeted at front-line services.

Ross Finnie: I will press you a little on that, cabinet secretary. We are trying to be helpful. In terms of inflation, the committee recognises that the current economic situation is not helpful. What information do you have on the rate of inflation that boards are advising you they may have to cope with in the current year? That information would assist the committee and allow us to form an intelligent view on whether the projection of 2.5 per cent is realistic. I ask you to be a little more specific.

Likewise, of course, we understand perfectly well that it is in the interest of health boards to

make efficiency savings. They are doing so because you have—very properly—directed that the savings will return to front-line services. That said, with all due respect, telling us that health boards have been set even better targets for 2008-09, 2009-10 and 2010-11 does not mean that boards will achieve the savings. It is laudable that boards have those targets, but it would help the committee to know the general level of efficiency that boards are attaining in the current year, so that we can examine the level that you are projecting for 2009-10.

Nicola Sturgeon: I will repeat part of my previous answer, as it might help in terms of the latter part of what Ross Finnie said. The figure that I gave for the estimated efficiency savings for the NHS and the entire health and wellbeing portfolio in 2008-09 is an overachievement against the efficiency savings target.

It is important to bear in mind the fact that the Government is not only setting but meeting our targets—indeed, in some cases, we are exceeding them. Of course, the £277 million that we estimate will be achieved under our efficiency savings targets this financial year is £277 million that will be redeployed and reallocated to front-line priorities. That is in patients' interests, and it is to the credit of the NHS and the wider portfolio that that magnitude of savings is being achieved.

10:30

As regards the overall inflation position, the NHS is not immune to general inflation. Ross Finnie's question is complex, as I am sure he is aware, because different pressures weigh down on health boards as in other parts of the public sector. For example, pay inflation is a significant issue for the health service. As you are aware, we have agreed a three-year pay deal for the staff who are covered by agenda for change that is affordable within the allocations that we have made to health boards. However, that pay deal obviously has a reopener clause, and if it were reopened—which is entirely hypothetical—any increase in the settlement would bring pressure to bear on NHS boards.

Similarly, boards face pressures because of the cost of utilities, just like every other part of the public and private sectors. The NHS has benefited over the past two years from fairly competitive fixed-price energy contracts that were negotiated centrally by NHS National Procurement. Those contracts expired at the end of September and NHS boards anticipate having to manage increased costs from April next year. All those pressures are being managed by NHS boards within the allocations that we have given them and the savings that they are able to redeploy from efficiency savings. In addition, there is a range of estimates for drug cost inflation. The continually increasing cost of prescribing is a pressure on NHS boards, but they are managing it in the way that they are managing other pressures.

Those are all genuine issues for the NHS, as is the general economic situation that is having an impact on inflation. In the past financial year, all NHS boards met their financial targets and reached break-even point and all NHS boards are predicted to do so in this financial year, too.

Ross Finnie: I am grateful for that information. Does it mean that you are as satisfied as you can be that your prediction of 2.5 per cent inflation in the current year might not be met, but nevertheless it will be managed by the NHS?

Nicola Sturgeon: The other point that has to be made in response to this general line of questioning—of which I am sure every committee member is as acutely aware as I am—is that the Scottish Government operates within a fixed budget. The 2.7 per cent gross domestic product deflator that applies to the overall Scottish budget also applies to the allocations that we have made to NHS boards.

In the context of the overall budget, we continue to prioritise health spending. I mentioned in my opening remarks the average increases over the spending review period, which are in line with the increase in the overall Scottish budget. When I took office in May 2007, the budget that was set by the previous Administration allocated 33.7 per cent of the total Scottish Government budget to health. At the end of the current comprehensive spending review period, the percentage of the overall budget going to health will be 33.7 per cent. We are clearly maintaining—rightly, in my view—the prioritisation of health spending in this country. When we debate the bigger economic climate or the rate of inflation impacting on the NHS and every other facet of our lives in Scotland, it would be remiss not just of me but of all of us not to be aware of the fact that we operate within a fixed budget and that any spending that is over and above our planned allocation to one area has to be found from another. That is the financial reality in which I and every one of my colleagues operate.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): We have probably gone as far as we can go on the issue of inflation; in short, it is being managed. However, efficiency savings are critical. You said that the likely outturn this year is going to be better than 2 per cent, but what do efficiency savings constitute? For example, is it reasonable to include within such savings property sales, budget adjustments and capital to revenue virement spending reductions? Although I acknowledge that many boards exceeded the previous year's 1 per cent target for efficiency savings, when you dig behind what the boards

have said they will do this year to double those savings, you have to ask how real they actually are. The object of making such savings was to apply them to front-line services, but you cannot apply a capital saving to continuing revenue expenditure. I have considerable concerns about how the efficiency savings will materialise and allow services to move forward.

Nicola Sturgeon: I am well aware that capital savings are not available for revenue spending on an on-going basis.

I will make a few points and then ask Dr Woods to respond. As I have said, the 2 per cent efficiency savings are challenging, although I remind the member that they are not as challenging as the 3 per cent efficiency savings that the Labour Opposition urged us to impose on the public sector when we were drawing up last year's budget. If we had taken that advice, we might now be having a very different conversation.

Efficiency savings do not reduce the level of service; instead, they allow a service to be delivered for less money and in a more cost-effective way. This list is not exhaustive, but the areas that deliver efficiency savings include contracting arrangements, commissioning, estates and facilities, and service redesign. Although redesign can impact on capital spending, much of it is focused on service delivery, the staff—and the number of staff—who deliver services and other workforce arrangements. Other efficiency savings come from national projects such as NHS National Procurement, NHS shared support services, logistics and improvements in prescribing and primary care. We can deliver—and are delivering—efficiency savings in a range of areas.

When I read the evidence that the committee took before the recess from the Royal College of Nursing and Unison, I was struck by John Gallacher's very positive comments on the positive impact of good procurement practice on efficiency savings targets. I would not expect Unison to praise anything unless it genuinely thinks that it is a good step forward and delivers efficiency savings without impacting on services. We are working hard on such matters to ensure that all of the money goes back into front-line patient care.

I stress that the money that health boards free up from efficiency savings does not come back to me or my team in the health directorate so that we can spend it on whatever we choose; instead, boards retain it for spending on their own priorities. That approach is very much in the interests of everyone who relies on the NHS.

Dr Kevin Woods (Director General Health and Chief Executive NHS Scotland): The cabinet secretary has listed a range of our national programmes, but I point out that a range of things is also going on at a local level.

The central issue—and the point that I think Dr Simpson is driving at—is the balance between recurring and non-recurring savings. We have examined the matter very carefully, and explored it with boards in this year's annual review round. One-off savings will arise from time to time, and it is right that we make the best use of them, but we also want recurring savings, which is why the extremely successful work on procurement is so important. The situation is similar in relation to drug purchasing, where we are making significant recurring savings. Although we are committed to ensuring that we achieve more recurring savings, there will always be opportunities for one-off savings.

To support boards in that respect, we have established a national efficiency and productivity programme, which is led by a senior official from one of our boards, with the involvement of many others. The programme considers the efficiency and productivity of many aspects of what we do, such as operating theatres, to ensure that we make the best possible use of our resources. As the cabinet secretary said—and as we tested in the annual reviews—every single penny goes back into front-line services.

Dr Simpson: I accept everything that is being said. I have no quarrel with it. Driving forward efficiency within the system is fundamental. Given the large funding increases in the past few years, there is the opportunity for efficiency savings of the sort that you have described. However, I remain concerned that we may run into danger by conflating one-off savings with continuing savings. For example, I am informed that the proposed efficiency savings include £35 million from property sales, which means that a significant proportion of the savings are one-off savings that, as Dr Woods said, cannot be used for on-going revenue streams. You have raised some important issues, but I am concerned about how we ensure that boards do not use capital receipts or one-off receipts to support revenue expenditure and, like Argyll and Clyde NHS Board, run into significant problems because rising general expenditure is backed by efficiency savings using capital receipts.

Nicola Sturgeon: I agree. Richard Simpson makes a reasonable and well-based point. I reassure him that we do not conflate recurring and non-recurring savings. As he knows from the examples that he has cited, NHS boards make non-recurring savings. As Dr Woods said, it is right that those savings are redeployed and used effectively. However, in terms of the scrutiny of boards' efficiency savings and the extent to which boards meet the targets that we set them, we do

not conflate recurring and non-recurring savings. We are very aware of the distinction, and of the necessity for savings to be made on a recurring basis. As Dr Woods has also said, in our NHS board reviews, we scrutinise the facts and figures of the efficiency savings that boards report to us.

Dr Simpson: To be clear on that, the 2 per cent efficiency savings comprise recurring moneys, and the one-offs are kept separate.

Nicola Sturgeon: No. The 2 per cent is a mixture of recurring and non-recurring savings. However, your general point about boards not using non-recurring savings to pay for recurring service delivery is well made, and we are very aware of it.

Dr Woods: I have an important point to add. Dr Simpson referred to the problems at Argyll and Clyde some years ago. Over the past few years, and certainly in the past year, we have put a great deal of effort into getting boards into recurring balance. The recently published annual accounts demonstrate that we have achieved an enormous amount in that regard. John Matheson can correct me if I use the wrong technical language but, to all intents and purposes, the NHS in Scotland is close to being in recurring balance, because we have reduced reliance on non-recurring spending to support boards' financial positions. That is a considerable achievement by the NHS in Scotland. The degree of non-recurring spending is at an all-time low. Any debate on efficiency savings must be put in the wider context.

10:45

Dr Simpson: That is helpful. However, until this past year, growth in NHS moneys has been significant, and health boards' ability to manage has been greater, because of the much bigger budgets. I am concerned about the future, as we move through what I accept will be three years of much tighter spending. I am interested to hear John Matheson's comments.

Dr Woods: As the cabinet secretary said a few moments ago, the forecast for the current year is encouraging, because the balanced position is forecast to be maintained.

John Matheson (Scottish Government Health Finance Directorate): As a finance director, I have always had a clear focus on the mix between recurrent and non-recurrent. Non-recurrent should be used for non-recurrent purposes, not to underpin recurrent. The trend within NHS Scotland is therefore welcome. Dr Woods is correct: the auditors' view for 2007-08 is that the amount of non-recurrent spend that underpins recurrent expenditure is at an all-time low and has reduced significantly from 2006-07 to 2007-08. Non-recurrent efficiency savings are helpful in giving breathing space in-year to allow recurrent savings to be developed thoughtfully, which will then underpin non-recurrent in future.

As Dr Woods says, the cabinet secretary, Dr Woods and I have had a clear focus on that in the annual reviews of health boards, to ensure that the underpinning is recurrent, and that proposals for efficiency savings are well advanced.

Michael Matheson (Falkirk West) (SNP): I want to ask about primary and community care service budgets. A considerable increase in the spend on e-health has been projected. What does the Government expect to gain in the NHS through such a rapid increase in funding over the next two years?

Nicola Sturgeon: In my view, e-health has enormous potential to improve delivery of care. That goes back to our previous discussion of efficiency savings, productivity and value for money.

Michael Matheson is right to suggest that the budget for e-health is significant over the course of the comprehensive spending review. It will cover a range of things, including the integration and interoperability of core NHS systems. We are using funding from that budget to begin development of a clinical portal that will have a single sign-on to different sources of patient information. We have also established an e-health fund to support improvements in primary care and community settings. That will be used particularly to modernise GP systems in order to support community systems that are delivered by nurses, midwives and other allied health professionals, and to support data sharing between health professionals and professionals in other agencies.

I will talk briefly about some of the key objectives of the spend in e-health for 2009-10 and 2010-11. I hesitate to say this when two GPs are sitting at the table, because we could end up in a whole new discussion, but we aim to introduce a new information technology system for GPs, starting in summer 2009. I have already mentioned the clinical portal with the single sign-on. We intend to introduce that in spring next year, with a minimum of three NHS boards going live by 2011. We also intend to deliver an online child health summary to help with integration of nationally held information on child health, and to introduce a range of other technologies that are all about improving delivery of services and how health professionals communicate with one another in the interests of patients.

Michael Matheson: The committee has considered telehealth and the benefits that could be gained from expanding its use, although committee colleagues with medical experience have told us that telehealth has been in

development for many decades now, and that limited progress is being made. Evidence that we received from the Scottish Centre for Telehealth highlighted a couple of barriers, particularly a lack of the inter-health board co-operation that is necessary to ensure that benefits can be gained from such an initiative and patient care improved. Given that the funding for e-health will obviously include telehealth, what more can Government do to ensure that we start to break down such barriers in order to get most benefit from the increase in funding?

Nicola Sturgeon: I recognise that there is a barrier, although we are already in the process of breaking it down. It is true that telehealth and telecare have been in development for many years. It might surprise some people to hear it, but I would not claim that the current Scottish National Party Government—great though it is—invented telehealth and telecare. We have invented many great things, but not those.

We are now seeing an exciting increase in the pace of change in delivery of these initiatives. In my travels around the country I have seen—I am sure that other members have, too—fantastic examples: endoscopies that were done in Shetland being looked at by consultants in Aberdeen, for example. Technological advancements in telecare have allowed people to stay in their own homes for longer, but with the comfort of knowing that they are being monitored, so that if anything goes wrong, someone will pick up on it. Tremendous advances are being made.

On the barriers that Michael Matheson talked about, obviously money is important. The systems require technology and equipment, and the set-up costs are quite resource intensive, so it is right that we invest properly. However, cultural issues also have to be addressed when we are developing telehealth. Some of those issues will be to do with relationships between different NHS boards. From what I have seen, a lot of co-operation is going on, particularly in the work that is being done between island or rural health boards and those in urban areas to cut down on the occasions on which patients have to travel considerable distances and to allow people to have their health care delivered locally. I will certainly do everything I can to encourage that to continue.

We are in the process of changing other cultural issues, as well. The use of telehealth and telecare has to be properly explained to patients: they have to feel comfortable with technology that might mean that the consultant who is reading their X-ray or looking at their endoscopy is many hundreds of miles away from them. That has to be factored in.

There is no doubt in my mind that this is the right direction to take. It is already delivering huge benefits in patient care, and it promises to deliver even more in the years to come.

Ian McKee (Lothians) (SNP): May I ask a quick question?

The Convener: Ian, I had you on my list for a supplementary question. There was no need to worry.

Ian McKee: It is just that it is not my main question.

The Convener: I do not ration questions, as you know. I am not allowed to.

Ian McKee: Cabinet secretary, will the new computer system for GPs—

Nicola Sturgeon: I knew it was a mistake to mention that.

Ian McKee: Will it actually talk to the computer system for nurses and other primary care workers, especially after the result of the review of nursing in the community?

Nicola Sturgeon: That is the intention but, as I am not a computer or IT specialist, I will hand over to someone else who is not an IT specialist, and he can say a bit more about it.

Dr Woods: The point is very important and the direction of travel is entirely consistent with our intention to make progress to a single electronic health record. That is why the work on the portal and the community health index number is so important. They have put us in a very strong position.

When considering the successor to the general practice administration system for Scotland, we thought hard about whether we should go for a single all-encompassing system for primary and community health services. We have been constrained to some extent by what the market can supply at this point, so we have divided the project into two. At the moment, we are focusing on a successor to GPASS. We thought hard about the evolution from GPASS, which will continue for some time, to the new GP-type system. However, we want to procure systems that will support connection with other relevant information systems. That is fundamental to all the work that we are doing in e-health.

Nicola Sturgeon: The end point of all the work will be a single electronic patient record, but our approach is a bit different from the one that is being taken elsewhere in the UK. We are not going for a big-bang new computer programme to deliver a single record: we have instead decided to take an incremental and progressive approach. If I can be non-technical about our approach, it consists of joining up bits of the system that exist already, modernising areas that need to be modernised and filling in gaps in the system. The

end point will be a system that consists of different components, all of which can talk to one another. The single sign-on portal will perform the function of a single electronic patient record. It is hoped that we will get there in a more sensible way than has been tried elsewhere.

Mary Scanlon (Highlands and Islands) (Con): My question relates to telehealth. Over the recess, I was in Orkney and the Western Isles. As Michael Matheson said, we have not made as much progress as we should have made, but one area in which tremendous scope for progress exists is self-management of long-term conditions such as diabetes, asthma and cardiac conditions. Much can be done in that area if health professionals talk to one another. I heard about a health visitor who spent a whole day visiting one person on an island. Rather than have an ad hoc approach, is there scope for conducting pilot studies on self-management of long-term conditions, given that there is an increase in spending? Would you consider commissioning such studies? The approach that I have suggested would be tremendously beneficial in any authority, especially island authorities.

Nicola Sturgeon: I challenge the assertions that we take an ad hoc approach to the issue and have not made significant progress on it. We have made significant progress in the past two or three years, not just the past 18 months. The Scottish Centre for Telehealth is designed to ensure that our approach is not ad hoc and that we trial and pilot different approaches that can be rolled out to other parts of the country, as appropriate. I do not know whether members have had the opportunity to visit the centre, but I encourage them to learn more about it, as it is genuinely interesting; I will visit the centre at the start of December.

A lot of work has been done and a great deal of progress has been made. Mary Scanlon is right to point to the advantages of the approach that she suggests across Scotland, especially in island areas and more rural parts of our country—areas such as those that she represents. There is a great deal of scope for cutting down the distances that patients and health workers have to travel and for giving people much more control of management of their conditions. That is entirely in line with the direction of travel for self-management of long-term conditions.

Lastly, I will inject a caveat, on which others might disagree with me. We must examine developments and make as much progress as possible technologically in order to ease delivery of services and enable people to stay in their own homes, but we must also always consider the situation from the human angle. Technology can do much for people, but it cannot provide company for somebody who is old and living in their own home. I believe passionately in the potential of technology in delivery of health and care services, but sometimes human intervention is needed. We should always scrutinise all developments from that perspective.

11:00

Mary Scanlon: No one disagrees, but it costs money and time to catch a ferry or a flight to Aberdeen when you feel unwell. I will stay with questions on the islands before discussing mental health.

The Convener: You can see what it is like for me, cabinet secretary. The members lay a trail in front of me.

Mary Scanlon: I am ensuring that I have put down a marker.

Nicola Sturgeon: I missed what Mary Scanlon was going to ask me about before mental health.

Mary Scanlon: I have not got to mental health yet—I am still on questions about the islands.

NHS Orkney still receives about £700 less per person per annum than does NHS Western Isles. Is that still justified? I know that the previous Government examined the issue and that the Western Isles' population is ageing—perhaps the situation is the same—but I have been asked to ask the question.

Nicola Sturgeon: I will make two comments, which I hope will help. We have a formula for allocating resources to NHS boards. As Mary Scanlon knows, that will change from the Arbuthnott formula to the NHS Scotland resource allocation committee formula. No formula will ever be perfect, but it is right to have an objective and transparent set of criteria to guide the allocation of resources to boards. Different factors that are at play in different board areas—deprivation, rurality and the pressures of greater travel times, for example—must be taken into account. That is why we have a formula.

As Mary Scanlon knows, we have established a working group to keep operation of the NRAC formula under constant review. Previously, we took a big-bang approach—a formula was in place for several years and was then reviewed and replaced wholesale. One of NRAC's recommendations was that the formula should be kept under constant review and we have decided to do that with the group that has been established, which will have input from NHS boards. We are committed to keeping under review issues such as that which Mary Scanlon raises. I hope that that helps.

Mary Scanlon: I have many questions, but I will go on to mental health issues. I note that there are

standstill budgets in mental health services. The budget for mental health awareness is £6.2 million and that for legislation and services is £21 million. Last week, I received replies under freedom of information legislation to questions about mental health services waiting lists, which are not held centrally. I was shocked that patients can wait four years and seven months to see a psychologist. In Inverness, patients can wait three and a half years.

I am concerned about the standstill budgets, but I am also concerned that I have still not worked out how to monitor local authority single outcome agreements and how we know that the money that used to go to mental health services will continue to be provided. I have asked Unison and everyone that has come along to the committee about that. I am still not clear about the treatment of mental health care in local government and I am concerned about the two standstill budgets.

Nicola Sturgeon: Mary Scanlon raised several issues that I will deal with in turn. In general, I hope that people appreciate and accept that we give mental health a high priority. This is not a party-political comment in any shape or form and it is not meant to be a verdict on any past Government but, over several years, mental health services in the overall NHS have not always been given the priority that they merit. There has been a determination for some time now—not solely in the past 18 months—to rectify that and to redress the balance. The Government is committed to ensuring that we improve our mental health services, just as we are improving our health services overall. That is reflected in the priority that we have given to mental health in this year's health improvement, efficiency, access and treatment targets, in which there is a greater focus than previously on aspects of mental health.

I recognise that there is an issue around waiting times for mental health. I would say, however, that people who are urgently referred are, by and large, seen within the 18-week waiting-time standard. Evidence from around the country backs that up. There are some issues to do with mental health services for children and adolescents, for example in access to therapy, in which waiting times in some areas are significantly longer than they are in others. We have made it clear that we want to tackle that and to drive down waiting times generally for mental health patients.

The committee will be aware that Shona Robison has given a commitment—as has the First Minister in Parliament—that the Administration will work to establish whether we can bring mental health services within the scope of the new 18-week referral-to-treatment target. I will not sit here and give the committee a categorical assurance that that is possible—there are a number of issues that we have to work through—but there is certainly commitment. It would be an important step.

Mary Scanlon referred in part to what I am about to say on two specific budget lines—mental health legislation and services, and mental wellbeing. The budgets that the Government has set represent the funding that we believe is necessary to allow us to work with our partners on the drive for change and improvement in prevention of, and in treatment of and sustained recovery from, mental health problems. However—this is what Mary Scanlon referred to in her question—the vast majority of spend on mental health and wellbeing will continue to be made from NHS boards and local authorities within the increasing and record general allocations to those agencies. The latest figures suggest that spending on mental health services by NHS boards and local authorities is in excess of £700 million a year. There is a big commitment to mental health, not just in the targets that we have set, the work that we are doing to drive down waiting times and the work that we want to try to do in the future to make a step change in waiting times, but in the big commitment on the budgets that are being allocated to mental health.

That brings me to the question about monitoring of single outcome agreements, which is important. I note that John Gallacher was asked that question. He was able to avoid answering the question because it is not his responsibility to answer it: I am not in that position. At the moment, two areas of draft guidance are being produced to guide monitoring of single outcome agreements. I am sure that the committee will want to return to the subject when that draft guidance is produced, and as it turns into final guidance.

The first piece of draft guidance is to health boards to assist them in the formulation of their local delivery plans. It will set out how they should reflect in their local delivery plans not just their plans for meeting the HEAT targets that are set for them, but the contribution that they agree to make locally, within community planning partnerships, to any additional commitments within single outcome agreements.

The second piece of draft guidance is being produced to support community planning partnerships. Its purpose is to identify outcomes and indicators for single outcome agreements and to suggest how progress on those outcomes and indicators should be monitored. The guidance is being produced by the Government's public services reform team, but the work is being taken forward by a steering group that includes representation from the Convention of Scottish Local Authorities, individual local authorities and

the Government. That important work is under way.

Single outcome agreements are in their infancy—this is their first year. Some have been agreed at community planning partnership level and others have not, but from next year, they will all be agreed through community planning partnerships. Just as the process of single outcome agreements is in its infancy, so is the process of monitoring them. However, I hope that what I have said will assure Mary Scanlon that the work is well under way within the Government. The committee will, if it so chooses, be able to scrutinise the product of that work in due course.

Mary Scanlon: I am pleased to hear that draft guidance is being drawn up. Would it be fair to say that, at the moment, there is no way of finding out whether, on the back of the abolition of ring fencing in local government, services and support for mental health are increasing, staying the same or decreasing? I accept everything that you have said, but given that we have two standstill national Government budgets, is there any way in which I could check whether mental health spending in local government is increasing, decreasing or whatever?

Nicola Sturgeon: Health boards are already monitored against their local delivery plans and the HEAT targets, and that will continue. I am not going to kick off a discussion about the pros and cons of abolishing ring fencing in local government. We have a new relationship with local authorities, enshrined in the concordat, that gives them the freedom to identify and respond to local priorities.

Mary Scanlon: I fully accept that.

Nicola Sturgeon: I understand that. However, no previously ring-fenced funding that was available to local authorities has been removed or cut. On the contrary, local authority budgets are larger this year and local authorities have a greater share of total Government spend than they had in previous years. There is absolutely no suggestion that any of the services for which funding was previously ring fenced have been cut back by local authorities.

As Mary Scanlon is aware, single outcome agreements are in place this year for every local authority. Some were agreed through community planning partnerships and others were agreed directly with local authorities. They already exist as a statement of local authorities' priorities and form the basis on which any member of Parliament or the public can monitor and hold to account local authorities against the priorities that they have set for themselves. Ultimately, local authorities—just like us—are accountable to the people who elect them for how they choose to spend the budgets that they are allocated.

Mary Scanlon: Convener, I have one or two other points to raise. If other members do not pick them up, I would like to come back to them at the end.

The Convener: That is noted.

Helen Eadie (Dunfermline East) (Lab): The Royal College of Nursing and Unison have told us that they are concerned about the reduction in the education and training budgets: the Unison representative told us that Unison is concerned about the significant decrease of £3.2 million in the workforce budget line, and the Royal College of Nursing said that the Government recognises the urgent need to deal with nursing student attrition, so the budget should not really be decreasing.

I would like you to respond to those claims by the Royal College of Nursing and Unison. I would also like you to put your response in the context of the distinction awards, where there is a budget line—

The Convener: Can we deal with the budget lines first and then deal with the distinction awards?

Helen Eadie: I think that it is important for the minister to respond in the context of how we value the staff in the NHS if the distinction awards of £26 million go to consultants and others in the NHS.

The Convener: So, it is the one versus the other.

11:15

Nicola Sturgeon: I am happy to comment on distinction awards for consultants, but if the previous evidence session is anything to go by, I suspect that people have substantive questions about them.

Helen Eadie raises specific and serious issues about the workforce and nursing budget lines. I will deal with her points directly in a moment, but I point out that those budget lines are not decreasing. For example, the workforce budget went from £21 million in 2007-08 to £31.1 million in 2008-09 and will rise to £32.4 million in 2009-10 and to £34.4 million in 2010-11. The nursing budget went from £147 million in 2007-08 to £153.7 million this year and will rise to £157.9 million next year and to £163.4 million in the year after. It is important to record that neither of those budget lines is decreasing.

I think that Helen Eadie refers to the variation between the draft budget for 2008-09 that we published last year and the budget that we are scrutinising today. When they are compared, the workforce budget line—but not the nursing line—is

reduced. Those reductions have come about simply because of reassessment of the costs of the planned implementation and policy. The workforce budget line that we are discussing—with some small exceptions for people who are seconded into the NHS—does not deal with staff salaries. It concerns the implementation of pay policy—the implementation of the agenda for change, the new contract and the working time directive. The reduction between last year's draft budget and today's budget is simply a reassessment of the implementation costs. It will have absolutely no impact on the policy behind that budget line, which will be delivered just as it was intended to be delivered when we published it last year.

Helen Eadie makes an important point on the nursing attrition rate. The attrition rate for nursing and midwifery students has been stubbornly high for several years. It is in the interests of all of us—of students and of the wider NHS—that we reduce that figure. We are working hard to do that. The intake of students whom we approved for nursing and midwifery last year decreased slightly, because one issue that people think might be at the heart of the attrition rate is the quality of the intake. We reduced the number slightly on the basis of putting in less to get the same out at the other end. The money that we saved was redirected into specific policies through a national delivery group to reduce attrition rates by putting in place support mechanisms for students. That is an important use of that resource.

Helen Eadie: The cabinet secretary is correct that I was referring to the distinction between the 2007 spending review figures and the draft budget. For the record, that shows a decrease of £3.3 million in the workforce budget but an increase of £4.7 million in the nursing line. That point is important.

I would like the cabinet secretary to comment on the distinction awards, which I raised with the Unison representative at our previous meeting.

Nicola Sturgeon: Distinction awards are a part of the system that we have in place to recruit and retain in Scotland the best medical skill, talent and expertise. I did not invent that system; I inherited it from the previous Administration.

Increases in the value of distinction awards year on year are determined by the Review Body on Doctors and Dentists Remuneration—the DDRB. I am fairly sure that the budget increase to which you have referred flows from the increase in the number of consultants in Scotland in the past few years. More people are eligible for a distinction award, which is the reason for the budget increase.

Distinction awards are awarded not by me or by anybody in the Government, but by the Scottish Advisory Committee on Distinction Awards. The system is currently under review by the Government and I understand that a report of that review is due to come to me for approval fairly soon. Obviously, I cannot comment on it because I have not seen it. The objectives of the review were to try to make the system fairer and transparent. When it is finalised and any recommendations are agreed, the committee may want to cast its eye over it.

Helen Eadie: I value your response to that, cabinet secretary. We must value every member of staff in the health service and I am sure that you do that. I welcome the fact that we will be able to have sight of the review in due course.

Could you provide the committee with a breakdown of the expenditure incurred under "Miscellaneous Other Services", including the historical expenditure in 2006-07 and 2007-08? It is a big budget line, and having everything lumped into that heading makes it difficult for committee members to scrutinise. If such a breakdown could be organised after the meeting, that would be helpful.

Nicola Sturgeon: I will happily send you as full a breakdown of that budget line as possible, but I can also give you some flavour of it just now, if that would be helpful. It includes a range of projects that are less than £10 million and various primary care services. For example, it includes the costs of reducing prescription charges to the point of abolition and of delivering free eye examinations. It also includes a budget line for opening up more access to primary health care, the costs of prion filters for CJD, funding for the implementation of NHS carer information strategies and money for the implementation of the independent review of NHS wheelchair and seating services.

I will refer to one other item, which is important because it explains the flatness of other budget lines—I think that we had this discussion last year. As you know, the budgets for some of the primary care contractor services are always a flat line until we agree the uplifts—I suppose that they represent an opening negotiating position for the Government—so the provision for increasing those lines when we agree the one-year or three-year deals with each of the professions is also contained in the "Miscellaneous Other Services" budget line.

Helen Eadie: Will you describe how equality impact assessment has influenced the spending decisions that have been made in the draft budget and how you ensured that it was carried out soundly?

Nicola Sturgeon: Equality impact assessment has been applied throughout the budget. As a Government, we have equality duties, which apply to our budget decisions just as much as to the other decisions that we take. Therefore, equality impact assessment is an integral part of the budget process.

It is for others to judge whether we have produced a budget that has a positive impact on equality. I firmly believe that we have, not only in my portfolio but across the budget. A range of matters in my portfolio focus on dealing with poorer health outcomes in areas of deprivation. They include the money that we will earmark to spend on alcohol and tobacco cessation, which will have a disproportionate impact on people in deprived areas, and the funding for the keep well projects, which are designed to improve health outcomes for people who live in our most deprived areas. They also include the abolition of prescription charges. Although that will obviously benefit everybody who pays for prescriptions, it will have a particular benefit for people who are not in one of the current exemption categories but who struggle with the cost of prescriptions. Many people will benefit greatly from abolition who suffer from long-term conditions, which can have an impact on income and standard of living.

I am proud of the draft budget, particularly in my portfolio, from an equality point of view.

Helen Eadie: You will appreciate my last question because—this is an Alex Neilism—it is in twae pairts.

Nicola Sturgeon: With Alex Neil, it is usually three points.

Helen Eadie: Will you comment on the fact that there are no targets for sport, although there are a variety of targets for health?

Nicola Sturgeon: My answer will be similar to the answer that I gave on mental health. We invest a considerable sum of money in sport every year, and that will increase as we move towards Glasgow 2014, for which we will have a significant financial commitment. However, the bulk of the spending on sport in Scotland is channelled through local authorities; a total of 90 per cent of all sports funding comes from local authority allocations. Every year, local authorities spend more than £500 million on sport.

The policy priorities for sport are contained in "Reaching Higher". The performance of the money that we and local authorities spend will be monitored and assessed against the objectives in "Reaching Higher". In addition—and this takes us back to the answer that I gave to Mary Scanlon—single outcome agreements will be increasingly important in the context of expenditure on sport. All my previous comments on the monitoring of single outcome agreements apply in that context as much as in the context of mental health spending.

Helen Eadie: This last question—

The Convener: Oh. I forgot about the other part.

Helen Eadie: It was raised by the Royal College of Nursing in a briefing that was sent to us. According to a recent Audit Scotland review, the additional cost of the general medical services contract has been met by the NHS boards' unified budgets, and the correction factor has limited NHS boards' ability to target funding at deprived, remote or rural areas. Should that situation be allowed to continue?

Nicola Sturgeon: I inherited the situation of the new GP contracts; however, I accept that the RCN's observation has some validity. The correction factor and MPIG—the minimum practice income guarantee, the details of which committee members will be intimately aware—have certainly acted as a brake on ensuring that we can target resources as effectively as we might in the more deprived areas. This Government is committed to tackling that problem—working as much as possible in partnership with the British Medical Association and the profession. With the BMA, we have just agreed on a UK-wide arrangement for next year's pay deal. Under the arrangement, MPIG will continue to erode. The DDRB will decide on the level of the uplift to be awarded to doctors, but we have agreed that the method of allocating whatever uplift is finally agreed will be applied differentially to different elements of the contract—to the global sum, to the correction factor, and to the other elements—in such a way that the correction factor will be eroded and the number of practices that rely on MPIG will be reduced. We are committed to working towards reducing that number, so that we can target resources more effectively on deprived communities.

We also have an agreement with the Scottish General Practitioners Committee this year. It is an agreement in principle—although a considerable amount of work remains to be done on the details—to consider the allocation formula in order to ensure that we are targeting resources to GP practices in deprived areas. Of course, we will have to be sure that we do not destabilise GP practices elsewhere.

The Convener: That was a helpful answer, and it allows me neatly to bring in Ian McKee.

Ian McKee: I wanted to ask more about the thorny issue of the minimum practice income guarantee. As we have discussed, it has been one reason why we have not been able to redress a particular problem—that of GPs who work in deprived areas receiving a lower income than GPs

who work in more affluent areas. That situation has persisted for the past 60 years, more or less.

The Convener: You are not as old as that, are you?

Ian McKee: I am not, but the situation has persisted for that long. Actually, I am older than that. I am in danger of losing my thread now.

This issue was discussed at our meeting on 24 September when the Minister for Public Health was here. She described MPIG as "continuing the old inequities." I think that we agreed with the minister when she said that.

11:30

The BMA has kindly sent me a statement of its negotiating position on the GMS contract for this and future years. It has in mind extremely leisurely progress towards the abolition of MPIG. It says that it is important for practices that

"the level of their income increase is decided by an independent body"

and that MPIG must be

"eroded over a number of years without reducing practice funding".

In other words, all practices must have an increase in funding while MPIG is being eroded. The BMA says further that

"practices should not be destabilised through loss of resources … it will take some time to carry out all of the necessary work".

Cabinet secretary, we have been waiting for 60 years for something to happen, but this will take a long time and will be very difficult. In the light of any budget, never mind a restricted one, I find it difficult to understand how you can increase the budget of all practices while reducing a huge inequity between GPs working in deprived areas and those working in affluent areas. We have just talked about consultants. They all receive a basic salary, but the 14 per cent of consultants who are regarded as extra-deserving are given fairly large increases that are, I believe, reflected in their pensions. Yet GPs who work in areas of stress where the need is greatest receive less than some of their colleagues. That situation needs more urgent action than just waiting for leisurely progress through the seas of the DDRB. Would you like to comment on that?

Nicola Sturgeon: Yes, although if I start I might not be able to stop. I find the committee's views both interesting and helpful. We need to have this debate in Scotland and I want to have it, as far as possible, in partnership with the profession and the BMA. I have had constructive initial discussions about the matter with Dean Marshall of the SGPC. If you look at the DDRB outcome for this financial year, the increase that was recommended by the DDRB was expressly applied only to the global sum. The DDRB recognised the need to begin to deal with the MPIG problem.

The deal that we have agreed with the SGPC and UK employers for next year will see reliance on MPIG continue to be eroded although there will be an increase for all GPs because of what I explained earlier—the differential application to different parts of the contract. I am not sure that I can add much to what I said earlier. I thoroughly endorse the Minister for Public Health's comments to the committee. We need to be prepared to tackle the problem and I want to do it in partnership as far as possible. I know many GPs, not to mention former GPs, who share that view. They recognise that if we are serious about making tackling health inequalities a top priority, we cannot shy away from the problem of the contract. I am encouraged by the response from and interaction that I have had with the SGPC so far this year, in relation to the agreement that I talked about and the initial agreement to look at the allocation formula, which is another important part of ensuring that we get things right. I am more than happy to keep the committee updated on that situation regularly, if you would find it helpful.

The Convener: That would be helpful.

Ian McKee: Many years ago GPs refused the distinction awards that consultants took because they felt that comparing one GP with another was impossible. On the other hand, you can compare workload with workload. Is there scope for introducing some form of distinction award for GPs who work in areas where the burden is greatest?

Nicola Sturgeon: I see your fellow former GP shaking his head vigorously at that suggestion. I am not going to endorse that view because this is not the right forum in which to make policy on the hoof and if I did, I would have a queue of GPs at my door when I returned to the office.

In the context of looking at the allocation formula, it is absolutely fundamental that the allocation of resources reflects the issues of inequalities and deprivation in our society. I will not say more about the distinction awards because I have already covered as much as I can about that.

The Convener: Yes—we got the flavour of it.

We will move on to Jackie Baillie, who has been very patient.

Jackie Baillie (Dumbarton) (Lab): Thank you, convener. I will try to make my questions brief, but I have several of them.

I take the cabinet secretary back to her opening statement, in which she rightly pointed to accelerating capital spending elsewhere in her

portfolio. Has that been done in the health portfolio?

Nicola Sturgeon: Are you asking whether we have accelerated capital funding?

Jackie Baillie: Capital spending. I am asking because of the economic context.

Nicola Sturgeon: I will answer that in two parts. First, the health part of my health and wellbeing portfolio has contributed to the acceleration of £100 million of housing funding in this and the next year. So, for example, the capital budget line shows that the health capital spend goes down by £16 million over two years, but that is returned to the health budget in 2010-11. Therefore, the health part of the portfolio has contributed to that acceleration. That is possible because of the profile of the spend. There is absolutely no impact on what we will deliver.

The other part of your question is about whether we have accelerated any health infrastructure projects. We have not taken any decisions to shift the profile of our funding on health infrastructure projects as a direct result of the economic situation. Obviously, when such decisions are made, shifting money is not the only thing that has to be done—we must also ensure that the projects are deliverable within a timescale. We have a substantial health infrastructure investment programme, which, with its current profile over the next three years, will contribute significantly to helping us through the tough economic times.

Jackie Baillie: So there are no opportunities for acceleration, otherwise you would have taken them.

Nicola Sturgeon: I would not say that. With respect, I said in my opening statement—although I do not mind repeating it—that, like other Governments in the UK, we are dealing with really difficult economic times. Our spending plans and programmes, both revenue and capital, will undergo constant review to consider whether there are opportunities to accelerate spending or to change spending priorities to allow us to respond to the economic climate. A substantial health capital programme is under way. At present, we do not plan to accelerate the programme, because it is substantial in this year and the next two years of the comprehensive spending review.

Dr Woods: I just add the obvious point that much of the spending is a result of capital schemes that were planned some time ago. The lead-in for projects such as the £95 million Aberdeen emergency centre is considerable, as you might imagine. We are considering the issues, but the practicalities of good planning must be accommodated properly.

Jackie Baillie: That is helpful to know.

I want to pursue Helen Eadie's point a little further. Cabinet secretary, will you share with the committee, perhaps not now, but in writing, how the equality audit was carried out on the budget? I accept absolutely the examples that you gave about tackling specific health inequalities, but your budget is much bigger than that. It would be helpful if you shared with us the systematic approach that was taken to equality proofing the budget. I am sure that that would also be of interest to the Finance Committee.

Nicola Sturgeon: I am more than happy to do that.

The Convener: The only issue with that is that we will need the information pretty quickly if it is to be of any use. We need to get our report done. That is just a caveat.

Nicola Sturgeon: We will certainly do our best to respond to that request as fully as we can.

Jackie Baillie: I turn to specific issues. You will not be surprised that I am going to ask about health care associated infections, particularly Clostridium difficile. We have a new HEAT target on C diff, which is welcome, and we have reports of bug-busting inspection teams, which are equally welcome. However, the announcement of £54 million over three years has not been reprofiled at all. As I understand it from the papers, the budget line remains unchanged for 2009-10 and 2010-11. Given that the £2 million that you announced is not new money but part of the £54 million, can we be assured that the robust action that is required will be backed up by new resources, rather than by resources that are taken from elsewhere?

Nicola Sturgeon: First, I can give you the absolute assurance, which I have given on several occasions and will give to anybody who wants it, that there is probably nothing that is more important to me than the battle against infection. Does that mean that I will always be successful in the difficult task of controlling and preventing infection? The answer is no, because we will always have to deal with issues of infection in our hospitals. However, I am committed to driving down the rates of infection and to ensuring that, in terms of investment and good practice in our hospitals and other health care settings, we do everything possible to win that battle.

You referred to a number of specific commitments that I have given, or have indicated will be given over the coming weeks. For example, next year, we will introduce a new HEAT target to reduce rates of C difficile in our hospitals, and we will formally announce in the next few weeks a proposal for a new inspectorate that will look at issues around the care environment in our hospitals. Those aspects are part of the vitally important battle to beat infection.

On budget issues, you are right that the £2 million that I have announced will be made available to support the delivery of the HEAT target. Setting a target is the easy bit; what really matters is ensuring that all the right things are done to deliver the target. The £2 million will be geared predominantly and specifically towards improving antimicrobial practice and policy in our hospitals. I am sure that you know, given your knowledge of these matters, that that is not the only issue, but it is probably the biggest in relation to getting on top of C difficile.

You said that the budget has not increased. However, the budget for HAI has increased from the budget that I inherited. The annual spend on tackling infection in our hospitals was £5 million in 2007-08. This year, the spend has gone up to £12 million; it will go up to £21 million next year and will be £21 million in 2010-11. The budget is increasing and it will largely support the introduction of MRSA pre-admission screening for our hospitals. The budget will also support the delivery of the HAI task force action plan, which will be supplemented by the action plans that we produced in August in response to the Vale of Leven situation, and it will support some of the work that I have talked about around antibiotic prescribing, which is so important in tackling C difficile.

Jackie Baillie: I do not doubt your personal commitment. However, I think that the committee shares an agenda of wanting to ensure that you have sufficient resources to put in place all that is required. I was perhaps not clear enough in what I said about the budget. The profile for three years that the 2007 spending review identified is as you have outlined it. That profile has not changed, but you have new challenges to face, one of which is C difficile. The additional funding gives a helpful focus, but if we stretch it and dilute it, it will have less impact and will become problematic.

Nicola Sturgeon: I am not sure that that will be the case in reality, for a reason that I am more than happy to explain. Members will appreciate that, in a sense, this is a moveable feast. We allocated money over this year and the next two years for the piloting of MRSA screening, and then its full roll-out. Early indications are that the cost of that piloting and rolling out will not be as high as the amount that was allocated in the budget. That will free up additional resources for other aspects of our fight against HAI. I do not expect any member to know that from the available budget information. The budget has certainly not increased from the budget that was published last year, but I think that we will get more out of it than people might have thought. As I said, the pilots are under way, and we have the budget aspect under close scrutiny. I am more than happy to provide the committee with information on that on an on-going basis, as far as possible.

Jackie Baillie: That is helpful to know. The order of magnitude of the saving will indicate how much is then freed up. Do you envisage having enough in that saving to implement both the HAI action plan in its entirety and the inspection teams? If not, will there be additional resourcing?

11:45

Nicola Sturgeon: We have set aside the budget to deliver the HAI task force action plan. Remember that, under the budget that I inherited, the action plan was funded to the tune of £5 million, which is certainly within the budget that I have set. We will continue to keep those issues under review. I am confident that we have budgeted for the financial impact of our policies on HAI. I have already pointed out that the potential savings in relation to MRSA screening will allow money to be freed up.

The priority that I give the issue does not extend only to sitting before the committee and saying that it is a priority. I mean it, and I will be tested on that in the actions that I take. If ever I believe that we are not spending enough on tackling infection in our hospitals, I will address that, but I am confident that the policies that we have in place can be funded out of the budget.

The other point, which I make not to change the subject from the budget but because I believe that it is important, is that although it is, of course, vital that we put in place adequate resources to tackle infection, we must also ensure that we address the cultural and behavioural aspects of tackling infection. This is not all about money, although money is important; it is fundamentally about ensuring that the cleaning of our hospitals is done properly in practice and that people who work in and visit our hospitals wash their hands regularly and in the way that is required to deal with different infection threats. The issue is about practice, behaviour and culture as much as it is about money. I assure all members that, across all those fronts, the issue has my top priority.

Jackie Baillie: I agree absolutely with your final comment. You will forgive me—I was trying to frame the questions appropriately because this is financial scrutiny of the budget, and I suspect that the convener would have ticked me off had I strayed beyond that.

Nicola Sturgeon: I accept that, but there is always context that must be taken into account in any financial discussion.

Jackie Baillie: In that context, and sticking with HAIs, can I invite you to ensure that we look at hospital-by-hospital reporting, which has a small

resource implication but perhaps addresses the real problem?

Nicola Sturgeon: I assure you that I am considering all those issues. I have said before and I will say again that of all the areas in which party politics is least appropriate, this is perhaps one of the top ones, but I am dealing with an inspection and reporting system that I inherited from the previous Administration. If some of the ideas that I am hearing now about inspection and reporting had been voiced previously, better systems might be in place.

Notwithstanding that, I am carefully considering those issues. I want to ensure, not only for my own benefit—although it is important that I have confidence in the systems—but so that I can assure members of the public and people who use the NHS that we are spending enough money, that folk are washing their hands when and how they should be, and that robust systems are in place that will alert me and others when things are not happening as they should be. I am entirely focused on that task.

Jackie Baillie: I, too, do not want to stray into party politics.

Nicola Sturgeon: I am sure that you do not.

Jackie Baillie: Nevertheless, there are substantial issues that are not resolved by your saying that HAI was a problem 18 months ago. The level of mortality that I witnessed in my local community when the prevalence rates were no different from those at any other Scottish hospital suggests that particular things were wrong. I hope that we can work together to put those right—if this is not the time for party politics, let us follow that through.

Nicola Sturgeon: If all I was saying was that HAI was a problem 18 months ago and that was the end of the story, your comment would be correct, but that is not what I am saying. I am pointing out that the systems have been in place for some time, so if there are deficiencies we must all take some responsibility for them.

My focus is on correcting any deficiencies in the system. You are perhaps the one person who is as immersed in and as knowledgeable about the situation that you describe as I am. I am aware of the issues that we have to address and I am determined that we will address them. Members should appreciate that HAI is not only one of the most important—if not the most important—policy areas for me, but one of the most difficult. I am sure that the committee will retain an interest in it.

The Convener: I think that we are all on the same side. We can pursue the issue. We know that we will never end the problem but a lot can be done. We certainly accept that a big culture change must take place and that money alone is not the answer.

I see that Mary Scanlon wants to get in. Do you want to ask about HAI, or do you want to raise something new?

Mary Scanlon: I have three brief questions that have not yet been raised.

The Convener: You never disappoint me. Perhaps I will get a chance to ask a question at the end. Off you go.

Mary Scanlon: Why is the budget for health screening being reduced from £14.8 million to £10.8 million over the next two years?

Nicola Sturgeon: That change, which relates not only to the profile over the next three years but to adjustments between last year's and this year's draft budgets, has been made as a result of a reassessment of the costs of implementing the policy. The budget heading supports not only our existing screening programmes, such as those for cancer, but other very substantial developments in screening. For example, it will, over the next two years, support the implementation of two-view breast cancer screening in Scotland's six screening centres. That programme, which I announced earlier this week, will be rolled out fully by April 2010.

The budget supports and will continue to support the roll-out of bowel cancer screening and will support the implementation of new pregnancy and new-born screening tests, which will be in place by April 2010. It will also provide support over the next two years for the planning for the commencement of the roll-out of abdominal aortic aneurysm screening. Clearly, the budget is dealing with major priorities.

Mary Scanlon will appreciate that, as the efficiencies that can be made in the introduction and delivery of those programmes become clear, we will be able to reassess how much it will all cost. However, the changes that she has identified will not impact on our policy ambitions and our ability to deliver them over the remainder of the spending review period.

Mary Scanlon: I fully support the introduction of those programmes, particularly the screening for colorectal cancer. I know that that is being rolled out at the moment, and I look forward to its becoming available in Highland and the Shetland Islands. I congratulate the NHS on its being able not only to maintain its screening programmes but to expand them while making 30 per cent efficiency savings. That is quite commendable.

Nicola Sturgeon: I will pass on your congratulations to the people responsible.

Mary Scanlon: On page 43, under the promoting equalities and reducing inequalities heading, the draft budget document says that one of the range of programmes to be introduced will address "violence against women". Although I certainly support such a move, I note that there is no mention of violence against men or violence in same-sex relationships, which, according to recent figures, has increased markedly. Are we to assume that the programme will address violence in general or will it specifically address violence against women?

Nicola Sturgeon: I am more than willing to come back to the committee in writing on the detail of that. One consequence of our equality impact assessment is that we are not allowed to discriminate on the basis of gender—or, indeed, on any other basis—in any of this. The convener will not look favourably on me if I kick off a debate on the relative scale of violence against women and that against men and on why I think that that justifies the relative differences in spend, because I am sure that other committee members will be quick to join in. However, I will more than happy to come back to Mary Scanlon on the detail of that budget line.

Mary Scanlon: Finally, on the issue of carers, which has not yet been mentioned—

The Convener: Can we have a short question, please?

Mary Scanlon: Okay. Is the target of 10,000 extra weeks of respite care being achieved and is it covered in the health budget?

Nicola Sturgeon: The funding for the increase in respite care, which is a specific commitment in the concordat and will be achieved, is included in the local government settlement. We and the Convention of Scottish Local Authorities have signed up to that and, as I say, the resources required to achieve the target have been allocated specifically for that purpose.

However, as I said earlier, the miscellaneous line in the health budget includes funding for implementing carer information strategies, which are very important. All health boards now have a duty to prepare and submit a carer information strategy. We have raised that subject at every NHS board review to ensure that all NHS boards are aware of their responsibility not just to have such strategies in place but to do what needs to be done to implement them.

The Convener: Helen Eadie has a short question.

Helen Eadie: Cabinet secretary, your budget is founded not just on your expenditure but on your income. In the context of the changed circumstances of the present economic crisis, are you having to review your budget against that background as regards the capital receipts that you expect to gain from the sale of property? What impact might that have, ultimately, on spend?

The Convener: That was my question—I was hanging on to it for the grand finale, but there you go.

Helen Eadie: Sorry.

The Convener: That is all right.

Nicola Sturgeon: Whoever's question it is, it is a very good one, which is highly pertinent in the current climate. The short answer is yes—we are keeping all those issues under review. The budget lines for capital receipts are extremely important for our capital programme. This year's capital receipts rely on the sale of Bangour hospital and Bellsdyke hospital, for example, so we will keep a close watch on that aspect of our budget as we grapple with the difficult economic circumstances that everyone else is grappling with.

I know that that is not a terribly detailed answer, but it is as detailed an answer as I can give at the moment, given that it is a developing situation, which we must monitor extremely closely. The question was highly pertinent; it would have been just as pertinent if the convener had asked it.

The Convener: I have a supplementary to that, which is not just about capital receipts. In the unfortunate event that the economic downturn were to continue, there might be job losses and other events in society that would attack and impact on the health and wellbeing of the public at large. There might be impacts on the justice budget, such as an increase in crime—I am not encouraging that, but it could happen. You have identified the many uncertainties that you face, such as those to do with capital receipts and what the inflation rate will be. Given that your budget is fixed, what contingencies does the Cabinet have for dealing with the quite extraordinary circumstances that exist, whereby we do not know where we will end up as regards the health and wellbeing of the public?

Nicola Sturgeon: I will resist the temptation to start talking about other budget areas or the budget overall; the Cabinet Secretary for Finance and Sustainable Growth is better placed than I am to do that.

The vast majority of my budget is allocated to health boards, although we retain money centrally for national programmes, such as waiting time programmes. We do not retain that money centrally for ever—it all eventually finds its way to health boards, but for specific issues. There is limited scope for responding to some of the pressures and challenges that you mentioned, but I do not want to leave the committee with anything

other than a strong sense of how challenging the current situation is for everyone, individually and collectively, across the private and public sectors.

Those challenges are particularly acute given that we as a Government are dealing with a fixed budget. We cannot take from one area to give to another without that having an impact elsewhere in the budget. That is a big issue. We will work with NHS boards to do our level best to manage those challenges as effectively as we can.

Let us all hope that the present economic downturn is short lived and not as bad as some predictions suggest that it might be, but you are right—the impact on health services will increase. We must manage that through our budget. At a time of rising unemployment, public sector employment is extremely important. The health workforce has increased quite significantly in recent years and is still increasing. I looked at the figures not that long ago, and the present head count shows that there are 5,000 more people working in the health service than there were when the new Government took office in May 2007. The size of the health workforce becomes even more important when unemployment is rising in other sectors.

The Convener: That takes us neatly up almost to midday. We have just about kept to our timetable. Thank you very much for your extremely thorough evidence. The committee has looked under many stones.

That concludes the public business. We will move into private for consideration of items 3 and 4.

11:59

Meeting continued in private until 13:14.

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