HEALTH AND SPORT COMMITTEE

Wednesday 30 September 2009

Session 3

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CONTENTS

Wednesday 30 September 2009

	Col.
SUBORDINATE LEGISLATION	2233
Health Board Elections (Scotland) Regulations 2009 (Draft)	2233
Health Boards (Membership) (Scotland) Regulations 2009 (SSI 2009/302)	2244
BUDGET PROCESS 2010-11	2246

HEALTH AND SPORT COMMITTEE
25th Meeting 2009, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (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:

Professor James Barbour (NHS Lothian)
Susan Goldsmith (NHS Lothian)
Liz Hunter (Scottish Government Equalities, Social Inclusion and Sport Directorate)
Robert Kirkwood (Scottish Government Health Delivery Directorate)
John Matheson (Scottish Government Health Finance Directorate)
Kathleen Preston (Scottish Government Legal Directorate)
Jackie Sansbury (NHS Lothian)
Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health and Wellbeing)
Kevin Woods (Scottish Government Director General Health and NHS Scotland)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 30 September 2009

[THE CONVENER *opened the meeting at 10:32*]

Subordinate Legislation

Health Board Elections (Scotland) Regulations 2009 (Draft)

The Convener (Christine Grahame): Good morning and welcome to the 25th meeting of the Health and Sport Committee in 2009. I remind members, witnesses and those in the public gallery to switch off their mobile phones and other electronic equipment. No apologies have been received.

The first item on our agenda is an oral evidence session on an affirmative instrument that sets out the regulations for the pilot elections of members to health boards in Fife and Dumfries and Galloway under the Health Boards (Membership and Elections) (Scotland) Act 2009. Members have a copy of the draft instrument with their papers for the meeting. I draw members' attention to the note from the clerks setting out the Subordinate Legislation Committee's concerns about rule 5 of the schedule to the regulations, which relates to voter eligibility.

I welcome the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon MSP, who is here to give evidence on the regulations. She is accompanied by Robert Kirkwood from the business planning executive of the Scottish Government and Kathleen Preston, solicitor with the health and community care section of the Scottish Government's legal directorate. I remind members that this session is an opportunity to ask the cabinet secretary and the officials accompanying her to clarify certain points. Once we move on to the debate, which will follow, officials will not be able to participate.

Ross Finnie (West of Scotland) (LD): I will word my question slightly differently from the comments of the Subordinate Legislation Committee. It is quite difficult to construe how the schedule to the draft regulations relates to schedule 1A to the National Health Service (Scotland) Act 1978, which is derived from the 2009 act. I accept that paragraph 9(4) of schedule 1A states what we "may not entitle" people to do. I do not wish to dance on the head of a pin, but is a provision that states that we "may not entitle" people to do something the same as expressly providing for an act to be an offence?

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): I take Ross Finnie's point. Paragraph 9 of new schedule 1A to the 1978 act makes it clear that an individual is not permitted to vote twice, regardless of whether they do so in the same health board area or in different areas. However, it does not go on to stipulate the penalties for doing that.

Ross Finnie: Schedule 1A simply states that you have no power to allow an individual to vote twice. There is no express provision for that to be an offence. Is that not a lacuna?

Nicola Sturgeon: The fundamental point of substance is that the 1978 act contains a clear provision that it is not permitted for someone to vote twice. Guidance to the returning officers will make it clear that someone who is registered to vote in more than one health board area is not entitled to vote in more than one area.

Ross Finnie: However, it is not an offence for them to do so.

Nicola Sturgeon: The 2009 act does not specifically make it an offence.

Ross Finnie: It is, therefore, not an offence under the regulations.

Nicola Sturgeon: The regulations flow from the wording of the 1978 act. Ross Finnie will be aware, as he has the text in front of him, that the act states that regulations

"may not entitle an individual to vote … in more than one Health Board area."

It is clear that it is not intra vires for the regulations to deal with that issue. The central point is that the 1978 act makes it clear that an individual is not entitled to vote more than once in either one health board area or more than one area.

Ross Finnie: I wholly accept that the wording of the 1978 act makes it ultra vires for you to make a regulation that permits people to vote in more than one health board area. However, the issue for me is whether there is express provision for that to be an offence. It is not quite clear to me why it would be ultra vires for the regulations to state expressly the penalty for voting more than once and, therefore, to make that an offence, given that schedule 1A states that people may not vote twice.

Nicola Sturgeon: Are you suggesting that that could and should be done in the regulations?

Ross Finnie: Yes.

Nicola Sturgeon: I do not want to pre-empt the debate that we may have later. I have

demonstrated that the 1978 act makes it clear that it is not permitted for someone to vote twice. If the issue that Ross Finnie raises is of concern to the committee, we could undertake, after the committee has recommended that the regulations be approved, to lay amending regulations to put the matter beyond doubt.

The Convener: Mary Scanlon has a question.

Mary Scanlon (Highlands and Islands) (Con): It is on another issue.

The Convener: I am sorry—I skipped past Helen Eadie. I must not do that.

Helen Eadie (Dunfermline East) (Lab): I do not mind, convener.

My concern relates to the issue that Ross Finnie raised. Health board elections have not yet been rolled out across Scotland—at the moment, only two pilot programmes are proposed. However, it appears that the regulations that you propose we approve do not determine the effect of rule 5 in the schedule to the regulations, which will be dependent on returning officers using existing local government rules and processes, almost as a code of practice. Ian McKee and I are members of the Subordinate Legislation Committee, which was most concerned that the position could have been made much clearer. The legal effect of rule 5 needs to be assessed carefully. That supports the point that is being made by Ross Finnie.

Nicola Sturgeon: I have already said to Ross Finnie that, if that were the view of the committee, it would be possible for us to give an undertaking to lay amending regulations, which would allow the committee to agree to the substance of the regulations today. Such amending regulations would make clear what I believe is already clear in the primary legislation—that it is not permissible for somebody to vote twice.

Helen Eadie: I have a further question. At a meeting in Fife, I was told that the returning officer was not consulted on the regulations. That is a matter of some concern. Also, the representations that were made by the health board appear not to have had much cognisance given to them. That, too, is a matter of concern in Fife.

Nicola Sturgeon: Officials from the Scottish Government met the elections officials in Fife and in Dumfries and Galloway on three occasions over the summer in preparation for the elections. In those discussions, the elections officials in both areas expressed their confidence in the arrangements and in their ability to deliver the elections to schedule on the basis of those arrangements.

Mary Scanlon: I have a question on paragraph 11 in part 5 of the schedule to the regulations, which deals with the list of restricted posts. The issue came up in a few of the committee's stage 1 discussions on the Health Boards (Membership and Elections) (Scotland) Bill, which established the pilots. I was surprised to see that what is stated in the regulations is as unclear as what was stated during the passage of the bill in respect of

"giving advice on a regular basis"

and

"speaking on the Board's behalf … to journalists or broadcasters."

The list of restricted posts will now be at the discretion of each health board. Will you give us more clarity about what you expect? When the policy is rolled out, we could find that national health service employees, general practitioners and other, independent contractors such as optometrists and pharmacists may or may not be eligible, depending on the health board. I was looking for clearer guidance. Will you enlighten us as to what you expect?

Nicola Sturgeon: The arrangements that are set out in the primary legislation and in the regulations for giving health boards the ability to draw up a list of restricted posts are identical to the arrangements that exist for local authorities to draw up lists of restricted posts. We have not created a new system; we have simply emulated the system that already exists.

Under that existing system, the adjudicator—about whom I will say more in a moment—issues guidance to local authorities. It is our intention that adjudicator guidance will be issued to health boards as well, in order to promote consistency among health boards in the kinds of posts that may or may not be included. I add the caveat that different people in different posts in different health boards perform slightly different functions; therefore, those lists will not be absolutely identical in all circumstances in two different health boards. Nevertheless, that adjudicator guidance will promote consistency among health boards.

The regulations give more detail than the 2009 act about the adjudicator, as was intended. The regulations lay down clearly what is effectively an appeals process for somebody who disputes the fact that their post is, or is intended to be, included in a list of restricted posts. They can ask the adjudicator to adjudicate on that and, as you can see from the regulations, due priority is required to be given to any such applications, bearing in mind the fact that an election is imminent. The regulations clearly lay down that appeals process. I stress that this is not a novel system; we are simply applying the existing local authority system to health board elections.

10:45

We are dealing with pilot elections. All aspects of the operation of those pilots will be subject to independent evaluation before Parliament takes any decision on a future roll-out. There is an opportunity to consider how the local authority system works in the context of health board elections and, in theory, Parliament could decide to change that if it took a later decision to roll out the elections.

Mary Scanlon: I appreciate that there are similarities between local authorities and health boards. However, there are also clear distinctions. For example, 90 per cent of patient contact with the NHS is in primary care.

Under the proposed system, an appeal would go to the Scottish Public Services Ombudsman, which could take up to 18 months, by which time the election would have passed. For those reasons, I am looking for a bit more clarity.

Given that local government does not contract with pharmacists, optometrists and GPs, would those professionals, given their contracts with the NHS, be eligible to stand for a health board election?

Nicola Sturgeon: Yes. Obviously, health boards can compile lists of restricted posts, but there is nothing in either the primary legislation or the regulations to suggest that a contractual relationship between a health board and a GP or pharmacist would lead to such roles being included on a list of restricted posts.

The legislation says that there are two sorts of roles that might cause someone to be put on a list of restricted posts: one that involves someone giving advice on a regular basis to a board, which is significantly different from a contractual relationship; and one that involves someone regularly speaking on a board's behalf to journalists or broadcasters. It is quite clear, therefore, that a board's head of communications would fall within the category of people who could be included on a list of restricted posts, but that a GP, optometrist or pharmacist who has a contractual relationship with a board and who, from time to time, gives the board opinions or advice would not.

Mary Scanlon: The categories in paragraphs 11(1)(a) and (b) of the schedule to the regulations could also apply to a senior consultant in the NHS. However, as long as they did not regularly give advice or talk to journalists or broadcasters, no one at a certain level of salary or responsibility would necessarily be excluded. Is that correct?

Nicola Sturgeon: Absolutely. It is not the nature of someone's contract or their seniority in the NHS that should be the key factor in determining whether they are on the list of restricted posts but the nature of their relationship with the board. I would expect that, if there were any doubt about whether someone should be on the list of restricted posts, the balance should favour their not being on the list because the thinking behind direct elections is to increase participation in the business of health boards. Therefore, I would not expect boards to take an unduly restrictive approach.

The Convener: Rhoda Grant has a supplementary question on the same lines.

Rhoda Grant (Highlands and Islands) (Lab): I return to the issue of GPs who are independent contractors standing for election. What checks and balances will be in place for them when the health board discusses its relationship with contractors and the like? Somebody who supplied goods and services to a local authority would need to declare an interest and leave any meeting of the authority. Will it be the same for contractors in a health board?

Nicola Sturgeon: I take it that you are asking what would happen if a contractor was an elected member of a board. I look to the lawyer beside me for the answer to that, but I assume that it would involve declarations of interest.

Kathleen Preston (Scottish Government Legal Directorate): Once someone is a member of a health board, there will be no distinction between categories as to their duties. They will be subject to the same duties and obligations as other members, which will include their not being involved in decisions in which they have a direct interest.

Rhoda Grant: Will there be any difference in that regard between GPs who are employed by health boards and GPs who are private contractors? Will they have the same status, apart from the fact that GPs who are employed by health boards will not have to declare an interest?

Nicola Sturgeon: I will repeat my point. I do not think that the fact that someone is employed as a GP is an issue. Similarly, I do not think that the fact that someone has a relationship with a health board as an independent contractor in and of itself excludes them from standing for election. The issue would be the nature of their relationship with the board, bearing in mind the two headings in the 2009 act. If the relationship was considered to be close enough, it may lead to somebody being included on the list of restricted posts. However, I stress that there are adjudication provisions in the regulations that effectively constitute an appeals process. Ultimately, as with local authorities, we are giving health boards discretion, to an extent. I have made it clear that I do not expect health boards to take an unduly restrictive approach.

However, we have produced provisions that will allow any individual with a dispute over their inclusion on the list to go to adjudication.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I have two questions, one of which is about the poll closing at 4 pm. It is a postal vote, is it not? Are there clear indications as to what would happen if we were in the middle of the sort of problems that we currently have with postal services?

Nicola Sturgeon: I am pretty sure that we can provide the committee with more information about the contingency arrangements that any returning officer will have in place for postal ballots when there is a postal strike. I hope that the current dispute will be over by the time we get to the health board elections in June next year, but you can never tell.

Dr Simpson: I hope so, too. The other issue that was widely debated was that of 16 and 17-year-olds voting. It is now indicated that voters born before 1 December 1993 will be able to vote or to stand as a candidate. Have we resolved the publication issue?

Nicola Sturgeon: Yes. From memory, I think that that was resolved through Ross Finnie's amendments at stage 3 of the Health Boards (Membership and Elections) (Scotland) Bill. You will recall that the Health and Sport Committee had significant concerns about our original proposal to publish a young persons register. We will now simply use the information on the local government register. You referred to the eligibility of people who were born on or before 30 November 1993. Effectively, that means that somebody who is 16 on or before 30 November this year will appear as an attainer on the electoral register and on the register that will govern the elections in June next year, so they will be eligible to vote in June next year.

Dr Simpson: But under the registration process that is happening just now, what has been done to circulate information to individuals about the register or to seek individuals to go on it?

Nicola Sturgeon: It simply involves the registration processes that local authorities undertake to ensure that they capture data on 16 and 17-year-olds to allow them to vote in other elections as soon as they become 18, so there is no change in that respect.

Dr Simpson: I appreciate that such a compromise is probably required. However, I presume that those who are 16 on 29 November this year did not fill in the application form for the electoral register a year ago. Under the present system, in which 18 is the age limit, people apply well ahead to get on the electoral register. Their names can be published on the register if they are over 16, and their birth date indicates when they will become eligible to vote. Do you see what I am getting at?

Robert Kirkwood (Scottish Government Health Delivery Directorate): Let me try to answer that point. From preparatory discussions with registration officers and returning officers in Fife Council and Dumfries and Galloway Council, we understand that both councils will run a sweep-up campaign following the canvass that took place over the summer. Towards October and November, under the sweep-up campaign, the councils will contact individuals who are entitled to go on the register because they will be 16 on or before 30 November.

Dr Simpson: Thank you very much.

The Convener: That concludes our evidence-taking session.

We move to agenda item 2, which is consideration of motion S3M-4820. Does any member wish to debate the motion?

Helen Eadie: Yes.

The Convener: Under standing orders, the maximum time for the debate on the motion is 90 minutes. I call on the cabinet secretary to open the debate.

Nicola Sturgeon: The purpose of the draft Health Board Elections (Scotland) Regulations 2009 is to make provision—under sections 1 to 3 of the Health Boards (Membership and Elections) (Scotland) Act 2009—for elections to take place to Fife NHS Board and Dumfries and Galloway NHS Board. As members will know, the act, which was passed on 12 March this year, makes provision for pilot health board elections to take place. As members are well aware, any decision on further roll-out of elections will be for Parliament to take following independent evaluation. Roll-out will also be subject to the super-affirmative parliamentary process.

The regulations that are before the committee today are a development of the draft regulations that were submitted to aid the committee's stage 1 consideration of the bill in October last year. The regulations confirm that the pilots will be all-postal elections that will utilise the single transferable vote system. The election procedures that are laid out in the regulations are consistent with the content of the 2009 act.

To try to keep the administrative arrangements as simple as possible, we have borrowed heavily from existing electoral practice in local government elections and national park board elections. That mitigates the risks associated with attempting to introduce new or untested procedures.

As we have just touched on, to take account of the views that were expressed in Parliament during the passage of the bill, the regulations contain a significant modification in relation to the voting eligibility of 16 and 17-year-olds. Rather than proceeding with plans to construct a separate young persons register, the regulations provide that we will utilise the existing electoral register for local government elections. As I have just said, that means that anyone who is 16 on or before 30 November this year will be entitled to vote in the pilot elections next year.

As we discussed, the Subordinate Legislation Committee raised a concern about the eligibility of people to vote in more than one health board area during the pilot elections. I believe that the primary legislation is clear, but I appreciate the Subordinate Legislation Committee's concerns and the comments that members have made today. Therefore, I am happy to repeat my undertaking that we could come back with amendment regulations to make it clear that it is not permissible to vote on more than one occasion. If the committee is otherwise satisfied with the regulations, I do not believe that such a concern should prevent the committee from recommending today that the regulations be approved.

Finally, the committee will also today consider the Health Boards (Membership) (Scotland) Regulations 2009. Although those are subject to a different procedure, I will briefly outline their content since I am here. They set out the make-up of Fife NHS Board and Dumfries and Galloway NHS Board after the 2010 elections. The overall size of those boards will closely mirror their current set-up with one key difference: elected members and local authority-appointed members will together make up a majority of the board's members. That will be achieved by reducing the existing contingent of executive members to five and by not renewing, or terminating early, some appointments.

With those comments, I am more than happy to answer any other questions that the committee might have.

I move,

That the Health and Sport Committee recommends that the draft Health Board Elections (Scotland) Regulations 2009 be approved.

11:00

Helen Eadie: I propose an amendment: we should defer the decision on the regulations until we have taken evidence from Fife Council's returning officer, which I hope could happen next week. The deadline for approving the regulations is 12 October, when Parliament will be in recess. I hope that, after we have heard next week from Fife Council's returning officer, and possibly from Dumfries and Galloway Council's returning officer, we will be better informed. The cabinet secretary has given some assurances, which are helpful, but the fact remains that the Subordinate Legislation Committee reported to the lead committee and the Parliament that

"the response provided by the Scottish Government has not assisted the Committee in establishing how as a matter of law eligibility of voters is to be established in circumstances where a person could be entitled by the criteria set out in Schedule rule 5 to vote in more than one Health Board election."

The Subordinate Legislation Committee felt that

"failure to make specific provisions for such circumstances and leaving the matter to the discretion of individual returning officers is considered an unusual exercise of the power, given that the 2009 Act anticipated that criteria for eligibility would be set in these Regulations and approved by Parliament and not in guidance."

I cannot say what my source is for the information that Fife Council's returning officer had not been consulted, but suffice it to say that the information was second hand and not from the returning officer himself. However, I believe that the returning officer has raised that concern and others. It is appropriate for the committee to try to ensure that the elections are run as smoothly as possible and with the full compliance, help and support of the returning officers.

I speak as someone who supported the Health Boards (Membership and Elections) (Scotland) Bill. I have never been an opponent of direct elections to health boards; indeed, I fought within my party to have the bill approved. I am not attempting a wrecking manoeuvre; I simply want to ensure that we get the best law and the best regulations.

Ross Finnie: I will be brief. I do not entirely agree with Helen Eadie's suggestion. I ask the cabinet secretary to elaborate slightly on the offer of an undertaking that she made in her opening remarks. Given that the Government believed it necessary expressly to provide in new schedule 1A to the 1978 act that regulations should not allow people to vote in two places, and given that the cabinet secretary referred to the use of local government legislation, under which voting in two places is an offence, it is slightly anomalous that it is not made expressly clear in the regulations that individuals, never mind the electoral registration officer, have an obligation to comply with the law. At present, there is no penalty, although an implicit offence is created in paragraph 9(4) of schedule 1A. If the cabinet secretary gave a clearer undertaking, I would be content to rely on that and to allow the regulations to proceed.

The Convener: As no other member wishes to speak, I will let the cabinet secretary address the points that have been raised and then we will decide what to do.

Nicola Sturgeon: With regard to Helen Eadie's comments, the decision to recommend that the regulations be approved today—which would, of course, be my preference—or to defer their consideration for a week is a matter for the committee, not for me. I guess, however, that I am trying to influence that decision.

I am grateful to Helen Eadie for raising the point about the returning officer. I simply reiterate that my officials have met election officials in Fife and Dumfries and Galloway and will continue to do so as we move towards next year's elections. It is clearly as much in our interests as it is in the interests of returning officers in both health board areas for the elections to proceed smoothly and we will work very closely with returning officers to ensure that that is the case. Indeed, I give a very strong undertaking to the committee in that respect.

As for Ross Finnie's comments, I hesitate to say what I am about to say, but I am going to say it anyway even though I might be proved wrong. I do not think that it is an offence under local government legislation to vote twice. I believe that as far as local government is concerned if someone is legitimately registered in more than one local government area they can vote twice. However, I stand to be corrected on that point.

The undertaking that I am willing to give today to the committee—the precise details of which I am happy to put in writing after the meeting—is that I will make clear in amendment regulations what I believe to be clear in the 2009 act, that it is not intended that people be allowed to vote twice. In other words, voting twice will not be permitted. As for what the regulations can do with regard to the creation of offences, I will have to take further legal advice on the matter. I do not want to give the committee an undertaking that I might subsequently find myself unable to meet, but I certainly undertake to make it clear in regulations that it is not intended to permit anyone to vote twice.

The Convener: Of course, my only option now is to ask whether the committee agrees to the cabinet secretary's motion.

Rhoda Grant: Does Helen Eadie not have a chance to come back?

The Convener: The motion cannot be amended at this stage.

Helen Eadie: But do I not get a chance to respond to the cabinet secretary's comments?

The Convener: No. The motion has been moved, and the cabinet secretary has summed up. If you have something additional to say, I might be able to be flexible. However, either the cabinet secretary withdraws the motion, which she has not done, or we proceed to the vote.

Helen Eadie: All I want to say is that deferring consideration until next week would give us time to find out the cabinet secretary's plans with regard to enforcement. If she is able to respond in time, we will be able to reach a decision before the deadline of 12 October.

The Convener: I am just setting out the procedural options for the committee.

Cabinet secretary, you could seek leave to withdraw the motion.

Nicola Sturgeon: I am sure, convener, that you will knock me into line if I am getting procedurally out of line. I am simply trying to divine the committee's mood. Instead of forcing the committee into the position of having to vote down regulations that I sense it broadly supports, I would prefer to withdraw the motion and give the committee the week that it requires.

The Convener: The cabinet secretary has sought leave to withdraw the motion.

Motion, by agreement, withdrawn.

The Convener: That was very helpful, cabinet secretary. We will return to the issue next week.

The next item on the agenda is draft budget scrutiny. I think that I will suspend—

Ross Finnie: No, no—

The Convener: Do you not want the meeting to be suspended, Mr Finnie?

Ross Finnie: We have another piece of subordinate legislation to consider.

The Convener: Oh, I beg your pardon. [*Interruption.*] I am kerfuffled here. The official reporters will have difficulty spelling that.

Health Boards (Membership) (Scotland) Regulations 2009 (SSI 2009/302)

11:09

The Convener: Item 3 is consideration of a negative instrument. Members will have a copy of the regulations, which are associated with a pilot health board election, and a note from the clerk.

The regulations specify the total number of members and the number of each type of member of Fife and Dumfries and Galloway health boards following next year's elections to them. The Subordinate Legislation Committee reports that

several drafting errors that it identified—and which are highlighted in the clerk's paper—were drawn to the Scottish Government's attention. In its response, the Government acknowledged the errors but stated that, in its opinion, they did not affect the regulations' validity or operation. However, it undertook to correct the errors at the earliest opportunity, and the Subordinate Legislation Committee was content with the response.

If members have no comments, is the committee content to make no recommendation on these regulations?

Members *indicated agreement*.

The Convener: I thank the cabinet secretary and her team for their attendance and the committee for keeping me in order as usual. I suspend the meeting for a couple of minutes so that I can undo my kerfuffle.

11:10

Meeting suspended.

11:12

On resuming—

Budget Process 2010-11

The Convener: We resume with item 4, which is our oral evidence session with two panels of witnesses as part of our scrutiny of the Scottish Government's 2010-11 draft budget proposals. Members have with their papers a Scottish Parliament information centre briefing on the draft budget proposals for health and sport.

Our first panel consists of witnesses from the Scottish Government's health directorates. We have with us Kevin Woods, director general of health and chief executive of NHS Scotland; John Matheson, director of health finance; and Liz Hunter, director of equalities, social inclusion and sport. You are all very welcome. I understand that Mr Woods wishes to make some brief opening remarks.

Kevin Woods (Scottish Government Director General Health and NHS Scotland): Thank you, convener. I thought that it might be helpful to the committee if I made one or two contextual points.

Overall spending on health will increase by 2.4 per cent in 2010-11, which will produce an average annual increase of 3.6 per cent over the three years of the spending review period from 2008-09. Health has been protected from a potential £129 million budgetary reduction that arose from the English Department of Health's capital baseline reduction of £1.3 billion.

Expenditure plans for sport remain as previously published for 2010-11 at levels some 26 per cent above the baseline from the previous spending review. In addition, we have provided £11.6 million as planned for preparations for the delivery of the 2014 Commonwealth games.

The budget for health next year is therefore £11.35 billion, which in cash terms is an increase of £264 million or 2.4 per cent and in real terms is an increase of 0.9 per cent on planned expenditure in the current year. That represents a sum of £2,281 for every person living in Scotland.

11:15

The indicative allocation for national health service boards is an overall increase of 2.7 per cent, including 0.4 per cent for waiting times support. Precise allocations adjusted in accordance with the NHS Scotland resource allocation committee formula will be confirmed later in the year following Parliament's consideration of the budget.

Boards' expenditure plans are of course supplemented by the 2 per cent efficiency target that has been set, although the resources freed by efficiency improvements will be retained locally. In that context, I am sure that the committee will be interested to know that in June this year we published an important paper that sets out our strategic approach to efficiency and productivity. In summary, provided that boards achieve their efficiency targets, they will have on average a minimum of 4.3 per cent additional resources at their disposal, excluding the waiting times transfer to which I referred. We believe that that will be sufficient to meet health pay and price inflation and provide for some local service developments. In addition, boards will receive additional allocations for specific purposes.

I turn briefly to our priorities. As the committee is aware, we published "Better Health, Better Care" as the action plan for health and health care in Scotland. The budget is designed to support its objectives, including programmes on health improvement; health care quality; the reduction of health care associated infections; improved waiting times; enhanced specialist children's services; and developments in e-health. Of course, this year we have also had to increase substantially the resources that we set aside to deal with the influenza pandemic.

The past few years have witnessed a very positive performance by NHS Scotland, including improvements in service delivery and effective financial management. Our intention is to build on that excellent track record and steer a course that ensures that we continue to provide the highest-quality patient care we can.

Ross Finnie: I want to establish the starting point for the projections that you are making. If I heard you correctly, you told us that, if savings are made, the boards will enjoy an increase of 4.3 per cent and that you want to build on effective financial management. What actual financial information do you use in reaching those conclusions? The way the system works is that we get a budget and then we get another budget; we never ever get any actual information. It is a maybe-if budget and then a maybe-if budget, and the bit in the middle is quietly forgotten about. I am interested in your assertion. Clearly, you are able to direct me to information that tells me that you are clear about how the health boards are actually performing.

Kevin Woods: Of course, annually I produce a report on the performance of the NHS. This year, that report will be published in November.

Ross Finnie: I think that that is my point.

Kevin Woods: I will come back on that in a second.

Last year's report demonstrates clearly that the health service has delivered on virtually every target that was set for it and that, at the end of last year—this position is being maintained in the current year—the health service was essentially in a very strong financial position. We have reduced its dependence on non-recurrent funding to the lowest levels that I can recall—an important achievement by boards. We keep the overall performance of the national health service under close review, and the overall position is healthy and reflects a considerable achievement by colleagues throughout NHS Scotland.

We also keep the individual content of the proposed budget under very careful review. We always try to secure more effective ways of delivering things that we are committed to and, through better housekeeping and considering the profile of spend, we seek to ensure that we get the maximum value from the resources at our disposal. Obviously, we consider expenditure trends in areas of our activity as well.

Ross Finnie: I want to be clear. We are talking about the 2010-11 budget. What financial year of actuals are you referring to?

Kevin Woods: Sorry?

Ross Finnie: You said that your report shows that the health boards are meeting every target. The budget document makes absolutely no connection between targets and the budget. You referred to actuals that you had studied. What year are we talking about?

Kevin Woods: Both the current year and the previous year.

Ross Finnie: So your report refers to the current year.

Kevin Woods: The year that we will report on in November is that ending 31 March 2009. I am also saying to you that the position that I described for that year is holding in 2009-10.

Helen Eadie: My question concerns whether priorities can be achieved without a financial allocation. I am particularly concerned about service developments for older people and cancer patients, who are listed as priorities but have no specific financial allocation.

Our SPICe briefing papers say that performance has been worsening in four of the 14 health-related indicators: overweight children, premature heart disease deaths in poor areas, alcohol-related admissions, and repeat emergency admissions for older people. It is not evident that that has informed spending priorities for 2010-11. Will you comment on those indicators?

Kevin Woods: The member makes a number of points. If I cannot remember all of them, I am sure that she will remind me.

Spending on dementia is, of course, part of the baseline allocation that goes to NHS boards, and there is already significant committed expenditure in that area. We are committed to publishing a consultation on a forward strategy for dementia, which we hope to do in the very near future. We expect that that strategy and the consultation on it will inform considerations about future resource requirements for dealing with dementia, which may impact on the next spending review period.

We take account of spending on older people's care in general, which is important. Members will know from the "Better Health, Better Care: Action Plan" that the rising number of people who live with long-term conditions and the need to improve services for them have become central to our work. We have made provision for that work in the budget—I am thinking of improvement and support in particular—and we have made a specific allocation of £3 million to redesign services.

A more general point needs to be made. As we look forward, we must take account of the ageing of the population and the growing numbers of older people. That was clearly spelt out in Lord Sutherland's report on free personal and nursing care. Through the ministerial steering group—a joint group that involves the Convention of Scottish Local Authorities—ministers have undertaken to embark on a detailed analysis of the resource pressures. A series of considerations is being given to those pressures. In that context, we will develop the integrated resource framework—I know that that is a bit jargonistic—to look at the totality of health and social care spend on older people. That is an important piece of work for the future.

That is how we are trying to address the issues in a strategic way.

Helen Eadie: I also asked about the four of the 14 health-related indicators on which performance has worsened: overweight children, premature heart disease deaths in poorer areas, alcohol-related admissions and repeat emergency admissions for older people. To save you going into detail, I press for a more detailed note of the financial spending on those policy areas and the earlier ones to which you referred. It is simply not clear from the papers that we have whether any money follows those policy areas. I understand what you say about strategies, but it is important that the finance follows them. Therefore, it would be helpful if we could have a detailed note.

The Convener: Unless Kevin Woods wishes to answer on the spot, the committee will accumulate a list of points and write to him about them. We will take a note of those points.

Kevin Woods: I would be happy to provide such a note. There is a lot of information to be presented, so it would take a lot of time. Many of the points that Helen Eadie raised are central to our thinking about the budget. To take one example, next year we will spend £44.3 million on alcohol, largely on brief interventions. That is an issue of considerable concern to us. Our work on target setting and budgeting is intended to address the points to which Helen Eadie refers.

The Convener: I see that line. It is spending on alcohol misuse, not alcohol-related admissions.

Kevin Woods: Yes. The funding for that is in the baseline services that NHS boards have but, if our measures on alcohol misuse are effective—the committee will be aware of the proposed legislation that will come before the Parliament—they should, in time, have a beneficial impact on alcohol-related admissions.

Mary Scanlon: I would like a clear-cut idea of performance on the 14 targets from last year. As an ex-lecturer, I think that your report card brings you an achievement rate of about 30 per cent. Out of 14 targets, five are improving, four are getting worse, data are being collected on three and two are the same. I am trying to examine what has not been achieved so that we can work out how to shift money to achieve it this year. Apart from the £0.9 million on alcohol misuse, I am finding that difficult. I say that to support Helen Eadie.

You will appreciate that we do this work once a year and it is not always easy. What is the difference and relationship between a national indicator; a health improvement, efficiency, access and treatment—HEAT—target; a key priority; a target that has become a standard; and the draft budget?

Kevin Woods: The committee will take further evidence towards the end of October and, by then, we will have published our proposals on HEAT for 2010-11. I know that, in the past, the committee has been concerned to understand how the budget and the targets that we set for the NHS match up. Our HEAT proposals will enable the committee to see the whole picture, which is partly what sits at the bottom of your questions.

We have sought to align all the material that we place in HEAT with the Government's purpose, the outcome approach and the national indicators. It may be helpful to give the committee more information on that to demonstrate how we are trying to achieve alignment. As we look ahead, we are giving some thought to the content of HEAT in order to match the budget and retain alignment with the national indicators and so on. If it would

be helpful, I am happy to cover that in a more extensive note.

With the transition from a HEAT target to a HEAT standard, we are saying that we believe we have achieved the target but that we want to keep the matter in focus. We want to ensure that the standards that have been achieved across the service continue to be achieved because they are important dimensions of performance.

11:30

Mary Scanlon: Before I come to the specifics, you are saying that the HEAT targets are going to be more closely aligned with the national indicators. Will the HEAT targets and national indicators then become the key priorities?

Kevin Woods: I am saying that we have tried to ensure that in setting targets and the budget for the health service we support the broader Government objectives as reflected in the indicators. Later this year, as part of the Scotland performs process, we will demonstrate the relationship between the two things in public reporting. As I said, my annual report, which will be published in November, will set out a more comprehensive analysis—as it did last year—of what you described as the report card.

Mary Scanlon: It is just that there are three separate headings, and I am trying to find out which heading underpins the budget. However, I will leave that and move on to the change from a HEAT target to a HEAT standard.

The target for the sickness absence rate was 5 per cent by the end of March 2009, but the rate for the Scottish Ambulance Service is 5.4 per cent, the rate for NHS 24 is 6.9 per cent, and the rate for the state hospital at Carstairs is more than 6 per cent. That HEAT target was not achieved, yet it has become a standard.

Kevin Woods: First, the target was 4 per cent, not 5 per cent.

Mary Scanlon: The picture is even worse, then.

Kevin Woods: It is not even worse, if I may say so, in that the overall position for NHS Scotland at 31 March was a sickness absence rate of 4.43 per cent. That represents an improvement on the previous year, when it was 5.14 per cent, so you can see that there has been a significant downward shift, which is continuing. In terms of hours and people released, that translates in a standard working week into something like 1,100 additional staff at work, so a significant improvement has been achieved through the work that we have done on sickness absence.

I want to make an important point about the sickness absence target. The approach that we have adopted in NHS Scotland is to support our staff when they report that they are off sick, and we have developed a range of innovative services to do that. One of the most encouraging things is the fact that that work has been done in partnership with our trade union colleagues, who are very supportive of what we are trying to do.

We did not reach the 4 per cent target by 31 March, but we made a significant improvement during the year and the indications are that that improvement continues in 2009-10.

Mary Scanlon: I am pleased to hear that you are supporting staff—that is excellent—but the rates at NHS 24 and the state hospital at Carstairs are still 50 per cent above your target. They are both more than 6 per cent.

Kevin Woods: I am confident in saying that the rate of improvement that has been achieved is continuing. The rates at some of those places were previously higher.

Mary Scanlon: I am pleased by the improvement, but that was not my question. My question was whether you have achieved the target. I welcome improvements, but I am being specific and the target has not been achieved.

I will move on to some of the changes in the budget. I notice that capital investment is down significantly, by more than £100 million. How will that impact on the NHS? I am delighted that spending on e-health is going up from £97 million to £134 million, which is a £37 million increase, but I am a bit shocked that telehealth is included not in e-health but in capital investment, which is going down by £100 million.

Although we are making progress on e-health, it seems that telehealth is coming to a standstill. From my understanding of the HEAT targets, it appears that greater use of telehealth would allow you to get a pass rate of more than 30 per cent. Can you explain the rise in investment for e-health, why telehealth has been shifted to capital investment, and what cuts will be made?

Kevin Woods: There are a lot of questions there.

Mary Scanlon: They are all on the same subject.

The Convener: With Mary, it is always a journey.

Kevin Woods: I will ask John Matheson to clarify some of the numbers on capital expenditure if necessary, but first I will comment on capital before moving on to the other issues.

We accelerated some capital expenditure—which amounted to £50 million—into 2009-10, and we now have to repay that in the capital programme for 2010-11. The acceleration enabled

us, by and large, to maintain the integrity of the programme in 2009-10, when we inevitably faced a loss in capital receipts because of the recession.

We are currently undertaking a careful examination of the profile of that capital spend across NHS Scotland. It is important that I reassure the committee, however, that we are confident that the reprofiling will have no adverse effect on our plans for three major capital programmes that are scheduled to start in 2010-11: the Southern general hospital, the new children's hospital in Edinburgh, and the Aberdeen emergency centre.

We always planned to increase spend on e-health during the next spending review period because we spent some time on a review of our approach to it, which was discussed at this committee and at the Public Audit Committee. We are now in the final year of the current spending review period, and we always anticipated that e-health spending would go up at this point. That increased spend will enable us to do various things that are important for a number of reasons to do with service quality, efficiency and so on.

First, the increased spend will enable us to increase our telecommunications capacity and to link systems together, which is important as we will be investing in the establishment of what we call the clinical portal. I will spare the committee the details, but it is essentially a way of creating the electronic health record, which is the prize that we have always pursued through the e-health strategy.

Secondly, the increased spend will enable us to make progress on the replacement of patient management systems in our hospitals, and the replacement of the general practitioner information system. This time last year, the committee was interested in how that system was going to operate and what its relationship would be with community nursing and other community applications. We are approaching it in a way that will ensure that the system that replaces the general practice administration system for Scotland can provide a platform for connection with those other systems.

The line for telehealth refers specifically—I believe—to investment in the Scottish Centre for Telehealth in Aberdeen, which we are committed to maintaining. John Matheson might want to comment on why it comes under one particular line in the budget rather than another. Telehealth may evoke images of video technology and so on, which is important, but we should not lose sight of the fact that the biggest application of telehealth in NHS Scotland is the operation of NHS 24. That system is performing extremely well and is central to our response to the flu pandemic. I take Mary Scanlon's point, which relates to the investment in the centre in Aberdeen, but we are investing heavily in telehealth in a broader sense.

The Convener: You mentioned the flu pandemic, Mr Woods. Does any part of the money that is set aside for that relate to telehealth, or does it concern other matters entirely?

Kevin Woods: The resources that are set aside for flu in 2010-11 are primarily for the immunisation programme. They will also ensure that we have sufficient supplies of antibiotics and antivirals and will, in part, support NHS 24 and the Scottish flu response centre. In addition, they cover a contingency that we do not believe that we need to use at this stage. We have the option of implementing the national pandemic flu service, which has been developed with other countries in the UK.

The Convener: That is embedded there.

I will let Mary Scanlon back in later on in the cycle.

Rhoda Grant: Last year, Audit Scotland published a financial overview of the NHS in Scotland, in which it identified cost pressures such as agenda for change and equal pay claims. Have figures now been attached to those cost pressures?

Kevin Woods: The good news on agenda for change is that we have completed the assimilation process for all staff. That was a huge undertaking, because it embraced the vast majority of people who work in NHS Scotland. Any arrears of pay that were due have been paid. There is an outstanding set of issues, where people have asked for a review of the outcome of agenda for change. All those costs have been met from within the existing baseline. We do not expect that to be a cost pressure in 2010-11.

Equal pay is a rather more complex issue, which we have discussed in great detail with Audit Scotland. I invite Mr Matheson to give you an update on that.

John Matheson (Scottish Government Health Finance Directorate): In concluding the accounts for 2008-09 we had detailed and productive discussions with Audit Scotland, the outcome of which was that Audit Scotland accepted my view and that of the directors of finance that it is not possible to put a financial value on the equal pay claims at this point, because of their generic nature. However, we have—quite correctly—acknowledged that equal pay is an issue by noting it in the accounts as an unquantified contingent liability. Although we acknowledge the issue, it is not possible to put a value on equal pay claims at this point. The auditors accepted that and the accounts of all NHS bodies were unqualified.

Rhoda Grant: Does the budget include a contingency to cover the outcome of the process, or are health boards expected to meet that from their own resources?

John Matheson: At the moment, because it is not possible to put a value on it, the accounts include a note on equal pay, but no financial value is attached to it.

Rhoda Grant: So you have no idea how the cost of equal pay claims will be met.

John Matheson: We have taken legal advice on the issue. Given the nature of the claims that have come in, it is impossible to quantify them at the moment.

Kevin Woods: I have another point about the implementation of agenda for change. Agenda for change is designed to be—and we believe that it is—an approach to pay in the NHS that is, if you like, equal pay proofed.

The Convener: Do you want to pursue the matter, Rhoda?

Rhoda Grant: That is puzzling—those two answers do not seem to add up. You are saying that you have dealt with equal pay.

Kevin Woods: I am sorry; I may have misled you. I am saying that there are some historical, pre-agenda for change claims for equal pay, but that agenda for change is an equal pay-proofed pay system for the NHS. We are talking about historical claims.

Rhoda Grant: Is it not possible, using the work that has been carried out on agenda for change and the historical position, to put a figure on what may be outstanding, or am I missing something?

John Matheson: The issue is finding comparators to assess the potential value of the claims that have been submitted. The comparators are not clear at this point, which is why no value can be put on them.

Rhoda Grant: But would the comparator not be the position post-agenda for change? Has that not dealt with those issues?

Kevin Woods: It is quite a complicated area and I would be happy to provide the committee with a note on the background that would set out the issues rather more fully.

The Convener: I will add that to the list.

11:45

Dr Simpson: You have concluded agenda for change, but would it be possible for your note to specify the appeals that are still pending? Those will be partly related to the equal pay issue. I know of people who are doing similar jobs in different health boards—even in different areas within the same health board—who are in different pay bands. There clearly are still problems. It is not just about the traditional approach to equal pay; it is about the comparators across health boards.

Kevin Woods: There is an important distinction to be made, which we will draw out in the note. I will say a few words about the review arrangements, which are to do with people comparing rates in different parts of a health board or between health boards. In partnership with our trade union colleagues, we have set up various machinery to ensure that we can compare the levels of reward so that there is consistency. Inevitably, however, there have been some requests for reviews, which are being handled. We will set that out for you in our note.

Dr Simpson: Audit Scotland's report on maintenance within the health service indicated that there is a £500 million maintenance backlog except in public-private partnership buildings where maintenance is part of the contract and, therefore, not a problem. I am not sure how that squares with your saying that all the targets are being met and your welcoming the lowest level of transfer from non-recurrent funding to revenue—which is excellent. If there is a £500 million maintenance backlog, there is still some way to go to bring things up to scratch. How is that being addressed in the budget?

Kevin Woods: That figure for the maintenance backlog includes a number of hospitals and facilities that are due for replacement as a function of the capital programme. The three examples that I gave are good examples of our legacy in terms of the fabric of existing facilities and that is why we are investing significant sums to address the issue.

Beyond that, we have made provision for the modernisation of premises and so on in primary care and community health care. Each year within the capital programme we also make resources available to health boards to enable them to address other backlog maintenance issues that may not be within the major capital schemes to which I refer. Mr Matheson might be able to give you a bit more detail on that.

John Matheson: I will also cover Mary Scanlon's question about the movement of £100 million. I reassure the committee that the total capital spend across 2009-10 and 2010-11 will be as per the indicated figures across the two years, amounting to £1.25 billion. The £100 million movement was caused by the acceleration of £50 million of capital expenditure from 2010-11 into 2009-10. So, the capital expenditure has increased by £50 million in 2009-10 and has been reduced by £50 million in 2010-11. That accounts for the £100 million movement.

As Dr Woods said, an element of the £570 million that will be spent in 2010-11 will be allocated to specific capital projects, including primary care developments. An element of that is also allocated on a formulaic basis, reflecting the need of individual organisations to spend money on extraordinary maintenance and deal with the backlog of maintenance. Detailed assessments are carried out at the local level to establish priorities in that. Boards will also receive money specifically for replacement medical equipment.

Dr Simpson: It would be helpful to get some more detail on that in the note. I understand that you will not have the detail down to the level of the last sphygmomanometer. Nevertheless, if you could make a general division between the capital spend related to extraordinary maintenance and what will fall out because the buildings will no longer be used—because there will be a transfer to new buildings—that would be helpful.

My other questions concern some of the reducing elements in capital spend. The reductions in expenditure on health screening and health protection are both described in your personal letter to SPICe as "refinements". A reduction in the health screening programme of 41 per cent in real terms and a reduction in the health protection budget of 25 per cent in real terms are both described as "cost refinements". To me, a refinement is when you make marginal adjustments to previously determined costs, whereas those reductions are quite substantial. How will you be able to lose nearly £6 million in health screening and £8.8 million in cash terms—£9.2 million in real terms—in health protection without those services being affected?

Kevin Woods: The £6.5 million reduction that you refer to is a function of some reprofiling of spend related to seasonal flu vaccine uptake by carers. There is also some reprofiling of spend in relation to genetics. Again, I would be happy to set out the detail of that for the committee.

I emphasise that we will continue to support some important initiatives within that programme, and the committee should be reassured that we will still be spending £9.5 million to slow the spread of blood-borne viruses and more than £6 million on sexual health services, and we will still be progressing the seasonal flu campaign.

In the context of health protection, we have considered the nature of our spend on hepatitis C with regard to what we seek to achieve. We have made a small transfer to the Scottish Prison Service in relation to hepatitis C, but we believe that we can deliver the additional treatments that we are committed to, which is an extra 500 treatments in 2010-11, from the resources that are available.

All those points are examples of how we keep this budget under review.

More generally, I should point out that in 2010-11 we have made specific provision for the pandemic flu situation that I referred to earlier.

Dr Simpson: I have no concerns about the transfer with regard to hepatitis C, but it would be helpful to get a note on health screening and health protection.

The reductions in workforce training and nurse training are fairly substantial. I am concerned that the seedcorn of nurses coming through will be affected by the fact that we are reducing the number of nurses in training. I appreciate that the intention is to improve retention to compensate for the reduction in the number of nurses training, but I see no evidence of that so far in terms of the anecdotal responses that I have had from various contacts. That is a piece of on-going work that has not yet achieved anything. I understand the intention, but I am concerned that the training budget is being reduced before there is any sign of your having improved retention. The review of nursing in the community has run into the sand and is, in effect, being abandoned, and there are extremely poor levels of recruitment in health visiting. I am concerned that we will end up facing a problem that will have been created by this budget. Could you reassure us about how you are tackling that difficult area of workforce planning?

Kevin Woods: Again, rather than relying on anecdote, it might be helpful if we supplied some more information on retention.

I am not sure that I would agree at all with the description of the RNIC as having run into the sand and been abandoned. We have learned a lot from that process. We have worked closely with colleagues in the Royal College of Nursing and other trade unions, and many important facets of that programme are continuing.

The more central point in relation to the nursing workforce is that the adjustments that we are making in the budget reflect the fact that we will continue with the agreed 2008-09 intake levels, which were informed by board workforce plans. Intake levels are being held at that level to reflect needs in the NHS. Obviously we make savings on student bursaries as a consequence of that, and that is part of the explanation for the fact that we do not need to spend as much money as we might have done. We believe that the numbers in training are adequate for the needs of the national health service.

Dr Simpson: Could I have one more reassurance, which is that there will be no cut in child care provision? One of the biggest retention issues is that, because of shift work on placements and so on, nurses have real difficulties

with child care arrangements. I hope that that is not cut.

Kevin Woods: I am not aware that there are child care cuts, but I will check that and cover it in the note.

Ian McKee (Lothians) (SNP): Dr Simpson talked about budgets that seem to be decreasing. I will talk about one that has a real increase of 5.6 per cent: the budget for distinction awards for hospital consultants is going up from £28 million to £30 million. As the award will be reflected in pensions, I imagine that, if we add the pension entitlements of people who are retiring, the total cost of the £30 million could go up to £45 million.

Distinction awards are widely regarded as a rather anachronistic set-up: a high-earning group gets the award; it is only for one lot of health service workers; 50 per cent of retiring consultants get a distinction award, which seems to go against the spirit of the thing; and there is quite a large variation depending on specialty and gender. Now that we are facing a much tighter budget, is there not a case for arguing that the budget for distinction awards should, at the very least, be flatlined, and the £2 million spent elsewhere on health services?

Kevin Woods: The principal reason for the increase in the cost of the distinction awards scheme is the increasing number of consultants in NHS Scotland. That increase has been one of our objectives for a number of years, and it has borne fruit, so more consultants are eligible for the awards. The value of distinction awards is determined by the Doctors and Dentists Review Body, which is the independent body that looks at remuneration for the professions. The scheme has existed since 1948, and it is an integral part of the—

The Convener: I do not think that we are seeing that as a plus at the moment.

Kevin Woods: It is important for the committee to understand the history of the award.

It is an integral part of the remuneration of senior doctors and it is provided to recognise clinical excellence and leadership. There has been criticism of the nature of the scheme, which is why the previous Administration set up a review to ensure that it was operated in a more transparent and demonstrably fair way. The cabinet secretary sent the outcome of that review to the committee, and it includes a number of important proposals to achieve just that. We will issue more definitive guidance in due course. The present Administration has accepted the outcomes of that review.

The award is an integral part of remuneration and it would be difficult for Scotland to deviate from a United Kingdom scheme because that would create a significant differential that could be disadvantageous to the health service in Scotland.

Ian McKee: Do you agree that terms and conditions of service for hospital doctors are a devolved matter and that it would be possible to diverge from the scheme? We are not bound by UK diktat on that.

Kevin Woods: It is a devolved matter, and to that extent, it would be possible to diverge from the scheme, but no Administration has chosen to do so.

12:00

Ian McKee: Not yet.

I will ask a question about the sport element of the budget.

The Convener: I am glad that you have come to that; Liz Hunter is sitting there and we have important questions to ask about sport.

Ian McKee: I think of everyone, convener.

The Convener: You do indeed, Ian.

Ian McKee: There seems to be quite a rate of decrease in the budget for sport as opposed to the budget for the Commonwealth games, which is a separate entity, yet when we took evidence on pathways into sport and physical activity it became obvious that an awful lot of work needed to be done to get people into not only sport as such, but physical activity. Can you explain how that fits in with such a diminution in the budget?

Kevin Woods: I am not sure that I believe that the budget has diminished. I will explain why, if I may. The overall budget for sport was always profiled in this way. As I said in my opening remarks, the funding for sportscotland is about 26 per cent higher than it was in the previous spending review period. I make my comments against that background.

There was some additional expenditure in 2009-10, which was to do with the reorganisation of the bodies in the sports world. Sportscotland has been created, bringing it together with the Scottish Institute of Sport, and six new hubs have been created. Liz Hunter will elaborate in a moment, but it was always planned that in 2010-11 spending on sport would be £43.3 million and that is what will happen—the budget is as was planned at this time last year. A very important point is that, as you say, in addition there is £11.6 million in the budget for the Commonwealth games. Again, that is the amount that we planned at this time last year and it is the amount that the organising committee was expecting and believes is sufficient for 2010-11. Overall, the position on sport is comparatively good.

Ian McKee: You are happy that the amount of money that is going into sport as opposed to into the Commonwealth games is enough to accomplish the ambition of the Scottish Government and the committee to encourage more people in Scotland into physical activity.

Kevin Woods: Within the sportscotland budget there are a number of important specific commitments, not least the active schools co-ordinators, which supplement the efforts that we are making to try to increase physical activity in schools—£12 million is set aside for that. There is a sum of money in excess of £1 million to strengthen coaching, which is an important factor in retaining people in sport. Of course, we have some additional resources—I cannot remember how many, but Liz Hunter might be able to help you with that—for high performance sport, which is obviously important as we prepare for the Commonwealth games. Beyond that, sportscotland has a facilities fund, which it is investing in improved facilities throughout Scotland.

Liz Hunter (Scottish Government Equalities, Social Inclusion and Sport Directorate): I will supplement what Dr Woods has said. Clearly, more can always be spent but, given that there is a 26 per cent increase in the baseline for each of the three years of the spending review compared with last time, there is a substantial increase in cash and in real terms in what the Government is investing in sport.

The £4 million reduction between 2009-10 and 2010-11 is explained by the relocation of sportscotland and the merger of the two bodies; there was a one-off payment in this financial year to cover that. As Dr Woods mentioned, there is £5.8 million in sportscotland's budget that it uses on elite sport and it is working towards the 2010 Commonwealth games in Delhi. A decision was also made that additional funding of £3.75 million would be found over and above the baseline sportscotland budget, largely over this financial year and the next, to support the coaching of elite sport and that pathway. That investment is being made in addition to the sportscotland line that you are looking at in the budget.

The Convener: I am in the hands of committee members. I am aware that the next panel of witnesses has been sitting around for some time now, but I see that Helen Eadie, Mary Scanlon, Rhoda Grant and Ross Finnie want to get in.

Rhoda Grant: I do not have a question.

The Convener: That pares the number down to three.

If members put their snappy questions on the record, the witnesses can answer them in their written response along with the other questions that have been raised. Are you content with that?

Members *indicated agreement*.

Helen Eadie: With regard to the workforce line, the SPICe briefing says:

> "the reduction primarily represents an expected savings in respect of Scotland's contribution towards running costs of several UK-wide medical bodies."

I would like more detail on that. The cynic in me feels that it is part of the break up Britain campaign.

Mary Scanlon: I have four snappy questions, the first of which is a supplementary to Richard Simpson's earlier question on workforce planning and the numbers of nurses and students in education. I listened carefully to Mr Wood's response to that question. I cannot imagine that all that much has happened in a year but, even so, the fact is that, in last year's draft budget, planned spend on nursing in 2010-11 was £163 million. That means that this year's figure has actually gone down by £11 million, not £5 million. Moreover, in last year's draft budget, the intended workforce budget in 2010-11 was £34 million, whereas in the 2010-11 draft budget it is down to £28 million. What, according to all your demographic figures, academic literature and so on, has suddenly changed in that respect?

Secondly, funding for health screening is considerably down, from £14.2 million in last year's budget to £8.5 million, which is even more of a drop than you anticipated last year. Last year's draft budget included £27 million funding for cervical cancer vaccination this year, but that is not mentioned in this year's draft budget. Where can I find that figure? Similarly, where has the budget line for cervical cancer screening gone?

My third snappy question is about the Scottish intercollegiate guidelines network guidelines, which are issued regularly and are welcomed by everyone. I understand that guidelines on diabetes have recently been published and that, in the past few days, a very good set of guidelines on stroke management has been issued. However, doing what the Government intends will come with price tags, and I see no price tags for achieving those aims.

My final snappy question is about the HEAT targets for reducing admissions, long-term conditions and so on. Telehealth could be the best innovation in the NHS in decades, with evidence from the telehealth pilot in Argyll—I know that another is running in Lothian—showing that there have been no hospital admissions for people using the new home pods or cardiopods. However, I am seriously concerned that telehealth has been taken out of the e-health budget, which has been increased, and lumped in with capital investment

for the Southern general hospital and so on, the budget for which is facing a huge cut. I seek assurances that telehealth will not be cut and that it will enjoy some of the increase in funding for e-health.

Those are my four snappy questions.

The Convener: There was a long preamble to that final one, mind you. In short, Dr Woods, has telehealth been cut?

Kevin Woods: We will be very happy to provide a comprehensive response to those questions. Many of the points that are being pursued are in the budget detail that is one level down from that which is presented. I understand the reasons for that. We will give you a full answer.

The Convener: We will not need to incorporate those points in a letter. Obviously, you can read the *Official Report* of the meeting.

I have not forgotten Ross Finnie—he is next.

Ross Finnie: To encourage you, convener, I have only 11 snappy questions.

The Convener: With short preambles.

Ross Finnie: I want just briefly to round up the issue of savings. I was enormously encouraged by the almost unequivocal assurance that Dr Woods gave that all those magnificent achievements on efficiency savings that health boards are making are being delivered and continue to be delivered. I do not doubt that, but I have a puzzle. I want to know what happened between 2008 and 2009 to allow you to make that assertion. Audit Scotland's "Financial overview of the NHS in Scotland 2007/08" stated that the claimed savings from the efficiency delivery plan amounted to £610 million—they are listed in exhibit 7 of the report. However, Audit Scotland was totally unable independently to verify any of those savings. Although I in no way doubt what has been put to us, I am extraordinarily interested to know what audit methodology the Scottish Government has adopted that has enabled it to do what Audit Scotland was manifestly unable to do only a year ago.

The Convener: That concludes the evidence session. I thank the witnesses for their evidence. We shall move on directly to the next panel of witnesses, who have waited long enough. I suspend the meeting for one minute to allow the witnesses to change seats.

12:11

Meeting suspended.

12:12

On resuming—

The Convener: Our second panel of witnesses are from NHS Lothian. They are here to give evidence about the board's efficiency savings and its lean in Lothian programme. James Barbour is the chief executive, Susan Goldsmith is the director of finance and Jackie Sansbury is the director of strategic planning. I thank them for waiting and for the board's written submission, which members should have received electronically last night. I take it that you do not wish to make an opening statement, now that we have that submission.

Professor James Barbour (NHS Lothian): I am in your hands, convener. I could give you two minutes on the context, or I could deal with that in one of the answers—whatever is easier for you.

The Convener: A snappy two minutes would be excellent. "Snappy" is the word of the day.

Professor Barbour: I will be snappy.

Thank you for inviting us. We began the programme in 2005, when we had just moved from having an internal market to single-system working. It was apparent to us that we needed to find ways of doing things in a fundamentally different manner. At that time, we had several strategic drivers to which we had to respond. There was the issue of mutuality and how we would empower patients and staff to be involved in the design of services. We embraced the concept of subsidiarity, which is about giving to the lowest possible level power and control over redesign of services. We also had issues to do with capacity. In NHS Lothian, we are continuing to respond to increasing demand and we need to be able to respond to that in a manner that is not solely about finding solutions that involve additional finance.

All those were, and remain, big challenges for us because our population is increasing, is increasingly elderly and its expectations continue to grow. We also had the specific difficulty that, to meet the new HEAT targets, in particular the cancer targets, and to deliver the performance that everyone is entitled to expect, we needed to redesign fundamentally what we did and we needed a vehicle that would enable us to do that and which would change how people worked and thought.

12:15

We alighted on the lean programme because it is, above all, intuitive for health service staff, given how they work. Solutions that are generated by front-line workers can be tried out and experimented with, hypotheses can be tested, and methods that are grounded in their knowledge can

therefore be introduced. Our watchword was that we should value our staff's ingenuity and creativity by implementing what they told us to implement.

When we started the lean programme, NHS Lothian was the only board in Scotland that was implementing it. We heard at the meeting of chief executives last week that all boards in Scotland are now embracing it, supported by the Scottish Government, in one form or another. I was delighted that Dr Woods confirmed the position with regard to the Edinburgh children's hospital. Even in that, we are subjecting the building design to lean processes.

NHS Lothian's ambition is to be Scotland's best, and to be in the world's top 25 health care systems. We intend to achieve that using the lean programme as a fundamental plank.

Dr Simpson: The programme is interesting. As a clinician, I was on the receiving end of little bits of it, and I occasionally observed it.

Subsidiarity should not be underestimated. Getting front-line staff to think about what they are doing and not having a top-down management approach are fundamental to the lean approach, which is productive through its empowering of staff, patients and other service users.

We asked you to come to the meeting to give evidence on the budget, so my question is related to the budget. At the end of your briefing paper, you have helpfully included a table with a final column that shows the types of benefits that are achieved. The committee is wrestling with time-releasing savings versus cash-releasing savings, and non-recurrent and recurrent savings within cash-releasing savings. We have been trying to get a handle on those things in order to understand efficiency savings properly, although I do not think that we have done so very successfully so far.

We can debate which of the savings are, and which might be, cash-releasing. Quite subtle distinctions are involved. In your table, productivity savings amount to almost half the total savings—the figure is about £1.94 million, plus the £150,000 non-recurrent savings from computed tomography scanning. Therefore, we are talking about roughly £2 million out of your predicted savings of £4.5 million. How do you define cash-releasing savings? What do you do with the money? Does it simply go back into the service or can you genuinely release cash for new services? Can you identify them? Is the Scottish Government picking that up from you? In his previous question, Ross Finnie suggested that Audit Scotland was unable to identify savings in 2008, but we are now being told that everything in the world is lovely.

Professor Barbour: I will answer the generality of that; Susan Goldsmith will then talk about the precise methodological points.

It is important to say that we in NHS Lothian have generated north of £80 million-worth of local efficiency savings over the same period. Those savings are auditable and can be checked, and are clearly embedded in the budget-setting process that we undergo. It is also important to say that, when we embarked on work on the lean programme with GE, we agreed up front that we expected a 3:1 ratio of savings delivery from our investment, but we have done better than that.

I will hand over to Susan Goldsmith to talk about the process through which we identify cash-releasing as opposed to productivity savings, although I will say that, where savings are cash-releasing, the cash is actually released and is recycled as part of the prioritisation process that we have set out in our submission. The money is retained in the system and reinvested to support aspirations and developments in the system.

Susan Goldsmith (NHS Lothian): Through the planning process, we agree a level of local reinvestment and take the money out of the budget. The lean programme allows local managers to deliver the savings that come out of the budget. It is important that we also track non-cash savings because, as Professor Barbour mentioned, we have pressures in respect of capacity issues as a result of population growth. It is important that we understand where we are freeing up capacity, so that when there is a requirement for additional services, we can contribute capacity and cash savings to that to offset any required investment. We carefully track cash and productivity savings, because we need both of them to support our agenda.

Dr Simpson: Your comments are helpful.

We wondered about incentivisation. The process is an incentive, as it gives people the space and time to examine whether they are doing things in the right way. I know that you have created a number of senior-led groups to do that. How do you incentivise people? How have you set up the teams? I believe that they have been asked to select their own members, which is interesting.

Professor Barbour: When we began the process, people thought that the lean programme might be slightly alien to them and they were uncomfortable with it. By the time we were halfway through the first programme, we were getting calls daily from people who wanted to go through the process.

Incentivisation works at a number of levels. The first and most powerful level is that almost all the health care professionals with whom I have worked over 32 years in the health service want to

make their service better: the incentive is to improve the service that is offered and to do so in a manner that is owned by you and your team. It was a huge incentive when people saw that they were being given protected time and space to come off the job to work for four or five days on problems with CT scanning or delayed discharges, and that they were going to be supported by implementation. The challenge in the system is that when people told us, as they did, that they needed fundamentally to redesign their workplaces, which included knocking down walls, we had to honour our commitment by delivering.

Interestingly, we have now gone beyond lean to a new programme that we call 5 x 5 x 5, as we have learned from the lean programme that the ingenuity of our staff knows no bounds. This year we are working on the five most pressing problems that NHS Lothian faces. We have created five teams to address those problems, with five people in each team, and we have allocated £50,000 per team to allow them to go anywhere in the world to bring back the world's best solutions for us. We have discovered the power of what people do.

It was important that teams were able to select their members. Partnership engagement was embedded in all the teams—the trade unions bought into the programme at the beginning and have supported it. The teams were drawn from the workplace on a multidisciplinary basis. In one case, their membership ranged from a neurosurgeon all the way through to administrative and clerical staff and hospital porters. The power of that approach must be seen to be believed. Seeing people enthused, focused in the workplace, owning the solution and implementing it is genuinely transformational.

Helen Eadie: I, too, congratulate Professor Barbour on what appears to be a fascinating approach to improving efficiency and productivity. An impressive number of partners are engaged in the process. How do you match that with political priorities? Members know that scarcely a month goes by without several issues of high priority and visibility being raised in Parliament. For example, Mary Scanlon and I have been working hard on the issue of infertility services. How do you address unmet need? Infertility services is but one area in which account is not taken of the views of people who are in need; there are many others. How do you prioritise such matters?

Professor Barbour: That is a pertinent question. The lean programme is not an answer to all problems. By its nature, it is focused on the process by which we do things. It will help to increase capacity and efficiency, but it will not in itself deal with any fundamental imbalance between demand for services and our ability to provide them. However, many of the issues on which we have focused, such as delayed discharges, how we meet the cancer targets and issues relating to the redesign of mental health services, have been political.

We have discovered that the process is benefiting from the engagement of patients and stakeholders, so for the first time in mental health, for example, patients, their relatives and other people who use the services have been involved. As Jackie Sansbury can tell you in more detail, that input was helpful, not least in enabling us to change how we operate our mental health services, and to close a number of beds and redirect services and investment into the community, which is what the patients told us they wanted. It does not work for everything, but you would be surprised at the alignment between the so-called wicked issues, or the things that we have to tackle as a result of the national agenda, the HEAT targets, our priorities and our ability to deliver them.

Helen Eadie: I am sorry if I did not hear or did not listen closely enough, but does that include people who have been on waiting lists for, say, three years? How does the process include such people?

Professor Barbour: We had issues with, for example, magnetic resonance imaging scanning; people were waiting for months at a time for a scan when they were very anxious. That process was redesigned; you have seen the output of that in our paper. The redesign included input from patients and the people who operate the process at local level—not just radiographers, but porters and so on—and did so in a way that enriched the process.

On the big problem of waiting times, we had issues with things like wheelchair access, for example, and how we could redesign the process in a way that was bespoke, customised, and personalised. Again, wheelchair users were actively involved.

Ross Finnie: I am very taken by what you have said. You have helpfully set out the outcomes that you were seeking to achieve, the various changes in methodology, management and management processes, and the changes in the engagement process from top to bottom, or bottom to top, depending upon which end of the axis one is looking at. That has identified deficiencies and where efficiencies could be made.

I am not so clear about how you have measured the outcomes and produced a financial value for them. I appreciate that it is dangerous for me to generalise and I do not want what I am saying to be taken as being unkind—particularly as your finance director is present—but the general picture

of financial and management reporting in the health board is not clear. The historic build-up of those systems has an accumulated cost, and it is extraordinarily difficult to analyse that cost. So, in addition to the management changes, can you give us a hint about the fundamental changes in financial reporting, financial accounting and management accounting that have enabled you to measure with some certainty the benefits that you have achieved?

Professor Barbour: I will have a go at answering that, and Susan Goldsmith will back me up.

Ross Finnie is right. As I said earlier, I have worked in the health service all my life and have gone from a position in which the budget was the amount of money that was spent last year with a bit added to it, to the current situation in which there is an increasing match-up between inputs and outcomes with the measures of productivity that are associated with that. In the lean programme, we reported on all the projects, so that each project was the subject of its own evaluation, of metrics that were agreed at the start, and of a hearing by top management. We also track monthly our local reinvestment programme—or, as we call it, our efficiency programme. Susan Goldsmith reports on that to the management team and the board. We track the progress of individual schemes.

When we did the lean programme, we also introduced our own locally designed performance management system, which enables us to track at all times where we are with things such as waiting list initiatives, delayed discharges, and sickness absence targets.

The final element is that we are moving into what we call programme budgeting; work on that began in NHS Lothian with John Matheson, from whom you heard earlier today. We are seeking fundamentally to analyse the cost inputs of big-spending programmes such as cancer, coronary heart disease and mental health and to consider the cost drivers and the outputs.

12:30

That work is increasingly reflected in a much more sophisticated budget-setting process, in which—as we have said—we adopt the principles of public value to give us at least some sense of the utility that we get for the money.

Susan Goldsmith might want to answer on the technical points.

Susan Goldsmith: I would love to say that the work is very sophisticated, but it is really about applying costs to a process that is being measured. It is important that we do that, because—as we said earlier—we are reinvesting by taking money out of a budget and spending it elsewhere. As the programmes are developed, we measure and track the process month by month, to ensure that the systems are aligned with what the organisation is trying to do.

Ross Finnie: My point may be slightly difficult to pursue. You could rightly claim that the general roll-out of the lean programme took you a step ahead of some other boards, although I am not keen to set board against board. The fact that those boards are now buying into a programme that is not dissimilar to what you have developed suggests that everyone views such an approach as the way forward.

Do you get the impression from inter-board discussions that all boards have the financial measurement capacity to support such a programme? I do not want to criticise individuals; I think that, as Mr Barbour mentioned, the historical position of health boards has hampered their adoption of effective financial and management processes.

Professor Barbour: That is another good question. Without being glib, we learned a lot from the GE people. Although not everyone has to work with GE, we chose to do so because its particular way of working, which it is very good at, is embedded in its company culture. The company told us from the outset that none of the lean programmes would work if we did not agree a priori on the metrics of success for measuring outputs.

Many of our people had to learn that discipline: it was not enough to say that we hoped that something would improve a little. People had to set targets against which the improvement process would be measured. Top managers, including finance directors such as Susan Goldsmith, had to be able to respond to the challenges that arose from the process.

We are a relatively big board, and we have invested quite a lot of our own money in improving our financial systems; we are in a consortium of boards that do that. A smaller board would need a clear understanding of what it would have to do to its internal processes to ensure that when it unleashed the energy, commitment and enthusiasm of its staff, it was able to respond in the type of precise way that you have described. Our view was, and is, that the programmes could not work if the metrics and the ability to measure them were not there at the outset for all to see.

Ian McKee: As a Lothians MSP, I declare an interest: I have followed the progress of the lean in Lothian programme for a long time, and I am a great admirer of what you are doing. My question is on selecting projects. You are right—subsidiarity

is important in terms of getting down to the grass roots, because that is where the ideas are. It is often the theatre orderlies and the secretaries who have a clear view of how things could be better organised. On the other hand, there are still people in the health service who say, for example, "This is how it's been since 1948, so it should continue."

Some people at a slightly higher level in the health service might inhibit the bright ideas that come from people who are below them in the chain. How do you get systems going in which people can, without fear of rebuke or discouragement, put forward good ideas that you might want to take up and explore?

Professor Barbour: Jackie Sansbury will talk you through the details, but I offer an important lead-in comment. One of the things that I might not have emphasised enough is that people who go through the programme are enriched with new skills. The quality of the training and experience undoubtedly enhances not only their ability to do the job but their attractiveness as employees. Once the programme took off we had no shortage of volunteers because people could see the benefits.

At the outset, we were pragmatic and we knew what was not working. One of the reasons why we picked the colorectal project was that meeting the waiting time targets was a big ask for us. Some of the challenges associated with changing clinical practice were considerable so we focused on that project as a touchstone for success for the rest of the programmes. When we got clinical buy-in and saw the level of support that came as a result of the colorectal project outcomes, it freed the way for other projects to follow. Jackie Sansbury can walk you through the sophistication of how we select the projects.

Jackie Sansbury (NHS Lothian): We have a project board that oversees all the lean projects. Once a year, at the beginning of the year, we try to allocate project time over the coming year. We assess the projects against the question whether lean is the right tool—as James Barbour said earlier, it is not the right tool for everything. If the projects are not suited to the methodology, we do not allow them to get through. The project proposals come from all the management teams throughout Lothian and are measured against strategic fit and what our organisation is required to deliver in the year according to our local health plan. We try to pick projects that will have a big gain for us.

When it comes to how we roll projects forward, a large number of staff either participate in events or are trained in various elements. That is linked to our organisational development and staff training capacity whereby staff at each level of the organisation have a set of core competencies. Understanding lean methodology and its application features at all those competency levels. Whether you are a supervisor, a manager, an executive director or whatever, you will understand how the methodology can be applied in the areas in which you work.

By linking together the building up of capacity in our staff so that they can carry out some of the lean elements and by having a team of people who are extremely skilled at running the entire process, we are building our organisational capacity for the longer term. The result is that more people out there understand the lean programme and how it can help us. Those people hold small events but when we need to take big, system-wide action, we use the change agents who sit in the lean team.

Ian McKee: Although that is impressive, what if I am a pretty junior, newly recruited porter in your hospital with a suggestion about dealing with the delays that are caused by the way in which patients are called in for theatre? Do I have to go to members of my management team to try to convince them first, or do I go to the project board or the head of porters and get them to agree that my suggestion is a good one to put to the next management stage? Alternatively, is there some way to short-circuit the process whereby someone with a new way of looking at things can bring such suggestions into your lean system at a different level?

Professor Barbour: Again, there is a good barometer of how we are trying to do things. Everybody who works for us goes through a four or five-day induction programme. As part of that programme, they get a presentation from me, either in person or by DVD, in which I say, "If you have any notions as to how you might improve our service, come and tell me, e-mail me or otherwise let me know and we can feed it into the process."

We can also say empirically that when we went into areas where ancillary staff were working, they found the whole process hugely empowering. The porters involved in the redesign of the MRI scanning service were thrilled that their views had been canvassed. As Ian McKee and colleagues know, the health service runs on rumour and an internal grapevine. Word about that consultation went round the organisation and trade union connections like wildfire. We have pretty much created a world in which if somebody has a notion about how to improve our service, of course they can discuss it with their supervisor, as is right and proper, but if they find that way blocked by inertia, I would like to think that there is now a route for that person to come through the organisation—even through our team briefing system, which

allows the opportunity for upward comment—so that good ideas can be picked up and not lost.

Mary Scanlon: I have only two questions. The first is on what you have been saying about timeframes, big gains and so on. What I do not see—although it no doubt exists—is what you are doing on public health and preventive care. Gains in those areas are not likely to come in this financial year or the next, but perhaps in decades to come. Is all the investment in public health and preventive care—and in health visitors and services for children—part of the process?

Professor Barbour: We are doing a lot of work on those things, which I can tell you about. As Jackie Sansbury said, not everything is susceptible to the lean approach. All the things that make for health inequality in our society, either in how we provide health care or in how people experience and live their lives outside the health service, are not themselves susceptible to a process that is concerned with how we organise our services in the health service.

I mentioned our 5 x 5 x 5 programme, and one of the five strands is health inequalities. One team is going worldwide, asking what can be done to give NHS Lothian the capability to move to a new paradigm for how to deal with health inequalities. For many years—all my working life—we have made incremental progress and we have measured lots of things: some of them get better, whereas some of them do not. I would like us to be much more engaged at a systemic level in considering how we use the money that we have and how we partner up with other organisations to get leverage in tackling problems that are to do with how people live.

We are very active. We have some superb telehealth projects, not just in relation to continuous obstructive pulmonary disease but in relation to coronary heart disease. By the end of this year, more than 400 houses in Lothian will be wired up, with a view to testing out, through a properly set-up and validated trial, how the programmes will actually help.

Looking over the horizon, we are redesigning our website to enable people to interact with us, including in relation to advice on lifestyle choices. Although the lean programme does not focus on those things specifically, many other parts of our work do.

Mary Scanlon: You answered a question that I did not ask, but I am delighted that you did.

I listened carefully to what you said in response to Ian McKee about how you have been including all staff, which is hugely commendable, but I want to know how you include the patients.

The second page of your written submission refers to:

"Quality of patient experience—defined in line with factors public consider to be important to their experience (excluding waiting times and clinical effectiveness)".

I would have thought that waiting times were critical to the patient experience, and that clinical effectiveness was also fairly important. You have not said much about how patients are included in building efficiency.

Professor Barbour: Jackie Sansbury will give you some precise examples, but we already know that waiting times are fundamental to the patient experience, and our organisational commitment to meet and, in many cases, to exceed the waiting time targets is absolute. Our numbers will demonstrate that.

For example, we applied the lean programme to cancer waits because we already knew that we could address patient anxiety and stress if we could take chunks out of the process. We have addressed one of the backlogs—in MRI scanning—and patients were engaged in that.

On clinical effectiveness, we are hugely engaged in the Scottish patient safety programme, and we are very active on our clinical governance commitments. One of the 5 x 5 x 5 lines involves the aim of achieving clinical outcomes for NHS Lothian that are truly world class and making improvements in the areas concerned. For example, some parts of our cancer pathways, particularly for lung cancer, are not yet at that level.

The fact that the things that you highlighted are not in the programme does not mean that we are not committed to them. Jackie Sansbury will be able to tell you about the patient engagement aspect.

Jackie Sansbury: I return to the specific question that Mary Scanlon asked about the criteria that we use to prioritise investment. When you referred to the "Quality of patient experience", you pointed out that that excludes

"waiting times and clinical effectiveness".

Clinical effectiveness is a criterion on its own, so it is covered as one of the six criteria. We consider clinical effectiveness, but it is a separate criterion from the one on quality of the health care experience. Waiting times are picked up under strategic fit, because there are ever-increasing and ever-improving national waiting time guarantees, which we are required to deal with. Those priorities are covered under strategic fit. I think that that answers Mary Scanlon's question.

12:45

As far as involving patients in the lean process is concerned, when we started, we used the technique that GE taught us, which was about using the voice of the customer. We interviewed people in advance of events in which we used a process called trystorming, which involves working out what you want to do, then rushing away and trying it. We did that live in a live CT department, for example. We spoke to patients as we went about the process to find out whether our ideas improved their experience.

As we have become slightly more comfortable with the process, we have been fortunate that patients have been prepared to give up quite large amounts of time to sit in with us on events such as work-out events or week-long kaizen events. Patients and carers have been members of the multidisciplinary group that has looked at what improvements need to be made to the service to deliver what we wanted to achieve. We have been extremely fortunate to have a group of willing people sit in with us.

The Convener: I think that the committee has run out of questions—or perhaps it is just that lunch is calling. We will never know, because members will not tell me.

Thank you very much for your evidence, which was extremely interesting, and for your patience—you had a long wait to give evidence. It was well worth hearing from you.

That concludes our formal business for today.

Meeting closed at 12:46.

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