HEALTH AND SPORT COMMITTEE

Wednesday 7 October 2009

Session 3

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HEALTH AND SPORT COMMITTEE
26th 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:

Tim Davison (NHS Lanarkshire)
Jon Ford (British Medical Association)
Theresa Fyffe (Royal College of Nursing Scotland)
John Gallacher (Unison Scotland)
Malcolm Iredale (NHS Highland)
Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health and Wellbeing)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 5

Scottish Parliament

Health and Sport Committee

Wednesday 7 October 2009

[THE CONVENER *opened the meeting in private at 09:45*]

10:46

Meeting continued in public.

Draft Budget Scrutiny 2010-11

The Convener (Christine Grahame): Good morning and welcome to the 26th meeting in 2009 of the Health and Sport Committee. I ask members, witnesses and the public to switch off their mobile phones and other electronic equipment. No apologies have been received.

Agenda item 1 is an evidence session on the Scottish Government's 2010-11 draft budget proposals. There are two panels of witnesses. Among their papers, members have written submissions from the witnesses on those proposals. I welcome our first panel: Jon Ford, head of health policy and economic research at the British Medical Association; Theresa Fyffe, director at the Royal College of Nursing Scotland; and John Gallacher, regional organiser and secretary at Unison Scotland.

I move straight to questions from members—they are very keen.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Workforce training and nurse training are among the budgets that have been cut. I want to understand whether that is appropriate. I know that there is a reduction in the number of nursing students who are being allowed into nursing, but I have seen no evidence yet of an improvement in retention. In addition, there has been enormous planning blight, particularly in health visiting, perhaps due in part to the review of nursing in the community. However, there is also very much an ageing nursing population. I address my question to Theresa Fyffe and John Gallacher, although I would like to hear from Jon Ford about the general issue of workforce planning, particularly in relation to nursing.

Theresa Fyffe (Royal College of Nursing Scotland): What it says in the budget boils down to a reduction in the number of trained nurses in the future. In 2008-09, the number of students dropped—that was agreed as a process. At that stage, the budget was going to increase this year. Suddenly, though, the position on student numbers has changed quite dramatically.

The delivery group has agreed to work, for one year initially, to find ways of improving attrition, which is running at 28 per cent; new figures are about to be released that show that that is not much improved. The intention is to get a better understanding of what we need for the student workforce. We are extremely concerned, because if we continue down this route and have too few registered nurses, we could damage the provision of safe, effective and quality care.

If we lose £11 million, it would cost much more than £11 million to rescue the situation in future years. We have been here before. In the 1990s, we cut the number of students and were dependent on overseas nurses and others. Because of European Union regulations, we do not have that freedom now.

John Gallacher (Unison Scotland): Unison shares the concerns about nurse training. We reflected those concerns in our submission and we support the RCN on that.

In general, it is not a new phenomenon for training budgets to be soft targets for cuts in difficult times, but it is particularly disappointing that that is the case in the national health service at this juncture, when agenda for change and the knowledge and skills framework that is associated with it are coming in, and when there is a heightened expectation among NHS workers in all job families that they will have access to training across the board. It is disappointing that training budgets will be tight or non-existent for the foreseeable future, just when staff, having gone through the banding exercise, had expectations of receiving development, extending their roles and perhaps changing jobs or professions. If training and retraining moneys are disappearing, that is extremely disappointing.

Jon Ford (British Medical Association): Medicine is in a slightly different situation from nursing in that there has been an expansion in the number of medical school places, although the major expansion that the Government announced is now coming to an end.

The intention behind the modernising medical careers programme was that training should be more intensive and should be provided over a shorter period. That approach is obviously vulnerable to any budget cuts, which would be a retrograde step for us.

Dr Simpson: I would like the witnesses to say whether they agree or disagree with my concerns. As John Gallacher hinted, part of the process that we are going through is about a change in roles—that applies particularly to nurses, but also to many people in technical posts, who are being

asked to develop their skills quite significantly because of the reduction in the number of junior doctors that will ultimately come about as a result of the European working time directive. Although there has been an increase in the number of people in consultant grades, that will not continue. Given the shift in roles that will occur, unless we maintain or, indeed, expand the training budget, we will fly in the face of all that we are trying to achieve in the development of the health service. I invite the panellists to comment on that.

Theresa Fyffe: That is absolutely critical. You have asked a key question about shifting the balance of care. Let us take community nursing. It is community nursing services and others that will be important for the delivery of long-term care and the treatment of long-term conditions. The role changes that will be required mean that we will have to fund the training of the community nursing workforce. We will have to find ways of enabling the members of that workforce to make the transition from where they are now to where they need to be. If the budget is cut, how will we do that?

The modernising community nursing board has just been set up and we are well under way with that work, but there is no evidence that the Government will provide us with the funding that we have argued for to deliver the change in community nursing. We are extremely concerned about that, given that the ageing workforce in community nursing and practice nursing is one of our biggest agendas. That is a big concern.

John Gallacher: In general terms, Dr Simpson is correct. The truth of the matter is that, with regard to the future workforce, the health service will have to grow its own. Demographics mean that there will not be a huge school population to take up posts in the health service, so it is vital that we have strategies for developing the existing staff in technical posts, information and communications technology posts and allied health professional posts. It is short-termism to cut off at source investment in some of the training strategies for those groups because such investment is essential for the health service in the medium term.

Rhoda Grant (Highlands and Islands) (Lab): I want to continue with a strand of questioning that I pursued last week about agenda for change and equal pay. I asked whether the budget contained contingencies to deal with those issues. On agenda for change, the answer that I received was that the matter had been dealt with. I was told:

"We do not expect that to be a cost pressure in 2010-11."—[*Official Report*, *Health and Sport Committee*, 30 September 2009; c 2254.]

The situation with equal pay was slightly different, but, basically, I was told that agenda for change had dealt with equal pay and that the only issues that would arise would be historical issues. I notice from Unison's submission that it sees agenda for change as a cost pressure. Why is there that difference in the evidence that we have received?

John Gallacher: There are still some cost pressures in the assimilation of agenda for change around reviews. The vast majority of staff have been assimilated on to new grades under agenda for change. I can provide detailed information, but at the end of July 16,601 people, or 34 per cent of the staff—a significant number—had requested a review of the band to which they had been allocated. The success rate so far has been about 33 per cent. There are still review pressures to feed through in all the boards. Obviously, if bands are altered, there is back money to be paid to October 2004 as well as the increase due to the change in grading.

Unison has given significant evidence on equal pay to the Equal Opportunities Committee. High numbers of cases have been lodged in Scotland. Recent judgments in England testify to the fact that the new pay system under agenda for change is equality proofed, but the historical, pre-2004 cases remain to be resolved. We have made submissions to the United Kingdom and Scottish Governments to try to resolve the issues. There are legal impediments to that in the tribunals process, but there is unfinished business around equal pay and it will need to be paid for at some point.

The Convener: The Equal Opportunities Committee is focusing its budget scrutiny on that issue and Unison has given detailed evidence to that committee. I will therefore move on to other topics, as the Equal Opportunities Committee will cover the matter in its report.

Ian McKee (Lothians) (SNP): I want to ask Mr Ford, in particular, about the Scottish clinical leadership and excellence award scheme, which was formerly called the distinction award scheme. Last month, the Cabinet Secretary for Health and Wellbeing told the Parliament that the scheme

"will emphasise contributions to the national health service above and beyond those contractually required and will be linked to NHS objectives."—[*Official Report*, 3 September 2009; c 19248.]

Do you agree with that definition?

Jon Ford: Yes. If you will indulge me for a couple of minutes, I will give you a little of the history behind the scheme, because it is relevant to the Government's considerations.

When the NHS came into being, those who were charged with paying consultants had to address the fact that, at that time, the very top consultants earned huge amounts of money in private practice. When they were subsequently translated

into the NHS, a question arose as to how to replicate the range of professional incomes and give a small number of doctors very high levels of reward when there was no market to determine who should get them. The distinction award system therefore had clinical excellence as its main criterion. A few consultants were permitted to earn large sums in the NHS and they were peer reviewed as to clinical excellence.

That was the starting point, but things change. Over time, things such as service contribution and leadership became as important as clinical excellence, so it became necessary to widen both the criteria and the people who choose the people who receive the rewards. To answer your question, the criteria have been widened, as have the people who choose the award holders, and the entire scheme is being reviewed. All systems—contracts, or any other award system—decay after about 10 years, so the scheme is overdue for some change. In principle, however, the idea that underpins it—the idea that the distribution of income should broadly reflect what the market would deliver—is still valid. Does that answer your question?

Ian McKee: It lets me see how you feel about things. I recollect a quotation that you will probably not agree with. Aneurin Bevan said that he was getting the consultants' co-operation in starting the national health service by

"stuffing their mouths with gold".

I accept what you said about a small number of consultants, but how do you relate that to the fact that 50 per cent of consultants receive distinction awards, or whatever they are called under the new scheme, when they retire?

11:00

Jon Ford: There is a mixture of rewards. The distinction awards are at the very high end of the reward spectrum and they are received by a very small number of consultants, albeit that at retirement the proportion is higher than it is in any cross-sectional analysis. Some of the rewards are through discretionary points, which are part of the consultant contract. To get to those, consultants have to pass through competency bars and the like. Not all the rewards are distinction awards as we understand them.

Cross-sectionally, at any given time, about 35 per cent of people are receiving a high award. That translates to a higher proportion among people retiring, which is simply the way in which the cross-sectional and longitudinal data pan out.

Ian McKee: Is it not a matter of fact that, for the most recent year for which figures are available, 50 per cent of consultants on retiring were in receipt of a B, A or A plus award?

Jon Ford: That is correct.

Ian McKee: Does that reflect the statement that you made about the need to reward a small number of consultants? Fifty per cent seems a large number, especially given that the lowest award is about the equivalent of the full pay of a junior ward sister or charge nurse.

Jon Ford: We have to distinguish between the numbers who are in receipt of an award at retirement and those who are in receipt of an award at any given moment in time. By definition, those at retirement are towards the end of their careers and so are more likely to receive an award and hold it for a short period. The fact remains that the number of A plus awards is about 1 per cent of the total number of consultants and the number of A awards is 10 per cent or so of the number of consultants at any given time. Those are modest proportions of the consultant stock to receive rewards that, for a lawyer, for example, would be insignificant as a proportion of the income distribution. We are talking about a profession in which, historically, before the NHS started, the rewards were even greater in terms of the distribution. Even now, there is a move towards such rewards in other public sector professions. For example, the very best headteachers and the highest civil servants receive large incomes.

Ian McKee: We are considering public money in the round. I know that some consultants receive an award for two or three years and that the reward is then carried on in retirement at half the rate until they die. That is because, in the pension system, the pension is based on final salary. The budget for the award scheme for 2010-11 is £30 million, but is it not true that the cost to the state and the Scottish health service via the pension scheme is up to £15 million more per year?

Jon Ford: It is certainly true that the rewards are carried on into retirement, as they should be, because it is a final salary scheme and the same applies to anybody who retires on such a scheme. However, I do not know about the £15 million consequences.

Ian McKee: I have a final point, if the convener will indulge me.

The Convener: Carry on—I am very interested, as I was wondering about the final salary scheme.

Ian McKee: The BMA's written submission states that the association is against

"costly experiments such as the introduction of directly elected members to health boards",

as they will

"drain much needed resources away from NHS Board budgets."

It feels that the money

"would be … better spent on direct patient care".

The cost of the pilots on directly elected health boards is almost exactly the same as the increase in the cost of distinction awards between 2009-10 and 2010-11. Do you not agree that it would be far better to freeze the budget for those awards at £28 million and spend the £2 million on direct patient care?

Jon Ford: No, I do not agree. The issue of how doctors' pay increases is not a matter for us. We give evidence to an independent review body, which advises the Government, which then has the choice of whether to implement that advice. Whatever the trade-off would be, it would not be one for me to decide; it is for the review body to decide. That body has a tradition of sometimes tapering pay awards so that the higher-paid doctors do not receive as much as the lower-paid ones. It takes a view of what is appropriate and affordable at any given moment.

There is not a simple trade-off between the rewards of doctors and clinical care, because doctors provide clinical care. The very best doctors provide the very best clinical care and are rewarded accordingly. I therefore do not accept the trade-off that you are talking about.

Helen Eadie (Dunfermline East) (Lab): My question concerns shifting the balance of care and services for older people. I am grateful to the witnesses for the excellent papers that they have provided as written evidence.

With regard to the RCN's submission, I wish to pursue carefully the issues around the fact that

"The information supplied is sometimes misleading"

in the commentary on various budget headings. You urge us to ask the Government

"to produce clearer draft budgets in future."

Unison's submission says:

"There is no national strategy for resource transfer between health boards and local authorities across Scotland."

The RCN also says that the Health and Sport Committee is not able to scrutinise what is happening with regard to single outcome agreements, and it highlights

"their potential impact on health and wellbeing budget allocations."

Such issues have a major impact in some instances on spend within the NHS. The RCN's written evidence goes on to say:

"the new governance arrangement in place with regard to local government funding allows local authorities to be more autonomous",

which creates special circumstances.

Will the witnesses expand on those comments? In my experience, local government budgets make a huge impact on the NHS budget for care for the elderly, in particular.

Theresa Fyffe: You asked about shifting the balance of care. In an in-depth analysis, we sought to understand whether there is provision for that, and it is not evident in the budget. That is true of the budget in general—it is not really possible to analyse it in depth to understand where the spend will be.

Shifting the balance of care is critical. I will highlight telehealth and e-health, as we did in our written evidence, both of which are important for the transformation of primary care services. In my view, nurses, midwives and allied health professionals will make the big difference around using e-health and telehealth—along with our medical colleagues. The e-health budget stayed, but the anticipated rise this year did not happen. Telehealth has somehow been subsumed as a subsidiary of the capital budget line. Where is it? E-health and telehealth were critical elements of shifting the balance of care.

To return to what I said about community nursing, if the modernisation board is to work as we would like it to, I do not see how the workforce cuts around education and training will enable the transformation of community nursing and other services to make a difference; in fact, that concerns allied health professionals, too. We are extremely concerned about the lack of transparency, and we need to understand how the changes will make a difference.

I urge an analysis to be made of what the local authority budget under the single outcome agreement is doing for policy implementation. Is it implementing policy? If not, the gap that will arise in relation to people who are not receiving services will effectively back into the NHS; in turn, that will mean that the acute hospitals will struggle to maintain the community services that are required, and those services will be unable to provide the support that will let the acute hospitals make the shift. We are extremely concerned about the lack of transparency there, and we believe that the details should be made much more explicit if we are to get to where we need to go.

Helen Eadie: The RCN's written evidence also refers to

"the lower contributions to UK-wide medical bodies, as outlined in the SPICe briefing",

and as shown in the budget. There will be a huge reduction in that funding. What information do any of the witnesses have in that regard? There could be impacts on the provision of training and education in Scotland if there is a withdrawal from that budget line at the UK level.

Theresa Fyffe: I wondered whether you had been given evidence to explain what that meant. We were just told, "That's the reason for the drop." The workforce programme delivers a number of streams of work that make a difference to the workforce for the future, in particular for the clinical community. We do not see anything that explains what the Government will change and what it will drop.

I return to the issue of working as teams. As an organisation, we are fully supportive of a move towards a change in the skills mix. Health care support workers are among our members and we see them as very important. However, the general workforce and training budget has been cut, which is where you would see support for the training of health care support workers and other practitioner roles, which would ensure the right environment for safe and effective patient care. I thought that, although that part of the budget had been cut, the budget might have been kept to allow us to look at those other areas, but I do not see that either.

John Gallacher: I turn to the resource transfer issue. Reference is made in Tim Davison's written submission to an integrated resource framework that is being built up. We need to get a clear picture of what resources are being spent by local authorities and health boards on older people's services, as we do not have a clear picture of that at the moment. Not a lot of moneys deriving from the closure of long-stay institutions are still available, so it is important that a picture is built up of what resources are being expended. Local authorities and health boards are conjoining their resources. They are not yet surrendering control of them and putting them into a single pot, but a lot of services are being resourced jointly. It is important that that is examined in some detail.

Helen Eadie: I was interested to read Tim Davison's submission. In your written submission, you talk about a projected £14.835 million underspend by the end of the year. The figures that you provide are extremely helpful, telling us which boards have an underspend. Although treatments still need to be provided to patients, those boards are not providing those treatments.

John Gallacher: As part of Unison's evidence, we gave you a snapshot survey of the position in individual territorial boards halfway through the year. The truth of the matter is that, when it comes to their annual reviews, those health boards will report that they have met their financial targets and have broken even.

The revenue budget for boards this year has got tighter. There is a lot of paddling going on below the surface to break even, and there are daily and weekly pressures on boards around prescribing, fuel costs and vacancy management. A number of boards are telling us that, in the current financial year, they are struggling to achieve efficiencies in the ways in which they would normally seek to achieve them. A number of boards tell us that, going into 2010-11, they are seriously considering cuts in jobs and services.

Our purpose in supplying the committee with that information was to say that, in the health boards—I nearly said in the real world—there is a huge amount of daily pressure. Through the partnership processes at board level, the staff side gets briefed and can enter discussions about how the cost pressures can be managed on an on-going basis.

The Convener: You mention the usual ways in which health boards achieve efficiency savings. Do you mean capital receipts? Is that to do with the recession and their not selling off property in a depressed property market?

John Gallacher: Yes. The sale of land has been one way in which some boards have addressed their deficits in the past. Given the current state of the property market, that may not be possible now.

Michael Matheson (Falkirk West) (SNP): You will be aware that we are dealing with a fixed budget and that there is a requirement on the committee, if it makes any recommendations for alterations to the health budget, to indicate which budget heading should see an increase and where that funding should be taken from. Given the comments that you have made so far and what you say in your helpful written submissions, which budget headings in the draft budget do you think should be reprioritised with a view to increasing the funding under those headings and where do you think that the funding should be taken from in order to provide that increase?

Theresa Fyffe: Obviously, I believe that nurse education and training must be reprioritised. If we continue down the line of trying to save £11 million from that budget, we will end up with a grave problem and a much greater figure than that will have to be found in the future.

11:15

I guess that the £11 million could come from the "Miscellaneous Other Services" budget, although I really have to question the transparency of that particular line. Although it is increasing 88 per cent from last year to a substantial £225.4 million, no commentary has been provided about what it actually includes. I suggest, therefore, that we look

there for additional money for priorities—or, that the committee attempts to understand what that budget line is intended to cover.

The fact is that, because education and training will not be able to sustain the proposed cuts, we will simply not have the workforce that we want for the future. Even though we are still working through the student numbers, we have had our budgets cut. At a meeting next week, we are supposed to agree the numbers based on workforce need; however, my clear understanding is that at the moment we are working not on that basis, but within a financial envelope. I acknowledge that—indeed, we work with the boards on that basis—but I have to say that such an approach will not give us a workforce with a sustainable future. These short-term measures will lead only to major problems later on.

John Gallacher: I agree that we need to think about the training budget, because it has long-term consequences. In our evidence on the budget this year and last, our biggest concern has been not about specific lines but about the overall balance; although the size of the cake is fixed, in both years more money has been retained in the centre than has been the case historically, so we would support any move to free up the overall budget for the territorial health boards that have to deliver these services every day. In short, we need to look at the make-up of the budget and examine the balance between what is retained in the health department and what is released to the boards.

Jon Ford: The draft budget already provides for some rebalancing with the shift from capital to revenue spending—with capital losing out at the expense of revenue. Despite our reservations about some of the problems that that will create for building programmes, it is probably a wise move in a recession. It is probably also wise to divert attention to services that will fund demographic change, which will happen, and so on. In that sense, the draft budget is probably—and rightly—erring on the side of caution. However, I agree that what we want most is for central and board spend to be rebalanced, with more money going to the sharp end instead of being retained at the centre.

Michael Matheson: What areas of the budget where money is retained by central departments could be shifted to the territorial health boards?

Jon Ford: Because the budget has less clarity than it should have, I cannot determine how much money is being spent in each sub-programme. I hope that people are not holding back resource that could be put into the front line, in the political expectation of their being able to drip feed it into the system later. That would cause problems.

John Gallacher: I agree. There is not a huge amount of detail about the portion of the budget that the health directorates retain. Obviously, the committee can inquire into what the money is being held for. I realise that central initiatives will need to be funded, but we need to ask the directorates as well as the boards what their share of the money is for and whether the current balance in the budget is correct.

Mary Scanlon (Highlands and Islands) (Con): I want to ask the British Medical Association about the health protection and health screening elements in the draft budget, although I know that the Royal College of Nursing has also raised issues in that respect. In the draft budget, funding for health screening has been reduced from £14.2 million to £8.5 million, even though the plan in last year's budget was to reduce it only to £10 million. That means that there is another £2 million less in the budget. The health protection budget has been reduced by £8.8 million from £36 million to £28 million, which had not been the plan in last year's budget. Moreover, in last year's budget, planned spend on cervical cancer screening was to rise from £18.5 million to £27.5 million; however, that budget line appears to have been lost somewhere under the "Miscellaneous Other Services" heading and no one knows whether the increase will happen, whether the £18.5 million will be cut to £8 million or whatever. We will certainly find out. Given that we are trying to empower patients to take control of their health care and to ensure that more preventive medicine is available, and given that our public health record is nothing to be proud of, I am concerned about the drastic cuts in these budgets. Why are these cuts happening and how will they impact on patient care?

Jon Ford: I cannot explain what the figures are doing. That is a question that you must address to the department, to find out exactly what the figures are disguising.

Mary Scanlon: But much of the screening is done by general practitioners.

Jon Ford: It is.

Mary Scanlon: I am wondering whether there is a change in that respect.

Jon Ford: No. The primary care budget—particularly the general medical services budget—is yet to be finalised, because it is a demand-led budget for the most part. In your documents, no increase is provided for it. It is not that that is causing it. The change in structure that the Government expects to be achieved sometime over the next year must be something more radical than that.

Mary Scanlon: So, the BMA really does not know how the cut in health screening from £14 million to £8 million will impact on patients.

Jon Ford: We do not know what it represents. The impact on patients will obviously be detrimental unless the money is spent under another budget head. We do not know where that money has gone.

Dr Simpson: The notes call the change "a cost refinement". Do you think that a reduction from £14.2 million to £8 million could ever be termed "a cost refinement"?

Jon Ford: No. As I was trying to explain, it is possible that the money has been shifted to a different head within the budget. However, that is a question that you would have to ask the department.

Mary Scanlon: Can you explain to me what is covered by the heading "Health Protection"? I am not quite sure what that covers. What will happen when that budget is cut by £8.8 million? Is it something in which the BMA has been involved? It is a cut of at least 20 per cent.

Jon Ford: No, we have not been consulted about that. To be honest, we would not expect to be consulted about the change between last year's draft budget and this year's draft budget. The change is being forced on the department by external circumstance—namely, the settlement from the UK. I am afraid that I do not know what the health protection budget was originally designed to cover, so I cannot comment on the impact of the reduction.

Mary Scanlon: We could get into arguments about the UK settlement. There are some increases in the budget.

Helen Eadie: There is a 2.7 per cent increase overall.

Mary Scanlon: My Labour colleague reminds us that there is an overall increase of 2.7 per cent, but she has to keep Gordon Brown happy—they share a constituency and Helen Eadie is loyal to the end.

I am concerned about the cuts in screening. Do you share my concern that we do not even know where the increase from £18 million to £27 million for cervical cancer screening has gone? I would have thought, given the fact that much of the screening is carried out by GPs, that that would be a matter of serious concern for the BMA.

Jon Ford: The screening budget cuts are a matter of concern. General practices are funded for it via their contract, which has yet to be sorted out in the budget round. However, the quality and outcomes framework, which is where most of the screening in general practice is centred, will not be affected. I am not able to say whether that particular programme impacts on general practice, but if the provision for screening has been reduced as a result of the budget cut, that is a serious issue.

Theresa Fyffe: I agree entirely. I would be extremely concerned about any cut in funding at a time when we want to increase cervical screening. Again, however, there is an issue with transparency. It is very difficult to analyse where the cut is being made and why. We certainly have not been engaged in the process.

I draw the committee's attention to the public health lines. The Government is reducing the advertising budget for public health campaigns. The Royal College of Nursing has worked in partnership with the Royal College of General Practitioners and the Government on the public health campaign towards a mentally flourishing Scotland. We really believe in getting out there, but where will the money for that come from? Will the boards have to undertake public health campaigns? How will we get the messages out there? We know that screening is important, but uptake is dependent on our getting the message across. I believe that, again, the impact will filter back into NHS services if we do not get the message across and improve screening numbers. If we do not promote preventive health messages, the consequences will be faced in the NHS in other ways.

Mary Scanlon: That is one of the major issues.

I will now talk about an increase in the budget, which should keep Helen Eadie happy. There is a welcome increase under the "eHealth" heading from £97 million to £134 million. Do you, however, share my concern that telehealth is not included for e-health, but is lumped into the "Capital Investment" budget, which is being reduced by £100 million?

Jon Ford: I agree entirely that that sends inappropriate contradictory signals.

Mary Scanlon: Is telehealth the way forward for enhanced patient care, given the financial challenges that we face?

Jon Ford: It is very much the way forward.

Theresa Fyffe: We are talking about a real example of how we will transform primary care services. Given our geographical context, telehealth and e-health are essential and critical to the process, and I want to think that that message is being given. Therefore, I do not understand why telehealth is not included under the "eHealth" heading.

Mary Scanlon: There is to be a capital investment budget cut of £100 million.

Theresa Fyffe: Exactly. That is a subject to raise. We do not yet know what cuts that will lead to.

Ross Finnie (West of Scotland) (LD): I have two questions. First, I want to pick up on the point that has just been made. To add to the confusion surrounding the differentiation between telehealth and e-health, we heard at last week's meeting the rather astounding—if not flabbergasting—statement that the work that NHS 24 carries out in answering telephones is now categorised as telehealth work. Do the witnesses agree with the Government's new definition of telehealth? When we pressed a Government official last week on the figures to which Mary Scanlon has referred, we were flabbergasted to be told that telehealth now means answering a telephone and not what we had previously been led to believe it meant. Do you agree with the new definition that a Government official has ascribed?

John Gallacher: As with all things, definitions relating to new technology can be broad.

The Convener: That is a tactful answer.

John Gallacher: Obviously, there is the high-tech end at which consultants carry out procedures remotely, sometimes in their own home, and—

Ross Finnie: I am sorry to interrupt, but I understand telehealth. I asked whether you believe that the work that NHS 24 does in answering telephones is capable of being redefined as telehealth work, as it was at the committee meeting last week?

John Gallacher: Obviously, the NHS 24 model, which involves effectively triaging patients over the phone and giving advice on ailments and preventive measures to the general public, which we have spoken about, provides medical services of a sort to the population. Perhaps that is not at the acute end, but the advice and services that are delivered represent a form of improving the health of Scotland. As to whether it is appropriately categorised, the NHS 24 board has its own budget and financial process.

Theresa Fyffe: I would not have defined it in that way, but I agree that NHS 24 is an important component of the service. We should see it in the round as part of that service, and only as working with the other means of telehealth. It is not the only part of the service. It is wrong to give the impression that NHS 24 will be the telehealth of the future; rather, it is an important component. Amazing work is being done on the islands and in other areas that will transform provision, which can make a difference to patient care across all the health care professions.

Jon Ford: I have nothing to add. Basically, it is possible to define NHS 24 as a telehealth service in that it is remote triage. Whether it is appropriate to transfer it from a separate budget heading into telehealth is a question for the accountants. If it is where it is in order to disguise or persuade people that there has been an increase in funding that there has not been, that is, of course, inappropriate.

Ross Finnie: My second question is about the debate that we have had this morning about increases in some places and decreases in others. Mary Scanlon referred to them. To some extent, it is a false debate. We discuss increases or decreases between one draft budget and another, but if we were doing the exercise properly we would be comparing the figures with an actual amount. The issue plagues this committee.

11:30

Do your organisations do research that makes at least a stab at what you think has been spent, so that a more informed judgment can be made about whether the budget that is presented represents an increase or a decrease? Are you as hampered as we are, in that we must consider two mythical figures, neither of which adds up to very much at all?

Jon Ford: There are figures in the draft budget for estimated outturn, but the answer to the question depends on whether one believes them to be an accurate estimate of what will happen. To some extent everyone who is budgeting must guess at the most recent expenditure outturn, which is what the budget does. That is why we are concentrating on differences between last year's draft budget and this year's draft budget; we are considering how plans have changed rather than how growth is occurring, which is a different issue.

If one believes the forecasts, then there is something in there that enables one to judge the growth. The question is whether one believes the forecasts.

Ross Finnie: I cannot think of many other spheres in which one spends one's whole life comparing one budget with another.

Jon Ford: There are not many, no.

Ross Finnie: I appreciate that you have limited resources, but my serious question was whether the BMA attempts to plot or chart from actual figures—which come out so terribly much later than would be useful—to ascertain whether there is a trend and whether the budget line is becoming false, because substantial differences begin to appear when it is plotted against actuals. The differences do not show when we just have a budget line, but when we interpose an actual on top of that, we expose a rather different picture.

Jon Ford: We have not done such work recently.

The Convener: We know that 70 per cent of the health spend goes on salaries and so on, and we all know about the current financial circumstances that the country is in. To what extent are your organisations taking those issues into account as you enter pay negotiations?

John Gallacher: For agenda for change staff, 2010-11 is the third year of a three-year deal. We are pleased that the UK Governments have committed to honouring the third year of the deal, which came in on 1 April—in the round it is 2.4 per cent on the pay bill. It is good that the three-year agreement is in play.

It is clear that in 2011 we will be back into the annual cycle of the pay review body process, which is—as members know—a form of pay determination that is different from straightforward, traditional collective bargaining. All organisations will submit evidence to the annual process when the timetable comes up. However, pay for this year is agreed and will, we hope, be delivered through the budget.

Jon Ford: As members might know, we have just published our evidence to the pay review body, because we are not in the agenda for change three-year deal. We are on annual evidence submission to the review body and we expect the body to pronounce on what the appropriate level should be some time in February.

We have taken explicit account of the affordability issue for the country as a whole. It is difficult, because the four nations have different levels of resource increase. For example, in England, primary care trust budgets will go up by 5.5 per cent, so there is a situation of differential affordability.

We have taken the view—I think that we have done so rightly—that anything that exceeded projected inflation would be inappropriate in the current climate. We have also taken the view that anything that got as high as the 2.4 per cent that agenda for change groups will receive would be inappropriate, because those groups negotiated a long-term deal and it is appropriate that there should be some premium attached to the risk involved in that, which we did not take. Our evidence suggests a 2 per cent increase in salaries. We have yet to see the results of the review, but the Government, and NHS employers, have suggested rather less. It is a judgment call for the review body, and we will have to see what happens.

The Convener: And the RCN?

Theresa Fyffe: I have nothing to add. I agree with Jon Ford. We are glad of the decision this year not to amend the review.

The Convener: Thank you—I just wanted to get that on the record.

Ian McKee: In times of financial shortage, what is the justification for providing NHS 24, apart from in pandemics? GP surgeries offer the same service to their patients. There are two sources of advice, and they sometimes offer contradictory advice, which can cause confusion.

Theresa Fyffe: NHS 24 seems to have responded well to the pandemic; in some parts of the country, the provision of that service has become very important. NHS 24 provides a very different service to the public. For example, given the nature of the pandemic flu, people have had to collect their treatment but could not enter the surgery. NHS 24 plays an important part in that. To avoid duplication, rather than saying that one service should not be there, we need to work better across boundaries.

Helen Eadie: My question is for Unison, although the views of the other witnesses would also be welcome. Unison said that although it welcomed the 2.7 per cent increase in the health budget, it was concerned that it was

"still held centrally rather than by the health boards who actually deliver care."

Will you expand on that?

John Gallacher: I think we covered that slightly in an earlier answer. A higher proportion of the budget is retained centrally. We do not have details of what that central budget is held for, but it is noticeable that the balance between distribution to the boards and retention at the centre changed last year and this year. It is a trend.

Helen Eadie: Would you want the majority of the budget to go to the health boards and a tiny bit to be left at the centre?

John Gallacher: I do not have the information to express a view about whether the current percentage is way off beam. I do not imagine that it is, but I think that the balance between central resources and board allocations needs to be scrutinised.

The Convener: These are questions that we can put to the minister.

Theresa Fyffe: It is not about percentages—we do not have the analysis to tell us what the percentage is. It is more about understanding and transparency about what is being kept centrally and why, and what is going to the boards. That is what is not apparent.

The Convener: We will ask the minister about that. That concludes the evidence from the first panel. I thank the witnesses for their evidence.

Our theme for the second panel of witnesses is shifting the balance of care. I welcome Tim Davison, who is the chief executive of NHS Lanarkshire, and Malcolm Iredale, who is the director of finance at NHS Highland, and who sat through the evidence from the previous panel. We will move straight to questions.

Helen Eadie: I thank the witnesses for their helpful submissions. I would like to deal with the issue of sustainability, which the Finance Committee has asked us to consider. How does the budget address—or not—sustainability? I am happy for either witness to respond.

Tim Davison (NHS Lanarkshire): Sustainability is really an issue for the longer term, so the budget for the next year or so is less important than the impact of the three-year reviews that will happen in three years' time and in six years' time. I make a point in my submission about shifting the balance of care. We have an ageing population, and if we continue with the current model of care, in which the larger part of care is institutional care, whether in a hospital or a care home, rather than home care, the ageing population—and therefore the increasing number of people who require institutional care—is not sustainable in financial or workforce terms.

The Convener: I am smiling because two members of the ageing population came into the room just as you were making your point. I hope that that was on camera.

Dr Simpson: I hope that it was not on the record.

Ian McKee: Seventy-five per cent of the committee are from the ageing population.

The Convener: I agree. I am not being personal.

Malcolm Iredale (NHS Highland): The pressures that a number of health boards will be under during 2009-10 have already been alluded to, and those pressures will continue for 2010-11 and, as Tim Davison indicated, into the spending review of 2011-12 and beyond. That indicates to all boards that we need new models and methods. Doing more of what we already do will not be affordable. We must look at things differently, understand how to spend resources better and work with our partners. That is the thrust of our submission, particularly in the area of resource transfer. We need to change and develop what we do to meet the challenges of population, demography and so on.

Helen Eadie: I will press you a bit more on that point. We can keep saying that we have a problem, but we need to see some evidence that we are addressing the issue of how we can make services more sustainable. Do you see anything in the budget that begins to address that?

Tim Davison: I reiterate the point that I made. It is not so much about this particular budget but about the subsequent three and six-year periods. You will be aware, I think—

Helen Eadie: I just want to interrupt for a second. The danger we face is of people saying that every year and the problem becoming perpetual.

Tim Davison: If I could just finish—

The Convener: Let the witness develop his point.

Tim Davison: We all expect a parliamentary debate in the next month or two about the demographic issue. We know that consultation processes around tackling the demographic challenge have already been launched in England and Wales. As I make clear in my submission, we expect a similar process of public engagement and consultation in Scotland next year that will build on much of the work that I have described in my submission. It is critical that we consult, engage, plan, and then put priorities in place for the budgets in the subsequent spending review periods.

The Convener: You mentioned resource transfer. Can you give an example of how you are uniting or combining with local authorities and making better use of both budgets? We have heard about that for years in the Parliament. Give me a little example of something that has happened in your board area in conjunction with your local authority that has helped both budgets.

Tim Davison: In Scotland, probably the biggest and most tangible example of an integrated approach that has radically shifted a model of care has been in learning disability and mental health services. Even as few as 15 or 20 years ago, in Scotland those services were dominated by the large asylum type of care involving 30-bed wards with one toilet at the end. There was very little support in the community.

We have now largely finished the process of remodelling that service. We have no long-stay institutions left in mental health and learning disability services, and the balance of care has shifted hugely towards care at home, either in small-scale supported accommodation or, more commonly now, in individual tenancies where people are supported by health, social and third sector workers in integrated teams. That is a significant and tangible example of how the institutional model of care was transformed into community care, how resources moved with the change, and how health and social services are

working closely together to support people in a radically different model of care.

We suggest that we need the same transformational approach to the model of care for older people and how we support them going into the next five, 10, 15 and 20 years as we had for mental health and learning disability services in the past decade or so.

Malcolm Iredale: I agree that learning disability is a good example. I have another example, from Argyll, where we have developed dementia services with the voluntary sector, the local authority and the health sector that are working well. It is sometimes difficult and challenging to provide such services in a home setting in rural environments where the population base does not support that approach. However, the services in Argyll have been successful, which encouraged us to consider how we provide services as we remodel health services. It is essential that we work closely with local authority partners, particularly in some rural areas, where there is not the population base to support services.

11:45

The Convener: Thankfully, you reminded us of the voluntary sector, which I did not bring into the picture. It is, of course, key to the approach that you described.

Helen Eadie: I return to the issue of resource transfer. NHS Lanarkshire's written submission states:

"The 1992 guidance on resource transfer is out of kilter with modern practice."

We all aim to provide more resources to primary care services, but it just does not seem to happen to any great extent. I ask Tim Davison to expand on his written evidence.

Tim Davison: I gave the examples of mental health and learning disability services to show that institutional care was dominated by long-stay care, which in many instances involved people living in hospitals for the larger part of their lives. In shifting the balance of care, we were moving not just from institutional care to home care but from a model of long-stay hospital provision to a community alternative. Resources transferred, too; as I say in my paper, over the past 10 or 15 years something like £330 million-worth of what was previously health resource has transferred to local authority budgets to reflect that shift.

The issue for older people is that long-stay hospital provision in the NHS for older people is vanishingly small and has largely gone altogether. The scale of provision is nothing like what we saw for mental health and learning disabilities. By far the larger part of NHS spend on services for older people is for acute hospital care. The issue is that the metrics are going the wrong way for us, because acute admissions of older people are continuing to rise. Our concern is that, if the model of care that we currently operate persists—this is the sustainability issue—as the total number of the elderly increases and the proportion of acute admissions of older people remains the same, the absolute number will increase. I am not sure whether it will increase to the illustrative number that I suggest in my paper or to a lower level; the point is that it will continue to rise.

If we are serious about transferring our resource from hospital care to community care, we have not only to stop the growth in older people's use of acute hospitals, but to reduce significantly the use of acute hospitals to a level that would free up infrastructure that could be closed or transferred. In the short to medium term, that is probably too great an aspiration, so the aspiration must be to try to contain and taper the trajectory of that growth. That will require a new model of care, which we suggest should be based principally on much better and faster rehabilitation and re-enablement, supported by provision such as that discussed by the previous panel: telehealth care and more complex primary care delivered at home.

Care should not be delivered only by social services. To go back to my original point, this is not about shifting the balance from health to social care; it is about shifting care for older people from hospitals or care homes to care in the home that is provided jointly by health care workers, social care workers and third sector workers. We perhaps sometimes mistake the shifting the balance argument as being about shifting from health to social care. It is about shifting from institutional to home care, in my mind.

Rhoda Grant: My question expands the same thread. We are talking about the shift of resources following the change in care, but it seems to me that the resources need to shift before we can actually change the care. If the care is not there in the home, provision cannot be shifted out of the institution. It seems to me, then, that the system almost has to be front loaded to get the change. Where does the funding for that come from? How can the funding that comes from acute care into primary care be tracked?

Malcolm Iredale: As Tim Davison mentions in his submission, the integrated resource framework is helping us all to understand exactly where we are spending the resource and what it is delivering for us. The integrated resource framework is about not just the resource that we spend but the activity that we buy for that resource. That allows us to start to look at what the resource is buying us and whether we can move resources by disinvesting

some resource in the short term to reinvest it in home care provision or whether we need to seek to provide, on a non-recurring basis, the up-front investment to which you referred in order to make that change possible. I stress that the integrated resource framework is helping us to understand exactly what we are getting for the significant joint investment that is provided by local authorities and NHS bodies.

Tim Davison: I was involved in the significant shift in Glasgow from the old form of mental health and learning disability services to working in the community. When that happened in the early 1990s, we had the luxury of what was called bridging finance, which provided millions of pounds to set up community teams jointly with social work colleagues before we closed wards. That was really helpful. Frankly, we do not have that luxury this time, so necessity will need to be the mother of invention for us.

Between health and social services, we spend billions of pounds on older people. As I said in my submission, shunting resources from one silo is very much an Oldspeak approach that is not fit for purpose. We need to recognise that we are spending billions of pounds supporting older people under one model of care that we need to transform into another model. We will not have the luxury of the bridging finance that was available in the early 1990s, although we are spending an awful lot more on such services than we did then. We will just need to be far more innovative, imaginative and joined-up than we have ever been. In my view, that is the biggest challenge facing the public sector in the next 10 or 20 years.

Michael Matheson: Health boards need to achieve a 2 per cent efficiency saving both in this financial year and in the next financial year. In practical terms, how will boards go about achieving that this year? What efficiencies are being considered in order to achieve the 2 per cent saving in the forthcoming financial year?

Tim Davison: The basis of that saving is probably just ever tighter good housekeeping. For example, the majority of our spend is on pay, so we have done a huge amount to try to reduce sickness absence. In my health board, we have reduced sickness absence to just a shade over 4 per cent, which represents a reduction of more than 1 percentage point. As we employ 12,000 staff, reducing absence allows us to spend less on overtime and less on bank nursing.

We have also done a lot of work with general practitioners and acute hospitals to try to restrict formulary prescribing costs. That is a constant issue because, despite the fact that we remove costs from the bottom, demand keeps pouring in at the top as new drugs become available. Nevertheless, in our existing formulary, we are constantly moving towards more generic drugs and trying to limit the number of drugs that are prescribed, such as when there is a choice of five drugs of which two have a similar health outcome.

We have also tried to restrict choice in relation to surgical implants, such as hip prostheses. Surgeons like to use different types of prosthesis, but the more that we can centralise and streamline things to reduce the range, the cheaper the cost is. For example, we used to provide several different types of surgical latex gloves, but we now have only one type for the whole of Lanarkshire.

As well as better procurement, energy efficiency has been a big issue. We have invested in everything from low-energy light bulbs to better insulation. Every health board has a list of such things as long as one's arm. Fundamentally, efficiencies are achieved through better housekeeping.

Given the predictions that I hear on the airwaves and in the media about the spending review that will follow next year's budget, I think that we will need to consider far more significant service redesign. I do not have the answer about what service redesign for older people will look like in tangible form, but I have cited examples of where significant service redesign has taken place in other areas. If we can do that for older people's services, that will go a long way towards allowing our services to be financially sustainable over the longer term. We do not have the answer yet, though.

Malcolm Iredale: I think that all boards are following a similar pattern. We have gone through what I would call an efficiency savings programme and have addressed good housekeeping issues involving vacancy management, sickness levels, prescribing and so on. We have also considered whether we can make our backroom services more efficient through sharing services and making better use of technology.

We are now starting to work on service redesign and are examining the beds that we are using. Have we got staffed beds? Are they all being used? Can we reduce the number of those beds or relocate some beds while still providing quality patient services? We will increasingly need to consider such issues. Some people referred to the process as salami slicing, as it involves taking off layer after layer in an attempt to be more efficient. However, I think that we are getting to the end of that now. One can always go further, of course, but I think that we have already had the big paybacks from the process.

Tim Davison talked about procurement. We have all become part of the national procurement project, as we all use central ordering and deliveries now. That has eased up some costs for

us, but there are a limited number of such things that we can do. At this stage, we need to move towards something more radical and long term.

The Convener: The paper from Unison says that NHS Lanarkshire will have

"a cumulative surplus of £14.835m by year-end".

Do you agree with that?

Tim Davison: That was the last year-end surplus.

I became chief executive of NHS Lanarkshire nearly five years ago. At that point, the board had a £20 million deficit. Over the past four years, we have turned that into a surplus. Our financial plan predicts that we will end this financial year with a reduced surplus of £12 million. That means that, in this current year, despite the fact that we have brought forward a surplus, we are spending £2 million more than our in-year budget. Our financial plan over five years uses that surplus to pay for £140 million-worth of new capital projects that the board has approved and which will come on stream over the five-year period. The five-year plan sees the £14 million surplus diminishing to £12 million, £8 million, £6 million, £4 million and nothing over the period. In effect, we have banked revenue on a non-recurring basis to pay for the additional recurring costs of capital over a five-year period.

The Convener: That is helpful. Your submission says that you have already allocated the money, and I wondered what had happened to it.

Michael Matheson: What were the cash figures for efficiency savings in your health boards in the past financial year, and what will they be this financial year?

Tim Davison: For Lanarkshire, this year the figure is about £5 million of cash; the rest is made up of a raft of productivity and capital-type issues.

We are still planning the coming year, and we have not yet got our board allocation—we have been given an indication of what it is likely to be, but we do not know exactly what it will be. The level of uplift going into next year, which is lower than it is in our current financial plan, is around £10 million. When that is combined with the requirement for cash-releasing efficiency savings of about £5 million that was in the financial plan for next year, we will have a target of around £15 million. However, as I said, in the current financial year, we are spending about £2 million more than we are getting in-year, despite the fact that we have a historical surplus. Unless we can reverse that, that will be added to the total as well. I would guess that we are looking at somewhere between £16 million and £18 million of cash next year, compared with £5 million this year.

Michael Matheson: And last year?

Tim Davison: Last year was of a similar order to this year.

Michael Matheson: So, £5 million.

Tim Davison: Yes, something of that order.

Malcolm Iredale: NHS Highland was one of the few boards that had a non-recurring deficit—in other words, we were funding recurring expenditure from non-recurring resource to the tune of about £8 million. We removed that at the start of this year, so we immediately made £8 million savings at the start of the year, and we are making a further £7 million of savings. The target is savings of £15.6 million this year, which is broadly in line with last year.

On the draft budget figures, the figure will be around £15 million cash next year as well.

Michael Matheson: Are you confident that you will be able to make that cash efficiency saving?

Malcolm Iredale: We achieved that last year, partly on a non-recurring basis, which is part of the challenge that we face this year. Plans are being brought forward. We have about £13 million secured with plans; we are just looking for plans for another £2million to £2.5 million to come forward. At this stage of the year, we have made good progress, which is down to the operational units.

12:00

Michael Matheson: Audit Scotland raised concerns about transparency in efficiency savings when it published a report earlier this year on some of these issues in the health service. It said that it was difficult to make a distinction between cash-releasing efficiency savings and time-releasing efficiency savings. How do you go about identifying the difference when you are drawing up the figures for your individual boards?

Malcolm Iredale: For NHS Highland, it is a cash saving when money comes out of the budgets. In other words, on the figures to which I referred, there will have been a reduction of £1 million or £2 million in the budget of the operational unit. That is cash out of the system, which the unit will not get this year and, importantly, it will not get in future periods. That is a cash-releasing saving. At the same time, some increases in activity are funded through increased productivity, or time-releasing savings. The same amount of money might go into the system, but it buys more output.

Tim Davison: It is hugely complex. We have thousands of budget lines, all of which are either on budget, over budget or under budget—Mr Finnie talked about budget and actual spend. There is huge fluctuation. The budget is only a

forecast. You take a view about what is going to happen.

When a new drug is introduced, we come to a view about its uptake and how much it will cost. When Herceptin was introduced in Lanarkshire, we took the view that would cost about £1 million. In real terms, the cost turned out to be greater than that—that was an overshoot.

We have to balance the bottom line. For every budget overshoot, we look for an equal and compensating undershoot. Sometimes we get it wrong by underestimating costs and sometimes we get it wrong by overestimating costs. We work in a highly complex, dynamic environment that in large part is demand led year on year.

Having said that, it is relatively easy to distinguish between what is a cash saving and what is not. Let us imagine that I have an orthopaedic department that has a £1 million budget and next year I manage to put through 10 per cent more patients than this year with the same budget, because we have been more efficient. That is not a cash saving; it is an efficiency gain, because we get greater productivity for the same amount. If that orthopaedic department puts through the same number of patients for £900,000, because we have reduced skill mix, merged theatres, changed on-call rotas or whatever, that is a real cash-releasing efficiency, because I have taken £100,000 out of that orthopaedic budget.

Lanarkshire's budget of £900 million is big enough, but Audit Scotland's problem is that when it tries to do a forensic, line-by-line analysis of a £7 billion budget, some of the meaning gets lost in the morass of detail.

From a health board perspective, ultimately, we manage the bottom line. We have millions coming in and millions going out. We have huge variation across thousands of lines. Every month, we are trying to manage the bottom line.

If we are to do everything that we want to do in our plan—this applies to both Highland and Lanarkshire—we will have to take cash savings out of our current spend in net terms. If we cannot take those savings out, we will have to start looking at tailoring back some of our aspirations.

Ross Finnie: Michael Matheson has asked the question that I was going to ask, but I want to press you a little further. You were enormously generous to Audit Scotland when you said that, because there were billions coming in and out, that made things very difficult for it. Of course, it is Audit Scotland's job to analyse that. Its audit techniques are intended to take account of the different flow across the whole body. Can you even hint at why Audit Scotland should conclude that it was totally unable independently to verify the savings that health boards have made? That is just a slight amplification of the question that Michael Matheson posed.

Tim Davison: From the perspective of my health board, I find that strange. We feel that we are able to distinguish between what is a real cash-releasing efficiency and what is a proxy efficiency, such as productivity. I cannot speak for Audit Scotland—I am not usually generous to it.

Malcolm Iredale: On a monthly basis, most boards report cash efficiency savings in detail to the non-executives and to the board in a fairly open way. I admit that it is harder to quantify absolutely the level of the non-cash-releasing savings. You may have a feel for it in some areas or, as with Tim Davison's orthopaedic example, you may be able to specify it. The cash side is much easier to define.

Mary Scanlon: I have two questions. First, if I can go from the general to the specific, I am sitting here in awe of the evidence that we have been given, because both NHS Lanarkshire and NHS Highland are operating against a background of rises in staff costs, medicine costs, equipment costs and building costs; the European working time directive; agenda for change; and equal pay. In addition, NHS Highland has experienced drastic NHS Scotland resource allocation committee cuts compared to the Arbuthnott formula, has had to make 2 per cent efficiency savings and, having been the board using the most non-recurrent income, has had to cut that back. That is against an uplift of less than 0.5 per cent of what NHS Highland has had in the past 10 years.

I am sitting here watching you say with total confidence that you can be more productive as a result of economies of scale, bulk buying, increased productivity and sharing services. If you are able to do all that—I appreciate that there is a three-year moratorium on replacing staff—does it mean that you were so inefficient in the past that this is painless? It sounds painless to me.

Malcolm Iredale: When I talk to colleagues or read the local press, I am aware that some of the things that we have tried to do to reduce expenditure have not been painless.

You are right that if we look back over the increases that the NHS has had over the past five or 10 years, particularly in Highland with the Arbuthnott increases—it is interesting that John Gallacher of Unison was here because we shared in this through the partnership forum—we see that we have dropped down from 8 or 9 per cent increases down to a 3 per cent increase this year. I will pick you up on your NRAC point as we got a minimum uplift of 3 per cent, which was the minimum for all boards this year, so it was less

than some boards got but it was certainly a positive increase rather than a loss.

It is not easy and, as our submission points out, we are working in partnership with local authorities and with the staff side to try to identify savings and work through these issues together. It is difficult at the moment and, as we say in our evidence, it will become increasingly difficult in the future.

Mary Scanlon: How will patients in Highland feel the impact of the cuts that you are bringing forward to meet your balanced budget?

Malcolm Iredale: With regard to the balanced budget and in all the efficiencies that we have tried to make, the first consideration has been to try to preserve the quality of patient care and maintain patient safety, hence my reference to backroom services such as procurement and measures such as the prescribing of generics when the same outcome can be obtained for a lower cost. We are trying to make all those efficiencies with minimum patient impact, but it will become increasingly challenging.

Mary Scanlon: But there were significant savings to be made, so you were technically inefficient.

Malcolm Iredale: We can all seek to make savings and I am sure that there will be further savings to be made, but it is getting increasingly difficult to achieve savings.

Mary Scanlon: I will move on to my second question. We are all struggling—I certainly am—with single outcome agreements. It is a fact that there is no ring fencing in local government and I am aware from a constituent that Highland Council has run out of money for care and repair, so anyone who wants any money or changes to their home must wait until the new financial year—even if they are 91. How do you know that the £17.352 million that NHS Highland gives to Highland Council is spent where it should be spent and that the situation is not leading to more acute admissions, which Mr Davison mentioned? Given that the council has run out of money less than six months into the financial year, do you go back to negotiate with it and say, "There has been an increase in the number of elderly people, so we will give you lots more money." How do you monitor that £17 million?

Malcolm Iredale: Across the piece, it is challenging to monitor all the resource transfer payments to local authorities. It can be done only in partnership. As the position in Highland Council, Argyll and Bute Council or any of the other councils with which we deal emerges, we talk about the pressures that we face and try to manage our way through them together. As I said, the integrated resource framework offers us scope to do that, because it recognises the resource pressures in both activity and cash that we face during a year. It is helping us to understand how to manage the position.

Mary Scanlon: I understand that, but a lot of money is being provided, and it is obviously not enough. If I were handing over £17 million to someone, I would want to know that it was going to the purpose for which it was intended. We are looking at the shift to home care; the Local Government and Communities Committee may do the same. You have been very polite, but can you honestly tell us that the amounts that appear in NHS Lanarkshire's submission go to where they are intended to go?

Tim Davison: I am involved in a review of resource transfer that is sponsored by the Scottish Government, under the health and care ministerial strategy group. The review involves the Scottish Government, the Convention of Scottish Local Authorities, some local authority representatives and some health board chief executives, of which I am one. There is a general sense that accountability for the resources that we hand over to local authorities and the assurance that they give to the NHS that they are spending it in the area in which it is intended to be spent are reasonably adequate. We can look at total investment in mental health, learning disabilities or older people and get general reassurance from the fact that councils are spending more in those areas, rather than less.

However, there is a residual concern in the NHS that we may be transferring resources at a fully inflated level and masking a reduction in investment of additional resources by local councils. In other words, resource transfer may be compensating for savings that are being made to the social work budget. An element of local trust and transparency is needed. Some social work departments would be concerned if the resource transfer pot moved from the health vote to the social care vote, as happened to delayed discharge money. Because of the lack of ring fencing, there would be at least a concern that the money would end up fixing the roads, rather than supporting community care groups. If it is retained by health, it is, in effect, ring fenced—that is the one element of ring fencing that is left, beyond the concordat.

As Malcolm Iredale and I have said, passing resources from one agency to another is like shuffling the deckchairs on the Titanic. The future is not about passing money between agencies but about integrating total public sector resource within a geography to get either more for the same investment or the same level of service for less investment.

The Convener: That is a good point, but how will the arrangement work when health boards and

local authorities are not coterminous? It is all right in my area, where they are.

Tim Davison: We have that situation in total. Greater Glasgow and Clyde NHS Board and Lanarkshire NHS Board are the only two health boards that do not have coterminous local authorities. We have fixed that locally by transferring the bits of North Lanarkshire and South Lanarkshire that are in the Greater Glasgow and Clyde NHS Board area into the Lanarkshire NHS Board area. Every other health board is coterminous with one or more local councils.

The Convener: That is interesting. I ask members to be mindful of the time.

Dr Simpson: The convener will be glad to hear that most of my questions have already been asked.

The Convener: In that case, I move straight to Ian McKee.

Dr Simpson: Most—not all.

I want to ask about the budget line entitled "Improvement and Support of the NHS"; I think that it used to be called "Change and Innovation". Are you comfortable that that is being handed out to boards to deal with shifting the balance of care, or is it being handed out to deal with new technologies and innovations? The budget line has been reduced, but everything that you have said suggests that, in what may be the last year of increase, we should concentrate our resources on trying to achieve long-term, substantial change.

You have spoken in quite a visionary way about shifting the balance towards managing the care of older people in their own homes. Should there be, for example, a clear and substantive increase in funding for telehealth to monitor people in their own houses? Is there clear evidence that the service redesign should be linked to shifting the balance of care? Should a proportion of the cash-releasing efficiency savings be specifically designated for shifting the balance of care?

In England, there are specific targets for such things. The PCTs in England are not allowed to have their implementation plans signed off unless they demonstrate the sort of vision that you are talking about. We have had plenty of discussion—we have meetings coming out of our ears, mostly between different boards, in which they reinvent the wheel. However, given that this is the last opportunity to create change with an increased budget, do we have the right targets?

12:15

Tim Davison: At the moment, we only have hunches. Some of the emerging priorities for reinvestment that I described on page 3 of the NHS Lanarkshire submission represent a range of hunches about the new model of care that I have discussed. We have not yet reached the stage at which we will turn each of those hunches into a tangible, costed service delivery model, with all the training and development requirements and staff redeployment issues that go with that.

The next year is a golden opportunity to plan, following the engagement and consultation process that I described to the committee earlier. That process will involve not only the public but much of the third sector and the user and care agencies, which can really add value. If the model that I described works, it will be supported enormously by unpaid and informal carers. If we can get a 30 per cent increase in unpaid carers, the cost profile of delivering that model is one thing whereas, if we only get a 10 per cent increase in unpaid carers, the cost profile is something completely different.

Even with millions of pounds to throw at the service redesign, we do not yet know quite what it will look like. With regard to mental health, which I mentioned earlier, the big set-piece changes in Scotland have happened since the 1990s. Such a culture change was a policy of the 1960s, but it took us 30 years to see the tangible manifestation of that. It is clear that we do not have 30 years to do that in relation to older people. Next year's budget is important, and it will be painful for many of us, but it is probably not the answer. This next year needs to give us the answers about how we will cope with the subsequent two spending reviews, and I think that most health boards feel that way.

I am sorry if that does not answer your question directly.

Malcolm Iredale: The committee will be aware that each board prepares a local development plan annually that sets out the aspirations and direction of travel. It is supported by a financial plan, which shows how it will be delivered in financial terms.

We should consider what we expect from the boards, and how much resource is invested. Otherwise—to return to an issue that was debated with the previous witness panel—money is retained centrally and handed out for specific projects, with all the bureaucracy that is involved in controlling those projects. We need to be able to task boards with the challenge, give them the resource to do it and then hold them to account for that, rather than trying to assign some central accountability for what may be a modest sum of money. We will have to add money from the voluntary sector and local authorities to the money that we are able to invest in such things, because there is not enough money coming in.

In response to Dr Simpson's point about new technologies, investment in such technologies sometimes allows us to change the balance of care—it is a step in that direction. There is no single answer; we have a range of tools in the toolkit.

Dr Simpson: One thing that concerned me when I was out of politics and was working in clinical practice again was the number of meetings in which we seemed to be reinventing the wheel. I worked in three different health board areas in a very short space of time, and the boards were all getting their clinicians to meet endlessly to talk about the same thing. How can we deal with the matter in such a way that everybody is not reinventing the wheel? There seems to be an awful, huge waste of time. That time could be released if we had lead boards and others did not act until their lead board had sorted things out. The other boards could then follow with local applications.

Tim Davison: I have been involved in community care for most of my career, and my personal view is that there is a dichotomy between a top-down, one-size-fits-all approach, in which people say, "This is what to do; get on with it," and the approach of local priority setting and local flexibilities, in which we recognise that no part of Scotland is the same as any other and that Orkney is different from Glasgow. Those two approaches are at opposite ends of the spectrum.

I was part of the joint future group that was set up during the first session of Parliament to consider improved health and social care working. We found jewels of brilliant interagency working with fantastic outcomes everywhere in Scotland, but nowhere in Scotland was doing all of them. The task that we set ourselves was to take each jewel and roll it out across Scotland, but there was a huge reaction against the mechanism for that—the top-down imposition of saying, "This works well in Stornoway, so you should make sure it happens in Leith"—because of the local priorities approach.

The concordat celebrates local priority setting and local flexibility for good reason, but the approach also throws up frustrations and we find ourselves saying, "Why can't you just get on and do it?" That is a dichotomy, and I do not have the answer.

Dr Simpson: That is repeatedly reflected in Audit Scotland reports. In day care, for example, there is a vast range of individual procedures. There might be reasons for that, such as the distances that are involved in the Highlands, but we need to understand what is going on. Surely we should be pressing boards much harder and saying, "Justify why you're an outlier on this."

The Convener: I ask Malcolm Iredale to respond briefly because time is pressing and we have to move on. We have subordinate legislation to discuss.

Malcolm Iredale: We have already got that approach working through national benchmarking groups and shared services, whereby we try to pilot things on a national basis and people can experiment with things. Certainly in Highland, we try to minimise the number of face-to-face meetings and maximise the use of videoconferencing technology to reduce the time that meetings take. We might still need to hold a meeting, but we can reduce the travel time that is required and thereby make the meeting as productive as possible.

The Convener: I think that we would all like to have fewer meetings.

Ian McKee: I have two quick questions. First, do community health partnerships have a role to play in spending money wisely and making the source and destination of that money more transparent? I do not think that you mentioned CHPs.

Tim Davison: It is folly to see community health partnerships as anything other than part of the health boards. We have two CHPs in Lanarkshire. One is coterminous with North Lanarkshire Council and the other is coterminous with South Lanarkshire Council. They are an integral part of the NHS in Lanarkshire. They manage everything that is not in an acute hospital. They are the outward-facing bits of NHS Lanarkshire to the two local authorities and the third sector in those areas. Their job is to manage the health and social care interface locally and the primary and secondary interface within the NHS. As such, they have an absolutely integral role. They are not somehow separate from the architecture of NHS Lanarkshire. They are just operational bits of my health board.

Ian McKee: So they have relationships with local social work services.

Tim Davison: Yes. As operational bits of NHS Lanarkshire, they are the driving force of local integration.

Ian McKee: You mentioned early in your evidence the importance of keeping elderly people out of acute hospital admissions. When I was a general practitioner before I became a member of the Parliament, I saw a successful innovation whereby carers and home helps were involved as important members of the health care team. They were given lectures, there were meetings, they were told to look out for things, and they were made to feel part of the team rather than being outside it. That meant that problems were seen and reported earlier and there were fewer acute

admissions. Is that approach being used as widely as possible?

Malcolm Iredale: We can always make improvements, but we certainly try to use that approach, particularly in rural areas. Contact is important. You are right—maybe we do not use it as much as we should. The point is well made. It is perhaps something that we could maximise.

Ian McKee: If people feel part of a team, they will go the extra mile and report things. That is helpful.

Tim Davison: I agree.

The Convener: That concludes our session. Thank you for your evidence. I understood what you told us about the boards—both the difficulties and the remedies. That is good, because I rarely understand what I am being told when I sit here. Thank you for giving your evidence so clearly.

12:25

Meeting suspended.

12:26

On resuming—

Subordinate Legislation

Health Board Elections (Scotland) Regulations 2009 (Draft)

The Convener: Item 3 is consideration of subordinate legislation. The draft instrument 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. Last week, the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon MSP, appeared before us to debate a motion on the regulations. I welcome her back to the committee. She is again accompanied by Robert Kirkwood, business planning executive with the Scottish Government, and Kathleen Preston, solicitor with the health and community care division of the Scottish Government legal directorate.

Members will recall that, during last week's debate, the motion was withdrawn after questions were raised regarding the pilot election to Fife NHS Board. The cabinet secretary undertook to come back to us with a response to those. A letter from her addressing the points that were raised is included in our papers. I invite her to outline the response and I will then move to members for any further questions that they might have.

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): As you said, members have the letter that I sent you at the end of last week, which addressed the points that were raised at last week's meeting. On the regulations that are before us, I briefly draw the committee's attention to the issues that were raised at last week's meeting. First, the Subordinate Legislation Committee had raised concerns about the fact that there are no specific provisions on dual registration in the regulations. At last week's meeting, I gave a commitment to introduce amending regulations that would make clear in the regulations that individuals cannot vote twice in the pilot elections. I sent a draft of the amending regulations that deal with that issue to the committee on Friday.

From that, Ross Finnie raised the issue of whether it is an offence to vote twice. At present, the draft amending regulations do not include any offences. That is because, as I am sure the committee will understand, importing a criminal offence requires careful consideration of the legal and administrative practicalities. I want my officials to consult external bodies and electoral registration and returning officers to ensure that

the inclusion of any offences would be practical and workable in the context of what are, let us remember, pilot elections. I took the view from last week's meeting that the committee considers it desirable that voting twice should be an offence. I am certainly happy to give the commitment again today, as I did last week, that we will seek to include that in the draft amending regulations before they are introduced.

I am grateful to Helen Eadie for the point that she raised last week about the ability of the regulations to deliver safe and effective elections. I hope that my letter to the committee has dealt with those concerns and confirmed that the Government, health boards and the local returning officers are confident that the regulations are fit for purpose. That addresses the points that I was asked to address. I am more than happy to take any further questions that the committee has.

12:30

Ross Finnie: I have no further questions; I just want to thank the cabinet secretary. The draft amendment regulations that the cabinet secretary has sent us will give the necessary clarity to rule 5 in the schedule to the Health Board Elections (Scotland) Regulations 2009. They will give equal clarity to the schedule that has been imported into the National Health Service (Scotland) Act 1978—schedule 1A. I am grateful to the cabinet secretary for that clarity. On the undertakings that she gives to explore further the making of an offence, I am content with what is set out in the letter.

Helen Eadie: Ross Finnie has captured everything that I wanted to say, so I will not repeat it. I thank the cabinet secretary for taking on board the concerns that we have raised. I have no further objections.

The Convener: As we have no further questions, that brings the evidence session to a close.

We move to item 4, which is a debate on the draft regulations. Does any member wish to debate them?

Members: No.

The Convener: In that case, I invite the cabinet secretary to move motion S3M-4965.

Motion moved,

That the Health and Sport Committee recommends that the draft Health Board Elections (Scotland) Regulations 2009 be approved.—[*Nicola Sturgeon*.]

Motion agreed to.

The Convener: I thank the cabinet secretary.

National Health Service (Discipline Committees) (Scotland) Amendment Regulations 2009 (SSI 2009/308)

The Convener: Item 5 is consideration of a negative instrument. Members have a copy of the amendment regulations and a note from the clerk. The amendment regulations amend the National Health Service (Discipline Committees) (Scotland) Regulations 2006 (SSI 2006/330) to provide that the limitation on the term of office of any member or deputy member of a discipline committee is increased from one year to three years. The amendment regulations also provide that the period of time within which a health board must notify a practitioner of their referral to a discipline committee is increased from two working days to five working days. The Subordinate Legislation Committee had no comments to make on the regulations.

Do members wish to make any comments?

Members: No.

The Convener: That being the case, are we content to make no recommendation on the amendment regulations?

Members *indicated agreement*.

12:32

Meeting continued in private until 12:57.

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