HEALTH AND SPORT COMMITTEE

Wednesday 28 October 2009

Session 3

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HEALTH AND SPORT COMMITTEE
27th 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:

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

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Wednesday 28 October 2009

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

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning. I welcome everyone to the 27th meeting in 2009 of the Health and Sport Committee. I remind members, witnesses and those who are in the public gallery to switch off their mobile phones and other electronic equipment.

Helen Eadie has sent her apologies, as she is unwell today.

The first item is a decision on whether to take item 4, which is consideration of our draft report on the Scottish Government's budget for 2010-11, in private, as is normal practice. Are we agreed?

Members *indicated agreement*.

Subordinate Legislation

Food Labelling (Nutrition Information) (Scotland) Regulations 2009 (SSI 2009/328)

10:18

The Convener: Item 2 is consideration of a negative instrument. Members have a copy of the Food Labelling (Nutrition Information) (Scotland) Regulations 2009 as well as a note from the clerk. The regulations amend the Food Labelling Regulations 1996 to implement in Scotland European Commission directive 2008/100/EC, which amends European Council directive 90/496/EEC, on nutrition labelling for foodstuffs as regards recommended daily allowances, energy conversion factors and definitions. The Subordinate Legislation Committee has made no comments on the regulations. Does anyone have any comments? If not, is the committee content to make no recommendation on the regulations?

Members *indicated agreement*.

Draft Budget Scrutiny 2010-11

10:19

The Convener: Item 3 is scrutiny of the draft budget for 2010-11. This is an evidence session with the Scottish Government on the draft 2010-11 proposals, and I welcome the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon MSP, to give evidence. She is accompanied by Kevin Woods, the director general for health and the chief executive of NHS Scotland; John Matheson, the director of health finance in the Scottish Government; and Liz Hunter, the director of equalities, social inclusion and sport in the Scottish Government. You are all very welcome.

Cabinet secretary, do you have any brief opening comments?

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): I will be brief. The context of the spending plans that we are discussing today is a real-terms cut in the Scottish budget for 2010-11. Together with the prevailing economic climate, that has presented a challenge for the Government in setting our draft budget for next year.

Notwithstanding the challenge of the reduction of £500 million in our expected budget for next year, spending on health has been prioritised. The health budget will increase by £264 million, or 2.4 per cent, between 2009-10 and 2010-11. That increase will take the health budget to £11.35 billion, which equates to £2,281 for every person in Scotland. National health service boards will receive an overall increase of 2.7 per cent, which includes 0.4 per cent that is being transferred recurrently for waiting times support, meaning that the cash increase for NHS boards overall will be 2.3 per cent. As in previous years, that funding will be supplemented by the 2 per cent efficiency savings that all boards are required to make, which will be made available locally to be reinvested in front-line services. Boards will, therefore, have available to them an overall 4.3 per cent in additional resources in their allocations. On top of that, they will receive additional allocations for specific purposes.

Next year's budget will result in an average increase of 3.6 per cent for health over the spending review period. As members will know, the Government has also taken the step of protecting the health budget from the £129 million impact of the reduction in the United Kingdom Department of Health's capital baseline. Our priority in health continues to be to deliver on the commitments that are outlined in "Better Health, Better Care". Next year, we will also face the

challenge of the H1N1 influenza outbreak, for which significant resources have been set aside.

As planned, the Government's expenditure on sport will be maintained at £43.4 million next year, which represents a 26.2 per cent increase over the last year of the previous spending review. In addition, we have allocated £11.6 million—again, as planned—to preparations for the 2014 Commonwealth games.

With those brief contextual remarks, I am happy to answer members' questions.

The Convener: Thank you very much, cabinet secretary. We will start with questions on the general category of cost pressures allied to efficiency savings.

Mary Scanlon (Highlands and Islands) (Con): The two issues are intertwined. I will start with a simple question about your letter to the committee, cabinet secretary. What is meant by "NHS logistics"? I see that you were looking for a saving of £13.3 million in that area but achieved a saving of £7.7 million instead. What was that target and why was it not reached?

Nicola Sturgeon: NHS logistics is a range of things relating to procurement and distribution. Effectively, it is the supply chain for getting things around the service.

The Convener: It is the vans.

Nicola Sturgeon: It includes the vans and the vehicles that distribute the drug supplies and other things around the service.

Mary Scanlon: Okay. Let us focus on NHS Highland. I notice that the figure for its savings last year—3.5 per cent—was the highest among NHS boards in mainland Scotland and the highest apart from the figures for NHS Orkney and NHS Western Isles, where there are unique issues. NHS Highland cut its spending by £16 million last year, and I know that it is making significant cuts this year. I have two questions about that. First, was NHS Highland previously very inefficient and was it easy to make those cuts? Secondly, when the chairman of NHS Highland calls you and says, "Look, we have made the biggest spending cuts in mainland Scotland," what is your advice? How will those significant cuts—the biggest in mainland Scotland—impact on patient care?

Nicola Sturgeon: Without wishing to be adversarial, I want to challenge your terminology. Efficiency savings are not cuts; they are efficiency savings and are about delivering the same service more cost-effectively. All the efficiency savings that NHS Highland—or any other board in the country—makes are not taken back to the centre but are retained locally and re-invested in front-line care, so efficiency savings that have been re-invested in front-line care have contributed to many of the improvements that NHS Highland has made during the past year, whether they be improvements in general waiting times or in cancer waiting times. I commend NHS Highland for exceeding its efficiency savings target, because that means that more money is available for investment in front-line patient care and less money is being spent on things that do not contribute to it. NHS Highland also had an underlying recurring deficit that it has been able to tackle through more efficient use of resources.

Mary Scanlon: Are you saying that all the money that is successfully saved through efficiencies is re-invested within NHS Highland, and that last year it did not and this year and next year it will not have any less money to spend on patient care?

Nicola Sturgeon: Absolutely. Every single penny of efficiency savings is retained locally. Every board is given its allocation every year, and within that it is set a target of 2 per cent efficiency savings. The money that is saved through efficiencies does not come back to central Government; it is retained by the board for re-investment in its area. Different boards have different priorities for re-investment, but that money goes to front-line care. In a range of areas boards are doing what they do more efficiently, from prescribing through to better estates management, which frees up more resource to improve the quality of patient care on the front line.

The Convener: Cabinet secretary, if we accept your premise that the savings are redirected to front-line patient care, how do you know that that is what happens to the money?

Nicola Sturgeon: Because the money stays in board areas and boards allocate the money that they have to the services that they are obliged to provide. As you know, we performance manage NHS boards annually—I am a considerable way through the annual reviews for 2008-09. The chief executive's annual report is coming out in a few weeks, and it will demonstrate that boards met virtually all the targets that were set for them. We see the evidence in shorter waiting times, shorter cancer waiting times, and better outcomes for patients. We see it—thankfully—in reducing levels of hospital infection and in the many examples of boards shifting the balance of care from acute to primary and community care. Across a range of areas, over the past number of years, we have evidence of increasing allocations to boards and boards taking steps to direct as much of their resource as possible to the front line.

The Convener: Ross Finnie, Richard Simpson and Rhoda Grant have supplementary questions on those points.

Ross Finnie (West of Scotland) (LD): Cabinet secretary, I want to press you further on savings and how we can rely upon them. Clearly, they play a critical part in your earlier assertion that health boards have, on average, access to a 4.3 per cent increase in their allocations.

You will be aware that, at our meeting on 30 September I asked Dr Woods about this issue, because I wanted to know what the health department was preparing and why Audit Scotland had been unable to verify the figures independently. On page 5 of the lengthy but helpful letter that Dr Woods sent to the committee, he narrates the methodology that the health boards use and concludes:

"This Outturn Report is published and presented annually to Scottish Ministers, the Finance Committee and Audit Scotland and is also published on SPICE."

Helpful though that is, the process is slightly circular. We start with my question, which is, why is Audit Scotland unable to verify the figures? Dr Woods then explains carefully what happens in the health board, but concludes by saying that the matter then goes to Audit Scotland. However, nothing in his letter explains why Audit Scotland was unable in its 2008 report to verify independently the savings figures. This is a matter not for Dr Woods but for most of the organisations that report to him. If the auditors are not satisfied about their ability to verify matters independently, one can take steps to check why that is the case and see whether one can reconcile the apparently irreconcilable differences.

I put it to you, cabinet secretary, that it is regrettable that the committee is unable to understand how on the one hand you make claims in good faith about additional savings, but on the other you are apparently unable to explain to us why Audit Scotland is completely unable to verify independently those figures.

10:30

Nicola Sturgeon: I will have a go at answering that, but I say at the outset that I cannot and do not speak for Audit Scotland. Should I say anything with which it disagrees, I dare say that it will draw it to your attention.

It is not the case that Audit Scotland cannot verify the efficiency savings: Audit Scotland does not go through the savings line by line because that is not part of the process that it undertakes. The process of verifying the efficiency savings is laid down on pages 4 and 5 of Dr Woods's letter to the committee. Accountable officers in the Scottish Government have to give assurances that the efficiency savings as verified by health boards are as they are alleged to be. That process is well established in the Government. As I understand it, the process of verification and audit of efficiency savings is identical to that used under the previous Administration. It has the stamp of assurance of accountable officers, and in the case of the health budget, Dr Woods as accountable officer gives assurance about the validity of the efficiency savings.

Audit Scotland can speak for itself, but it does not go through the savings line by line with a view to verifying them. It is more a case of its not doing that as opposed to its not being able to do that.

Mary Scanlon: Audit Scotland tried to do it.

Ross Finnie: I accept that the cabinet secretary cannot speak for Audit Scotland. I am not querying whether the process has been going on for the past 100 years; if it had been going on for the past 200 years, it would not necessarily make it right.

It has been drawn to our attention that the wording of the Audit Scotland report is very unclear. It uses wording that mirrors what the cabinet secretary is saying—it can tell us where the figures have come from, but there is absolutely no reference to that in its 2008 report. The auditor's purpose is not to accept at face value everything that it is told by those who have prepared the information, but to check independently the veracity and validity of claims. I would have thought that £610 million and an increase of nearly 2 per cent in the amount that is available to health boards was material. I am not arguing with the cabinet secretary, I am merely saying that I would really like to be able to say, "Good. We've got an assertion from Dr Woods and his department and from you as the cabinet secretary, and we can now see in the Audit Scotland report not just that the figure has been prepared, but that it has been subject to independent scrutiny."

Nicola Sturgeon: I will make two brief points in response. The first is to find some common ground with Ross Finnie. The NHS's performance on efficiency savings is impressive. I am assured by the process that is narrated in Dr Woods's letter that the efficiency savings are genuine. That is good news, because it means that more money is going back to the front line.

If the committee feels that more of an assurance process is required involving Audit Scotland, the committee or the Government would have to discuss that with Audit Scotland. I will repeat one point and make another. I repeat that the system has been in place for all the years of the efficient government programme, so it is the same system that the previous Administration used. Secondly, as Dr Woods's letter points out, the mechanism that health boards use to provide their own assurances on efficiency savings was subject to discussion and agreement with Audit Scotland. As

I understand it, Audit Scotland has approved and agreed the mechanism that health boards use. I am satisfied that the process that is in place provides the assurance on efficiency savings that people have a right to expect. If the committee requires further assurance, that will have to be discussed with Audit Scotland.

Ross Finnie: I assume that Dr Woods—who in effect is the client—is satisfied, but the wording in the Audit Scotland report is not helpful. It simply does not allow one to infer that Audit Scotland has been able to conduct the process, so there is a bit of a gap. I do not know whether Dr Woods has sought clarification from Audit Scotland on that. I accept the cabinet secretary's point that it is for the committee to take up the point with Audit Scotland, but, as the client, has the health department raised the matter with its auditors?

Kevin Woods (Scottish Government Director General Health and NHS Scotland): The arrangements are not specific to the health service; they apply throughout the efficient government programme and relate to all aspects of Government spending that are subject to the efficient government regime. I am not sure whether my colleagues who are responsible for the issue have had a specific discussion on that precise wording, but there has been a lot of discussion about the methodology, which is narrated in the letter.

The Convener: Richard Simpson has a question. Is it on the same tack, Richard?

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Yes. The discussion has been helpful. Efficiency savings become much more important with a more restricted budget. The King's Fund says that the health service needs a 4 per cent increase annually just to stand still. Apart from the issue that my colleague Ross Finnie talked about, one issue is that we are finding it difficult to get to grips with the various forms of efficiency savings. We have time-releasing, cash-releasing, recurrent, non-recurrent and capital savings. From the inquiries that we conducted directly with boards last year, we found that some accounting changes were being regarded as efficiency savings. There is some clouding of the issue, so we need greater clarity.

Is it possible, feasible or desirable to spread best practice among boards when savings have been obtained? Is that being done? Also, where is the money being spent? To return to my original point, that becomes crucial in a tighter budget situation. Do we have an analysis of where the money is being applied, particularly the money from the cash-releasing savings?

My final question is also on efficiency savings. If the savings are non-recurring, new efficiency savings need to be made in the next year. However, can recurring cash-releasing savings of, for example, 1 per cent be counted as part of the efficiency savings in the next year? Even though the savings are recurring, do they provide the baseline for the next year, or are they included in the next year's savings?

Nicola Sturgeon: They are year on year.

Kevin Woods: I can give some numbers. In 2009-10, we expect £203 million of efficiency savings, of which we believe £176 million will be recurring.

One of the areas that we examine closely in our discussions with boards at the annual reviews, which the cabinet secretary chairs, is the extent to which boards meet their efficient government targets on a recurring basis. We should not disregard non-recurring opportunities, because they arise and are important. Richard Simpson also commented on time-releasing savings, which are also extremely important, because they create additional productive opportunities. A good example of that is PACS, which we have introduced throughout NHS Scotland. Similarly, many of our investments in e-health will release time.

The Convener: I am wondering what PACS is.

Kevin Woods: Sorry, it is the picture archiving and communications system, which makes digital X-rays widely available much more rapidly. It is an impressive system, which has been rolled out throughout NHS Scotland. It is a good example of how e-health applications of one sort or another and investments in information management and technology can improve productivity.

Nicola Sturgeon: I will add a couple of points. Richard Simpson has raised some pertinent points. I am very keen for efficiency savings to be as transparent as possible, both in terms of how they are made and how the money is reinvested. As I said earlier, the NHS has very good performance to report in that area. Knowing what is going on in that regard is in the interests not only of the NHS but of the committee and the wider public. I am happy to undertake to look at how we can present even more information than we do already in order to provide the committee with as much insight into that as possible.

Richard Simpson made a good point about best practice. As he will be aware, we have established the efficiency and productivity board, which will consider how boards can make efficiency savings, then share that information. Helpfully, we have a copy of the board's report with us, which we can circulate to members. The board's task is to look at where there is best practice and where efficiency savings can be made, and ensure that that is shared across the NHS.

On recurring and non-recurring savings, Dr Woods gave the expected figures for this financial year. If we look at the financial year on which I have just reported to the committee—2008-09—we see that health boards alone achieved a rounded-up £204 million in efficiency savings against a target of £155 million, of which £160 million was recurring savings. The target was therefore met on a recurring basis. Overall, of course—I know that the committee has discussed this point previously—the NHS's dependence on non-recurring funding is at its lowest level in living memory, which is obviously very good progress indeed.

Lastly, just to echo Dr Woods's points on time-releasing savings, cash-releasing savings are important in the sense that they free up money for reinvestment. However, the committee has previously raised the issue of sickness absence targets. The reduction over the past year in sickness absence has effectively led to more than 1,000 extra staff working on the front line. Time-releasing savings are therefore important, but in different ways than cash-releasing savings.

Rhoda Grant (Highlands and Islands) (Lab): I have a short supplementary to Mary Scanlon's first question, and another question on efficiency savings. Can I ask it now?

The Convener: Yes. We have lurched straight into efficiency savings and bypassed cost pressures, but we will return to the latter in the next batch of questions.

Rhoda Grant: I have a short supplementary to Mary Scanlon's earlier question about NHS Highland. We may agree that the efficiency savings that it has made are reinvested in front-line patient services, but a deficit saving has also been made. Can you confirm that that deficit would mean money being taken out of the budget?

Nicola Sturgeon: I am not sure that I follow the question.

Rhoda Grant: Okay. NHS Highland has made efficiency savings and has met its target—let us just park that—but given that NHS Highland has a deficit, the money that is used to repay the deficit is surely being removed from services in Highland.

Nicola Sturgeon: Again, I challenge that, because efficiency savings are not about service reduction but are about delivering the same service more cost effectively. Efficiency savings are therefore not about making cuts; they are about doing the same thing for less money.

In respect of dealing with a recurring deficit—this applies to any board that is in that situation—it is obviously in the interests of patients at the front line that the deficit is dealt with, because that puts the board on a stable and sustainable financial footing and enables it to sustain services year on year. Money is not being taken out of the budget; it is being invested to secure the services that the board—in this case NHS Highland—provides.

10:45

Rhoda Grant: But it surely must be taken out of the budget. I accept what you are saying about putting the board on a stable footing and all that, but if you have a deficit and you pay it off, that means that money is removed from the budget—the figures indicate that around £7 million has been removed from the spending profile of NHS Highland.

Kevin Woods: John Matheson might want to add a little bit of technical information, but a straightforward explanation for the situation is that the board cannot continue to deliver services on a sustainable financial basis unless recurring funding is available to it, so it has to make savings from within its operations to meet that underlying deficit. That is what has been going on in NHS Highland and in all our boards over recent years, and it is what has got us to the position that the cabinet secretary described. Beyond that, once boards have got into that position, the efficiency savings that they make are available for reinvestment in local services, but they have to get to that recurring financial balance. That is the prize that we have been pursuing over several years, and the health service has achieved a great deal to get to that point.

Nicola Sturgeon: It is effectively about ensuring that the services that are delivered this year can still be delivered next year, so it is fundamentally important. Beyond that, additional efficiency savings will be reinvested in additional or improved services. I do not know whether John Matheson wants to add anything.

John Matheson (Scottish Government Health Finance Directorate): I have two very brief points. I confirm that NHS Highland got the core uplift, so it did not get a reduced uplift compared with other boards; it got the core uplift in 2009-10 of 3.15 per cent. NHS Highland was overly reliant on non-recurrency, which, to its credit, it corrected in 2008-09 through the delivery of additional efficiency savings that have enabled it to reduce its reliance on non-recurrency, which was too high, and it accepted that it was too high. That has enabled it to look forward to the future from a more sustainable base.

Nicola Sturgeon: To round off the answer to this question, the other point that we should not lose sight of—I suspect that we will come on to it in respect of cost pressures—is that, even putting efficiency savings to the side, we are dealing with a health budget for next year that is a growth

budget. It is a lower growth budget than in previous years but health boards—before we even get to their efficiency savings—will have more money next year in real terms than they do this year.

Rhoda Grant: I think that we can agree to disagree.

My second question is about the reduction in the nurses training budget—the cabinet secretary will be aware of the Royal College of Nursing's concerns about that. How does the reduction square with the age profile of the nursing workforce, given that we need more nurses to be trained so that we can deal with large retirement numbers quite soon? We are also looking at a flu pandemic and there are training issues about bringing nurses back into the workforce. In addition, if we are serious about changing the balance of care from acute to primary, that has training implications. There are three big lumps that seem to demand more funding rather than less; I am not sure how that squares with a reduction in the training budget.

Nicola Sturgeon: Thanks for raising that important issue. With your permission, convener, I will take a couple of minutes to set out exactly what the position is on that budget line. I preface my remarks by saying that a record number of nurses are working in the NHS. The increase in numbers that was started under the previous Administration has been sustained and further increased under this Administration, so we have more nurses than ever before. Our challenge is to ensure that we continue to have the right number of nurses in the service. It is in nobody's interest to have too few nurses being trained to meet our needs and address the changing nature of how we deliver health care—Rhoda Grant rightly alluded to that—nor is it in anybody's interest to have too many nurses coming through the education system and then being unable to find jobs. Getting the balance right is an on-going challenge.

I will make a couple of things absolutely clear about next year's budget. No decisions have been made about the student nurse intake numbers for 2010-11, which means that the budget line that is before us emphatically does not assume a reduction in the numbers of student nurses going into training. On the contrary, for planning purposes it assumes that student nurse numbers will remain steady at the level that they are at this year, which happens to be the level that they were at last year: 3,060.

The budget covers what we require to pay in bursaries for students. In effect, it estimates the costs of providing bursaries for that number of students. That cost depends partly on the total number of students but also on the demographics of the student population—because, for example, those with children will get the child care part of the bursary—and on uptake levels. To arrive at the number in this year's budget, we have looked back over the past couple of years to find out how much the bursaries for that number of students cost us. Assuming that we will have the same number of students next year, that is what we estimate it will cost us to provide them with bursaries. The figures absolutely do not assume a cut in the number of student nurses next year. That decision has not yet been made. There is a process that we go through every year before arriving at that number and it is under way. It involves workforce predictions being prepared by boards, and the RCN and other trade unions being given the opportunity to comment on those predictions and put forward evidence that they have gathered. We are not yet at the conclusion of that process.

The Convener: That information is useful to the committee. I am prompted by our adviser to suggest that, if there were supplements to the draft budget that explained such factors in the language that you have just used, we would not have to ask you to explain those points when you appear before us. It would be useful to have such explanatory notes.

Nicola Sturgeon: We are happy to take that suggestion away. Obviously, there is a balance to be struck—if there were explanatory notes for every line in the budget, we would end up with a document that was bigger than anybody could cope with. However, I accept that the budget line that we have just discussed is open to an incorrect interpretation if you do not have access to all the information. Of course, the explanation that I have just given was included in the letter that Dr Woods sent to the committee after his appearance.

In future, we might consider putting more of that sort of information into the budget documentation.

The Convener: It could form a supplement, rather than being included in the budget document. It would be useful to committees.

Rhoda Grant: I accept what the cabinet secretary said, but her points do not deal with retraining nurses who have been out of the workforce if they are recalled to deal with the flu pandemic. With regard to the balance of care question, I take it that those who were in the employment of a health board would be being retrained as part of their work and would therefore not require a bursary. However, what happens to people who are coming back into the workforce and need their skills updated?

Nicola Sturgeon: If we get to a situation in which boards need to call on retired staff or staff who are not currently in the workforce—which is an issue that Dr Simpson has asked about before—some of that cost would inevitably fall in

this financial year, with the overall cost perhaps being split between this financial year and the next.

The Government has already given an undertaking to pay the re-registration fees of nurses who need to be re-registered. We already pay return-to-practice course fees for nurses who are returning to practice, if they have either a permanent job or a bank job to go to. That commitment has been there for some time and is not specific to H1N1, but it might be of use in the scenario that you outline because, obviously, it would be helpful to those who might be required to come back into the workforce.

The decisions on whether boards need to supplement their staff in that way are for individual boards to make in light of their experience of the flu pandemic over the next period. I have said previously—if not to the committee, then certainly to the Parliament—that boards have been required to submit their workforce plans for the pandemic, setting out what they would do in particular circumstances. NHS Education for Scotland also has an integral role in ensuring that staff training and upskilling requirements, which are a feature of our critical care plan, are properly catered for.

Ian McKee (Lothians) (SNP): I will ask three questions, if I may.

First, the cabinet secretary acknowledged that the Scottish Medicines Consortium is widely admired throughout the United Kingdom and, indeed, the world for the scrutiny that it gives to new medicines. That, combined with our other mechanisms for watching prescribing and so on, has probably contributed to the good figures in your list of improved prescribing and drug purchasing initiatives and the fact that the 2 per cent efficiency target was exceeded to some extent. However, medicines account for only 15 per cent of the health service budget. Are you convinced that the mechanisms that we have in place for monitoring expenditure in the other 85 per cent of the budget are as efficient as those for monitoring pharmaceutical expenditure?

Nicola Sturgeon: The short answer is yes. The entire NHS budget undergoes considerable scrutiny. We have already had a lengthy discussion about the process of validating and verifying efficiency savings. Boards are required to meet stringent financial targets, and they do meet them, in the main, year on year. There is a great deal of scrutiny and management of boards' budgets. As you rightly say, prescribing budgets have rendered significant efficiency savings. It is good that we are driving those budgets down, but drugs budgets and prescribing budgets clearly remain an important element of what NHS boards do. As well as assessing drugs, the SMC helpfully gives the boards foresight of what they have to plan for and the basis on which they can plan for new drugs that come into play.

Ian McKee: I wonder whether the boards would benefit from an external body, like the SMC, that looked at other expenditure. I appreciate that the boards do that themselves.

Nicola Sturgeon: We also have a great emphasis on efficiencies through procurement. NHS National Services Scotland is helping to drive down procurement costs and thus to drive efficiencies. Outside the drugs budget, procurement costs form a big proportion of the overall NHS budget.

Ian McKee: Thank you. It might not surprise you to hear that my second question is about the budget for distinction awards for hospital consultants. I see from Dr Woods's letter that the budget is increasing by 7 per cent, from £28 million to £30 million. The letter states that the awards are for the

"Motivation and retention of consultants"

and that the increase is partly due to an increase in the number of consultants.

I can see that spending £30 million on 500 consultants probably helps to make them happier. Whether that increases the motivation of other health service workers who do not get such awards is a different issue. Given that, under the heading above "Distinction awards" in Dr Woods's letter, we see that the sum of money that will be spent on vital research will stay much the same, how can it be justified to increase by 7 per cent the amount of money that goes to this small group of health service workers?

Nicola Sturgeon: I will answer the question as frankly as I can. In doing so, I acknowledge the committee's interest in the subject. I will avoid the temptation to comment on the happiness or otherwise of the consultant population, but I acknowledge that the issue is an important and valid one to raise.

I will not go into detail on the background. The committee knows that the system has been in place since the inception of the NHS. It is important to make the point that it is a UK-wide system, because it relates to our relative competitiveness, as a country, in attracting the best doctors. It is an integral part of the system of reward and remuneration for our senior doctors.

11:00

Each year, the review body on doctors' and dentists' remuneration recommends the level of uplift in the value of distinction awards and the number of new distinction awards that are available. Every year there is a mix of awards that

are recycled as a result of consultants retiring or resigning—which are met within existing budgets—and new awards that reflect the growing consultant population. The DDRB has not yet made its recommendations for next year but, in our submission to it, we have argued for a zero per cent uplift in the value of distinction awards and for the total number of awards for next year to be broadly similar to the number available this year. That said, our budget assumes that the body will recommend that the number of awards be increased. Of course, we do not have to accept its recommendations but I remind the committee that, if we did not do so and the rest of the UK did, we could be undermining our competitiveness in the consultant market. The committee should be aware of that. I hope that that bit of background to distinction awards explains our reasoning behind the current budget line.

On a general point, as Dr Woods told the committee a few weeks ago, the increase in the budget largely reflects the increase in the consultant population. Because we have dramatically increased the number of consultants in the NHS, the number of awards has also gone up. However, the number of awards that have been given has not risen exactly in line with the rise in consultants; for example, between 2008 and 2009, there was a 12 per cent increase in consultants and a 4.5 per cent increase in awards. As a result, the percentage of consultants with awards is actually declining very slightly.

I am simply seeking to set some context and background. I know that there is a range of feelings on this issue and, as I have said before, if I were starting with a blank sheet of paper I would not necessarily design the system that we have in place. Nevertheless, it is the system that we have and in making changes to it that have not been made elsewhere in the UK we have to be mindful of any impact on this country's ability to attract the best doctors to our NHS.

Ian McKee: I understand the situation that you are in but, with respect, I point out that the increase in consultants has taken place in a group that does not normally receive distinction awards and I would therefore be surprised if the number of such awards issued had increased proportionately. Moreover, as awards tend to be given to consultants in their last few years of practice, it is a bit difficult to see how the system helps retention.

I agree that it would be wrong to abolish the distinction awards system in Scotland as it would place us at a gross disadvantage to the rest of the UK with regard to consultant recruitment. However, do you not agree that some reduction at the margins, just to indicate our intentions, would not result in a great flow of consultants to the rest of the UK and would, at the same time, reassure the rest of the health service and the people of Scotland that we were keeping an eye on the situation and doing something about it?

Nicola Sturgeon: Again, let me be as frank as possible about this. We do not yet know for definite the DDRB's recommendations on distinction awards but, in its draft budget, the Government has made an allowance for what we think it is likely to recommend. Obviously, as part of the budget process, the committee will determine whether those judgments are correct.

The distinction awards budget could be held steady if, as we have argued, there is no uplift in value and only recycled awards are available next year. That is certainly possible. However, if we in Scotland were to take that view unilaterally—and I understand why some people feel that we should do so—that might have a knock-on effect on our competitiveness in the consultant market. The committee can draw its own conclusions and make its own judgments in that respect; I am simply pointing out the implications of such a move.

Dr Simpson: Let me explain the committee's concern. I understand the points that you made about competitiveness and the increased number of consultants and so on, but if distinction awards are really a motivational and recruitment tool to ensure that we retain our competitiveness, why do so many consultants receive them in the last three to four years of their working lives and therefore receive a significant uplift in pensions? That does not seem to square with the policy intentions of the awards. Where in the draft budget does the additional money appear for the increased pensions that result from such awards in the last three to four years of consultants' working lives? Is that accounted for in the "Distinction Awards" line?

Given your negotiating position with the DDRB in arguing for a zero per cent increase in awards, why do you not adopt the same tactic for the "Distinction Awards" budget line as you have done with the "General Medical Services" line, by simply keeping the same figure for next year and burying any potential increase in the "Miscellaneous Other Services" line? The Government has not increased the GMS budget line—no Government ever does so—because that would give away the Government's negotiating position. Why have you not done the same with distinction awards?

Nicola Sturgeon: I think that the answer is that we do not have negotiations with consultants on distinction awards. Although the DDRB has a remit in recommending the salaries of, for example, general practitioners, the recommendation is often preceded or followed by negotiation. Therefore, different arrangements apply. However, Richard Simpson raises a legitimate point.

NHS pensions are included not in the health section of the budget document but in the Scottish Public Pensions Agency section. The table on page 34 of the draft budget includes a line for the "NHS in Scotland pension scheme".

Finally, Richard Simpson asked whether it is in line with the policy intention for distinction awards to be given to consultants towards the end of their career. Obviously, I cannot comment on how the policy has operated since the scheme began in 1948—my responsibility covers only the past two and a half years—but the practice will have accumulated over that period. However, the previous Administration instigated a review of the system, the findings of which I have recently endorsed. The changes are intended to open up the system within the consultation population. For example, people can now only self-nominate for awards rather than be nominated by others. That is intended to help increase gender, racial and ethnic minority equality and to open up the awards to consultants at different stages of their careers. Obviously, we will need to see what impact those changes have on the distribution of awards, but that is the intention behind the changes.

As I said, I am not unsympathetic to the points that the committee is making. I have explained the background to the awards, why that budget line has increased and what it is intended to cover. I have also explained the possible implications of holding that budget line steady. I know that the committee will take account of the advantages and potential disadvantages of that.

The Convener: I want to move on to another topic.

Ian McKee: I will withdraw my third question—

The Convener: Have you forgotten it?

Ian McKee: No, no.

The Convener: How dare I suggest such a thing.

Ian McKee: Okay, I will ask my third question.

The Convener: No, I suggest that we move on—

Ian McKee: I was about to suggest that before that calumny stung me into action.

The Convener: Oh, did it? I must remember that when you are sleeping. Mary Scanlon will move us on to another topic.

Mary Scanlon: I want to ask about telehealth, which I have been fairly consistent in asking about throughout our consideration of the draft budget. I note that, in the draft budget document, the "eHealth" budget line is up by £37 million, but the "Capital Investment" budget is down by £105 million. I was somewhat surprised to learn that telehealth is lumped in with the capital budget, which faces a huge decrease. I was even more concerned when I read the letter from Kevin Woods, in which he states—immediately after telling us that telehealth is not in the e-health budget—that funding for telehealth is not being cut and will benefit from the increase in the e-health budget. His letter then states:

"There are no plans to cut eHealth spend on Telehealth in 2010-11."

We are told that the e-health budget, which is increasing, has nothing to do with telehealth. We are also told that telehealth is in the capital budget, which is decreasing by £105 million. Do you understand why I am a little bit confused? Will you consider creating a separate line for telehealth?

Nicola Sturgeon: I was not confused until Mary Scanlon asked her question. I am now a wee bit confused, but I will try to answer the question as simply as possible. Hopefully, I will give the member the clarity that she seeks.

I will deal first with the capital budget. Telehealth, as opposed to the e-health line in the budget, to which I will return, has always been included in the capital budget—there is no change. The reduction of £100 million in the capital budget to which Mary Scanlon refers was explained at a previous session. It is not a reduction in the overall capital budget but a result of the reprofiling of the capital budget because we accelerated £50 million from 2010-11 into this financial year, as a response to the economic situation. That allowed us to compensate for lower-than-expected capital receipts and to keep the capital programme on track. The money must be repaid next year, which has the effect of reducing next year's capital budget by £50 million. It had inflated this year's budget by £50 million, so the overall effect is a change of £100 million. It is not a cut—it is a reprofiling.

The telehealth portion of the money is relatively small, and there will be no change to it. It covers funding of £1 million a year to the Scottish Centre for Telehealth, which will soon come under the overall aegis of NHS 24; that funding will be continued. Local allocations are also made to boards for their on-going spending on telehealth projects. There is no anticipated reduction in that area, so there is no reduction in telehealth spending in the capital budget.

The committee is aware that next year the budget for e-health will increase. We always anticipated that, in the first two years of the spending review period, some project planning for the things that we are planning to do would be required and that much spending would need to be back-loaded into the third year of the spending

review period. That is evident in the profile of the budget. The budget line for e-health will pay for improvements in telecommunications and the new clinical portal—which is, in effect, the electronic patient record that we have discussed for many years and are now close to delivering in a pragmatic, sensible way—among other things. It will support the new GP system, which will have the ability to talk to other systems, such as community nursing systems, and the new hospital patient management system.

Mary Scanlon asked whether everything could be brought together in one budget line. I am happy to consider whether that is possible and whether it may be a better way of presenting the information in future budgets. I hope that I have managed to reassure the member that we are not only maintaining spending on telehealth—I use that as the umbrella term—but substantially increasing that funding next year.

Mary Scanlon: The cabinet secretary will agree that there is no indication of what the telehealth budget is, which has caused concern. Dr Woods's letter states:

"There are no plans to cut eHealth spend on Telehealth".

In the budget, those are two different lines. There has been a bit of unfortunate contradictory wording.

Nicola Sturgeon: I agree with Mary Scanlon that there has been confusion of terminology in respect of telehealth. People talk about e-health, telehealth and telecare; often, but not always, they are talking about the same thing. We are trying, not just in budgets, to rationalise the terminology a wee bit, so that people understand what is being talked about. We may have to reflect that clarity and simplicity more in the budget.

Mary Scanlon: I am talking about projects such as the cardiopod and the pilot in Argyll that has generated huge cash-releasing savings.

The Convener: I would like to move on. We have not touched on cost pressures or any of the other issues with which the committee wants to deal. I invite members to ask questions about cost pressures.

11:15

Michael Matheson (Falkirk West) (SNP): In projecting its budget, what analysis does the Government undertake of the potential cost pressures that may arise in the NHS in the coming year? What process is used? Is there something practical that committee members can examine to give us a better feel for how that analysis has been carried out?

Nicola Sturgeon: I am happy to put what I am about to say to you in writing to aid the committee's understanding of the matter. It is a complex issue, and I know that the committee seeks assurance on it. My answer will contain a number of figures, for which I apologise in advance; I will try to set out the subject as comprehensibly as possible.

I said in my opening remarks that the boards' increases—not their efficiency savings—for next year are 2.7 per cent. We can disregard the recurring transfer of waiting times money, which constitutes 0.4 per cent of that figure, and the 0.15 per cent that will be allocated among some boards to bring them up to their NHS Scotland resource allocation committee parity. We therefore begin with a figure of 2.15 per cent as the base increase that all boards will get next year, which equates to an extra £178 million in cash terms.

From our analysis, we estimate that the biggest pressure that boards will have to meet from that amount comes from pay costs. It is more than an estimate, because most agenda for change staff are in a three-year pay deal, so we know what that cost increase will be next year, and we have made an assumption for medical and dental staff. The increase in the pay bill for next year, based on what we know, is £115 million.

Another pressure is non-pay inflation. We—and the Department of Health—assume that the gross domestic product deflator, which is 1.5 per cent for next year, applies to other parts of the budget. We therefore estimate non-pay inflation at £43 million. That brings us to a total of £158 million, out of the extra £178 million that boards will have next year, which leaves the boards with £20 million for local service developments, and all their efficiency savings to reinvest in front-line care.

Michael Matheson: That assessment does not go down as far as specific patient-centred services; it strikes me as being concerned with national issues such as pay. It seems that you do not carry out an analysis of specific patient areas.

Nicola Sturgeon: It is, in effect, an assessment of what we consider to be the inflationary pressures on boards. Service developments around individual patients, which you might be referring to, are what boards face once they have dealt with the inflationary pressures, which I have just detailed as amounting to £158 million. Anything extra that boards have is available for them to invest in patient service improvements. Out of the increase that we are giving boards next year, they have £20 million plus the £165 million in efficiency savings to reinvest in front-line care.

Michael Matheson: It is apparent that efficiency savings are important in funding patient service development, but for how long is it sustainable to

expect health boards to meet the target of 2 per cent year-on-year efficiency savings?

Nicola Sturgeon: The Government has set its efficiency savings targets for the lifetime of the spending review, and it has to take a view on how it will move forward from that point. I do not wish to pre-empt that view, with regard to future expectations not only on the NHS but on the public sector in general. My view, based on what I genuinely think is a very impressive performance in the NHS, is that there is still some way to go in making efficiency savings. If we consider some of the targets to which boards are working—on reducing emergency admissions and bed days, and increasing the number of day-case operations—it is apparent that they are delivering patient care in ways that are better for patients and more cost-effective, but I think that boards accept that there is still some way to go.

Rhoda Grant: I want to ask about shifting the balance of care and the costs associated with that policy. Obviously, if we are changing from acute to primary care, the appropriate services need to be available in the primary care sector before people can be moved out of the acute sector. That means that services in both sectors must be funded at the same time. You have talked about £28 million of additional money. Is that sufficient to enable you to pump prime primary care services in order to deal with the change in the balance of care?

Nicola Sturgeon: That additional money is available for investment as boards see fit to invest it depending on local circumstances. Of course, boards have an obligation to spend their budgets so that they meet their targets and objectives and Government priorities to deliver care in the optimal way.

It is clear that the health budget is important in shifting the balance of care, as are local government budgets because of the relationship between the two in the context of community care. We are working on an integrated resource framework that will help to map the costs of providing care for older people so that the distribution of funding is much clearer and we have a much clearer idea of how we must invest to deliver a shift in the balance of care and ensure that services are geared up to meet demographic changes.

Rhoda Grant: It would be useful to get information about that when it is available, because the committee has been considering the matter.

Nicola Sturgeon: We can probably provide more information about the work on the integrated resource framework. Several boards are participating in it. At the moment, it is pilot work, but the framework will obviously be important for the way forward. We will provide as much information as we can about it to the committee.

The Convener: Are we talking about a long or a short list of boards?

Nicola Sturgeon: Four boards are involved.

The Convener: Which boards are they? I am sorry if I have put you on the spot.

Nicola Sturgeon: Thank you for that, convener. I cannot remember which boards are involved and do not have that information in front of me, but we will provide it.

The Convener: I just threw in that question; it was a bit unfair to ask it. Obviously, committee members are interested in which boards are involved—they may be in their areas. We will find out.

Ian McKee: My question is supplementary to Rhoda Grant's question. Cabinet secretary, are you confident that the pump-priming costs that health boards incur in shifting the balance of care will be protected from efficiency savings? It must be rather tempting for a health board that wants to make its efficiency savings to cut into something fairly non-specific, such as those costs.

Nicola Sturgeon: I suggest that those costs are not a tempting target because boards are, for good reasons, focused on delivering more in the community and less in the acute sector. That is better for patient care, and boards know that it is a more cost-effective way of delivering care. They are so focused on that that I do not think that those costs are a tempting or easy target for them.

I want to point to another budget. Obviously, boards must spend their resource allocations in a way that supports the shift in the balance of care, but there is also a budget line for improvement and support of the national health service. That is national funding that can be allocated to boards to help with redesign work.

Ian McKee: Are you happy that the correct mechanisms are in place? Audit Scotland said in a report that, in order to provide more community services, NHS boards, through community health partnerships, need to redesign services and transfer resources from acute to community settings. Of course, community health partnerships have no influence at all on secondary and acute hospital care, so they are not really provided with the tools to supervise the transfer of resources. Are you satisfied that there is enough scope for the mechanisms to work efficiently?

Nicola Sturgeon: I dispute the suggestion that CHPs or community health and care partnerships do not have any influence on spend on secondary and primary and community care. However, to answer your main question, I believe that we are

on a journey, and we have not yet reached the destination.

We are engaged in the shifting the balance of care exercise, which is big. It is about redesigning services and, to some extent, changing people's mindsets; it is about changing what people expect from the NHS and how the NHS expects to deliver that. A lot of work is going on. Boards are under a lot of pressure to demonstrate their success as opposed to saying simply and vaguely that they are shifting the balance of care. It is a feature of annual reviews—boards must show how they are doing it—and the work that I have mentioned on the integrated resource framework is another part of the journey. We are not there yet, but we are definitely heading in the right direction.

Dr Simpson: I have a quick supplementary and then I will ask my question.

Major shifts have occurred in learning disability and mental health care, which have been moved into the community very successfully. However, the shifts took an awful long time, and it was not until bridging finance was put in place to allow the community services to be developed before the wards were closed that the policy was really successful.

I understand fully that the shift in the balance of care is not entirely about savings, but nevertheless there might be savings to be made, so will you allow any savings that might be generated in future years to be set against efficiency savings targets? Boards that are thinking about efficiency savings might be thinking about short-term or immediate savings or changes that they can make, whereas in some areas, such as in shifting the balance of care, the savings might not come until two, three, four or five years down the line, although there might be some indication of the savings that could be made.

Will boards be allowed to set those savings against efficiency targets? Will bridging finance come from the centre under your health improvement budget? It is going down in real terms from £47.9 million to £47.2 million.

Nicola Sturgeon: We now have the access fund, which is specifically supporting the redesign work around waiting times. That is just a slight contextual point.

Dr Simpson: Okay.

The Convener: Contextual is a lovely word.

Kevin Woods: In the past, bridging finance was necessary because we were dealing with large institutions and the changes we were making required careful planning over a long period of time. As you say, the transition was very successful.

We are now making large numbers of multiple changes to increase capacity in primary and community health care and with our social care partners to ensure that people can be cared for locally and avoid hospital admission. For example, the investment that we are making in brief interventions for alcohol, which is aimed at supporting primary care, is part of creating capacity to manage people and prevent the downstream pressure on the acute sector from alcohol-related admissions. That will take a long time, but it is one example of the kind of spend that we are making. It is outlined in the budget to create capacity to head off the downstream consequences and thus, over a period of time, shift the balance and focus of care. We are talking about a whole series of changes like that one.

Of course, when boards want to make more specific changes that are akin to the ones that were made in the past, they can, in their local financial planning, make provision for that by building up resources. I admit that that is a challenge in a period of tight resources, but the thrust of our strategic direction is to go that way.

Dr Simpson: That is helpful.

When things are very tight, the main things that tend to be attacked are maintenance and training. We have already discussed training, but page 5 of Kevin Woods's letter refers to the planned backlog maintenance programme to deal with the backlog bill of £500 million that Audit Scotland identified. To put that in context, is there an increase to meet that backlog, or are the plans roughly the same as the annual expenditure on maintenance that has occurred before?

You might not be able to give us an answer to that—perhaps you would like to come back to us on it—but it is important that we do not allow the backlog to grow. We need to know whether the maintenance budget is static or increasing from previous years to prevent an increased backlog in future years.

11:30

Nicola Sturgeon: I will try to answer that, but we will have to come back to you with the detail on some of the comparisons with previous years. I have already explained the reprofiling of the capital budget over the three years—it is higher overall than it was in the previous spending review if memory serves me, but we will confirm that.

On backlog maintenance, boards' local delivery plans for next year have identified collectively £140 million of planned capital investment in rolling maintenance programmes for 2010-11. That does not include the significant spend on reprovisioning, which is a way of dealing with maintenance backlog. Next year we will spend £62

million on the new Southern general hospital, £35 million on the Aberdeen emergency care centre, and £25 million on the new Royal hospital for sick kids in Edinburgh. Dealing with the Audit Scotland backlog bill, as Richard Simpson described it, is partly about rolling programmes and partly about rebuilding and refurbishing large parts of the NHS estate.

That expenditure does not include the additional funding for primary and community care modernisation. Some £50 million is allocated next year for primary and community care refurbishment programmes, and there will be significant spending on capital maintenance and capital replacement. We can try to provide information on how that compares with previous years, but your general point about the need to ensure that we are improving the estate on an on-going basis is well made.

The Convener: Before we move on to more general questions, I have a quick question about the sports budget.

I am concerned to see that the general sports budget has decreased significantly in cash and real terms. That seems to be a consequence of providing for the Commonwealth games in Glasgow in 2014. When we looked at whether there would be a legacy from the Commonwealth games, evidence to the committee was quite negative. The committee will remind me if I am wrong, but we were told that in the case of all previous international sporting events—the Olympics and the Commonwealth games—there were no data to support a lasting legacy for improving the health and sports participation of a nation. We did not want that to be the answer, but it was the answer that we got from witnesses.

Although we applaud Glasgow's having the Commonwealth games in 2014, I am concerned that, against that background, ordinary sports are losing out and we do not know whether the Commonwealth games will enrich activity throughout Scotland because, as far as we know, to date that has not happened elsewhere.

Nicola Sturgeon: I acknowledge that concern that the committee has expressed previously, and I will try to answer your question in stages. I dispute that the mainstream sports budget—if I can call it that—is reducing, but I will come back to that.

The Government concedes that we have to up the game compared with previous Commonwealth games when it comes to securing a legacy. Lots of people will tell you that no previous Commonwealth games have managed to secure the legacy that we think we should try for and that we think is possible. That is why we are putting so much effort into the Commonwealth games legacy plan with which the committee is familiar and why that will be as big a feature of the next few years running up to the games as the staging of the competition itself. I hope and expect that the committee will take a close interest in the development and delivery of that legacy plan over the next few years.

The mainstream sports budget is exactly as it was planned to be over the three years. It is £4 million less in 2010-11 than it is in this financial year 2009-10, but the straightforward reason for that is that there was a specific one-off allocation in this financial year to take account of the costs of the organisational changes that were made to sportscotland.

There is therefore no change to the sports budget—it is as we always intended it to be. It covers a range of measures, including active schools co-ordinators, support for coaching and a facilities fund. In the past few years, sportscotland has spent a significant amount on improving sports facilities.

As Liz Hunter did when the officials appeared before the committee, I draw the committee's attention to the fact that, over and above the sportscotland line, another £3.5 million—with £1.2 million in the present financial year and £2.3 million in the next one—has been agreed to support elite sports development. That is currently in the miscellaneous budget line. Earlier this morning, I was investigating why it is in that line and not in the sports line. We are certainly considering putting it in the sports line in future, but the money is there and it will be added to the figures that the committee has.

The Convener: I hear what the cabinet secretary says about elite sport, but I am afraid that the committee was cool about that issue after our inquiry into pathways into sport. We were concerned about the inactivity of Scotland's schoolchildren. We are pursuing sport and activity for fun, rather than elite sport.

Nicola Sturgeon: I know that the subject is close to your heart, convener.

The Convener: I am a very sporting person, as everybody knows thanks to Margo MacDonald.

I will leave that issue, but I just wanted to put down a marker. Michael Matheson has a supplementary question.

Michael Matheson: My question is about sports lottery funding, which is not directly in your budget, cabinet secretary, although it has a large bearing on support for sporting initiatives. Do you have any insight into the on-going reduction in sports lottery funding? Do you anticipate that it will continue to reduce?

Nicola Sturgeon: I do not have the projected figures, but we can provide them if we have them. I imagine that we do.

Michael Matheson: I know that that is not directly in your budget, but it sits closely with it. That funding plays a large part in supporting initiatives.

Nicola Sturgeon: The issue is important. It relates directly to the convener's point about the Commonwealth games legacy because a reduction in lottery sports funding would impact directly on our ambitions for a legacy programme. The issue is a concern to us. We have voiced that concern on many occasions and we will continue to do so. Scotland is losing out because of the lottery contribution to the London Olympic games. We think that that is wrong and that it should be rectified. We have raised with the UK Government the fact that the regeneration funding for the Olympic games is not Barnetted, which would allow us to have consequentials in Scotland. We continue to raise a range of issues, as they have a bearing on our sports budget.

Ross Finnie: The cabinet secretary was good enough to admit that she is slightly puzzled, as we are, as to why the elite sport budget appears in the miscellaneous line. More generally, the committee is still struggling with the miscellaneous line. Is it possible for the committee to be provided with more analysis of that figure? Even with the good offices of the Scottish Parliament information centre and our adviser, Andrew Walker, we are still struggling on that. No doubt, you have a great advantage over us, but we are still wrestling with it.

Nicola Sturgeon: I am sure that we can provide the committee with more information, but I can briefly give you a flavour of what is in that line.

One aspect is for dealing with primary care pressures and developments. Richard Simpson raised a point about having the wherewithal in the miscellaneous budget to deal with any increases in GP pay, which is an example of that. We also take account in that line of expected savings in the pharmacy drugs pricing arrangements. There is a range of miscellaneous programmes, such as that on impairments, and NHS board allocations that are not in the baseline, such as the Highlands and Islands scheme.

There is also a range of miscellaneous programmes that have funding below £10 million, which is why they do not appear separately in the budget. Those include community care section 10 grants; funding for dentistry access and school dental services; funding for managed clinical networks; funding for the organ donation task force, which is important; and funding for the patient focus and public involvement initiative. Those are just some examples of what is included in that line, but I am sure that we can provide more information if that would be helpful to the committee.

The Convener: It would indeed.

Dr Simpson: As a supplementary, I believe that the cervical screening budget has been moved into the miscellaneous line.

Nicola Sturgeon: That is right.

Dr Simpson: We do not quite understand why that has occurred.

Nicola Sturgeon: We have managed to deliver significant procurement savings in the cervical screening programme—[*Interruption.*] I am sorry. I mean the cervical cancer vaccination programme, not the screening programme, funding for which is in the board allocations. As I say, we have delivered savings in the procurement of the vaccine. However, it forms part of the miscellaneous budget line because of certain price sensitivity issues around the arrangements with the vaccine providers.

Dr Simpson: So there are confidentiality issues. That is helpful.

The Convener: Our next questions concern cost pressures in the health budget resulting from reasonably foreseeable risks.

Dr Simpson: Is there a separate budget line for the clearly very important and quite successful patient safety programme? I am not clear where it comes in the budget, and my researchers have been unable to find it. Secondly, do we now have the same kind of central reporting system for patient safety incidents as they have in England? I realise that these questions are quite detailed. I would be happy if you wanted to get back to me on them.

Nicola Sturgeon: I am more than happy to write in detail to the committee on the second question.

The Convener: If you want to supply any supplementary information in writing, that will be fine.

Nicola Sturgeon: The reporting and investigating of things that go wrong in the health service is obviously a complex issue. I will provide the committee with that information.

On Richard Simpson's first question, we think that funding for the patient safety programme is in the miscellaneous line, but we will confirm that for the committee.

Kevin Woods: I should add that we have started consultation on a very important quality strategy, which sets out some of our thinking on this matter. We have looked hard at lessons that

have been learned from major inquiries into failures elsewhere in the UK, and we have put together a number of proposals for developing reporting systems to complement the NHS's clinical governance arrangements, which I know the committee is already aware of. Our intention with the quality strategy is to be much more systematic.

Dr Simpson: That is helpful.

Nicola Sturgeon: If the committee had the time and inclination, I would very much welcome its perspective on the quality strategy, which, as Dr Woods has said, is out for initial consultation.

The Convener: Noted.

Rhoda Grant: Although Kevin Woods's letter deals to an extent with the risks associated with agenda for change appeals and equal pay claims, I am still not clear what those risks are. Given that the trade unions have told us that they might well be substantial and significant, how will they be dealt with and which budgets will be used to cover them?

Nicola Sturgeon: For the sake of clarity, I point out that the issue of agenda for change reviews, which I will come back to, is quite separate from that of equal pay claims.

In its budget scrutiny, the Equal Opportunities Committee has taken substantial evidence—from me, among others—on equal pay reviews. In short, 12,000 equal pay claims are currently lodged against the NHS in Scotland, about 9,000 of which are pre-agenda for change claims. That is significant, because the ruling in a recent tribunal case that agenda for change is an equal-pay-proofed system means that we do not have to worry so much about claims that postdate its introduction.

At the moment, because claimants have not yet submitted any information about comparator posts, we do not have sufficient information to quantify claims or, indeed, to reach a view on how many, if any, of them might succeed. In order to substantiate an equal pay claim, the claimant must show that someone in a comparator post was doing work of equal value but getting paid more because of their gender. As I say, we do not have that information, which would allow us to assess the validity of or to quantify claims.

Audit Scotland, the auditor, has agreed with our treatment of this issue. We cannot put it into the budget with a figure beside it, because we do not know what that figure would be—we do not have that information. At this stage, it appears in the accounts as an unquantified contingent liability, with the agreement of Audit Scotland.

11:45

Rhoda Grant: It would be useful to know where the funding of any liabilities would come from.

Nicola Sturgeon: In all likelihood, we will have to consider that when we get to that stage. However, at the moment, we cannot even make a best guess at the likely quantification of those claims. If we were to try to find that money in the budget just now, we would in effect be taking it out of good use elsewhere. We do not even know whether any of the claims are likely to succeed. If we get to the stage where we think that some of them are likely to succeed, or some of them do succeed, we will have a better idea of the quantification. Depending on what it is, we will have to make judgments about how to meet that liability. We simply do not have sufficient information to do that, which Audit Scotland accepts.

The Convener: I do not want to tempt fate but, mercifully, the swine flu outbreak does not seem to have reached the stage that might have been anticipated. What will happen if it becomes catastrophic for your budget? Where is the contingency for that?

Nicola Sturgeon: In total, we have budgeted £55 million for next year, £19 million of which is capital and £36 million of which is revenue. The delivery of the vaccination programme and other clinical counter-measures such as antivirals and antibiotics, additional funding for NHS 24 to deliver the Scottish flu response centre that it is delivering just now and any necessary upscaling of it, plus a contingency, which we do not intend to use at the moment, of going into the national pandemic flu service would all be fundable within the money that we have put aside for that.

Flu is continuing to increase. It is not increasing dramatically; there is more of a gradual, steady increase at the moment, although that might change. We are seeing a sharper increase in the number of people who are being hospitalised and we have had a number of deaths in the past couple of weeks.

The vaccination programme is now under way. Supplies of vaccine in the first few weeks will be limited—we were always aware of that—but as soon as supplies are forthcoming they are being distributed around the service so that we can get on with vaccinating people.

We have a range of contingency plans, from doubling critical care capacity through to getting in additional staff, should we require them. The latest version—the third version—of the planning assumptions was published last week. The committee will be aware that these assumptions are not hard and fast predictions; they just take what we know about the virus, based on our

experience so far and the experience of the southern hemisphere during its winter period, and make the best estimate of what we might face. The assumptions have reduced the estimate of the clinical attack rate over this second wave, which we now consider that we are in, from up to 30 per cent to up to 12 per cent, which is a significant reduction. The estimate of the maximum number of deaths has come down considerably, too. That is good news but, nevertheless, we could still face a very severe situation over the winter.

The Convener: I am happy to move on. We now want to finalise our thoughts on a couple of points: long-term thinking for the NHS and the style of the budget documents. I invite questions on the first point.

Ross Finnie: Cabinet secretary, you will be well aware that the Finance Committee specifically asked subject committees to probe the nature and extent of long-term thinking and the evidence for that. We are well aware that we are at the end of a three-year cycle. It is always quite difficult to know whether—at a strategic Scottish level or local health board level, which is just as important—that means that long-term thinking is not as evident as it might be. Will you help the committee by pointing us to evidence of long-term thinking at strategic level? Also, how do boards demonstrate that at the end of a three-year cycle?

Nicola Sturgeon: Obviously, our budget at present is intended to deliver on the commitments that we set out in the "Better Health, Better Care: Action Plan" back in 2007. Beyond that, there is a range of pieces of work under way nationally, with the involvement of boards, to plan for things that lie ahead. We have already talked about shifting the balance of care, which is an on-going exercise that still has a long way to go. It is about looking at how we deliver NHS services in the longer term, so it is very important. Similarly, the work on long-term conditions ties into shifting the balance of care. We know that we face an ageing population. In the future, many more of our older people and a much higher proportion of our overall population will live with long-term conditions than has been the case until now. There is work on long-term conditions that is looking at how we deal with that.

The quality strategy, the consultation for which we have just kicked off, is also about looking at how we align our budgets, targets and priorities in the health service to contribute to the aim of being one of the highest-quality, best health care systems in the world. The other piece of work to which I would draw attention is the ministerial strategy group on older people's services, which Shona Robison chairs. Again, it is related to some of the other bits of work that I have talked about to do with shifting the balance of care. It is looking ahead at the dramatically changing demographics of the country and working with health boards and, indeed, social care partners to work out how we respond to that.

Those are all forward-looking pieces of work, which our budget this year and in future years will be designed to support.

Ross Finnie: That was helpful. The second part of my question was on health boards. Our committee adviser has looked at some of the plans that health boards are preparing. From preliminary examination of those, they look variable both in the length of period that they cover and in the detail that they provide. I therefore have a two-part question. Do you, as cabinet secretary, or does the health department issue any instructions to health boards on the nature of the long-term provision that they should include and the detail that should be available? If so, are you satisfied with that? The committee is having difficulty in finding that information online.

Nicola Sturgeon: Before I give a bit more detail on the boards' objectives, let me say that all the work that I spoke about in the first part of my answer to your question is work that boards are integrally involved in. Beyond that, the health improvement, efficiency, access and treatment targets for 2010-11, which are now published in draft form, are a combination of immediate targets for boards to, for example, reduce waiting times, and longer-term targets that are about supporting the strands of work to which I referred. For example, there are HEAT targets for shifting the balance of care and increasing the proportion of older people with complex care needs who are being cared for at home, which is an important aspect of shifting the balance of care and reducing emergency hospital admissions. Boards therefore work to support immediate targets and longer-term systems changes and service developments to meet the change in circumstances that we face, and they report against their HEAT targets annually.

Ross Finnie: That is reporting, but we are talking about budgeting. Our difficulty is that we are interested in where you and the health department require health boards to provide detail and at what level, but I am not sure whether that is a requirement. Over what number of years do the boards keep rolling forward? Having a requirement from central Government and from you for a three-year cycle is helpful and encouraging. The trouble is that getting to the end of the period slightly militates against longer-term thinking. We very much appreciate the need for HEAT targets to be integrated in that process. However, in some of the evidence that the committee has heard on the budget, it has been difficult to find clear linkages, because of a dislocation between the budget statement as a financial statement and the various

HEAT targets and the rest. There is a bit of a gap in our understanding and our ability to comment to the Finance Committee in that regard.

Nicola Sturgeon: In a sense, we assess boards against outcomes rather than inputs. That is increasingly true of the public sector in general, given the way in which we assess public sector bodies. When we judge boards on whether they are achieving their targets for caring for older people at home rather than in hospital, we judge them on what they achieve instead of judging them on whether they spend £5 million or £6 million on that. All boards are required to spend their resources to meet their local objectives and their HEAT targets, which in turn feed into the delivery of the Government's national indicators.

The targets that are set for boards are a mixture of short-term and longer-term targets, in recognition of the journey that boards have to make. I believe that there is a fair way in which to assess boards' performances over a period as well as within individual years.

Ross Finnie: I wholly accept that. I am a great advocate of judging people by outcomes and not by inputs but, nevertheless, in the budget process, we have to respond to the Finance Committee and tell it whether we have been able to satisfy ourselves, on the basis of the information that is available, that boards are engaged in longer-term planning. You said earlier that that forms part of your engagement with boards at a strategic level, but it is proving to be extremely difficult to see evidence of that planning in individual boards.

Nicola Sturgeon: I will let Dr Woods comment in a moment but, to take an example that has not been without controversy over the years, NHS Greater Glasgow and Clyde's acute services review, which dates back to 2002, is redesigning and in some cases rebuilding its acute estate but is doing so in a way that supports the shift in the balance of care. We now have two ambulatory care and diagnostic units in Glasgow that are supporting that. That is a good example of long-term planning by a board and the long-term allocation of a budget.

The budget for the new Southern general hospital, which extends some years into the future, is a good example of a board's work to plan over an extended period of time. The board has allocated budgets not only to improve its hospital estate and other parts of its estate, but to support the strategic objective of delivering more care in the community.

Ross Finnie: I would have to accept that in relation to greater Glasgow, but I would reserve my position in relation to Clyde, which is dealt with as an entirely separate entity—there is an element of prejudice in that, but we will not go there.

Nicola Sturgeon: That is a whole new topic. It is not unrelated but, nevertheless, it is a new topic.

Kevin Woods: There is of necessity some variation in the responses of individual boards because of where they—

The Convener: Excuse me. It is interesting that you raise that point. Our adviser is showing me the financial plan for NHS Greater Glasgow and Clyde, which covers one year. We also have the plans for NHS Lanarkshire and NHS Tayside, which cover five years. Is it possible, and would it be within the cabinet secretary's remit, to ensure that the boards' plans covered a standard period of, say, three or four years, rather than having that variation?

Nicola Sturgeon: I am not sure what you are looking at, but I will bring in Mr Matheson.

The Convener: I am looking at NHS Lanarkshire's financial plan, which covers 2009-10 to 2013-14, and the one for NHS Lothian, which also covers five years, whereas the one for NHS Greater and Clyde's plan covers only 2009-10. It is a one-year plan.

Nicola Sturgeon: I take the point.

The Convener: I just wonder about that, because you are going down the route of—

Nicola Sturgeon: I am not sure that you are necessarily comparing like with like. It may well be that there is a document—

The Convener: That is the difficulty.

Nicola Sturgeon: We would have to know what you were comparing to know whether it was a valid comparison.

The Convener: I think the point is to get at what the committee often finds when it looks at the reports of the boards and their accounting reports, and it is the same with their plans. There is no standard presentation between the boards to allow the committee to see what is going on. There is such a variety of documents and the presentation of documents varies between boards. Of course they should have autonomy and be able to make their own decisions in many respects, but the presentation of the information makes it difficult for us to follow. I think that the committee would agree with that.

Nicola Sturgeon: I ask John Matheson to say something about the financial framework within which boards operate. We will then deal with service planning.

12:00

John Matheson: The basic thrust for any NHS board is its five-year financial plan, which makes assumptions about pay uplift and price inflation.

We ensure that those assumptions are realistic in light of the knowledge that the health directorates have. The five-year planning model takes account of the anticipated capital programme over the five-year period and its revenue consequences. Greater Glasgow and Clyde NHS Board's financial planning will take account of the fact that it must go beyond its basic 2 per cent efficiency savings to ensure that it has sufficient resource flexibility to meet the additional running costs of the ACADs and, further ahead, the Southern general.

I am happy to enter into detailed discussion about individual examples, but that is the basic planning model. It is a five-year model. Obviously, there is a greater richness of detail in the early part of the five-year period.

The Convener: Because time is pressing, I will simply make a point. From a lay point of view on the committee, it is difficult for us to read across the plans because of how they are presented and their timescales. On a separate point, the Parliament's health committees have asked for years for the standardisation of boards' accounting reports so that they could see what was going on across boards, but that is still not happening. They are not synchronised.

Kevin Woods: Mr Matheson has just outlined a common financial planning framework. We have a common framework for annual plans in relation to local delivery plans, which are related to HEAT targets, on which we report.

Earlier, I made the point that there is of necessity some variation in the approaches to service and capital planning in individual boards because of local circumstances, progress that has been made in the past and so on. We have tried to inform the process through things such as "Better Health, Better Care: Planning Tomorrow's Workforce Today" and "A Force for Improvement: the Workforce Response to Better Health, Better Care", which give strategic direction on the workforce, and the work that we have done on remote and rural areas. We expect boards to use all that material, to integrate it with their own analysis of the local situation, and to come up with proposals for developing local services, out of which proposals for capital investment will perhaps emerge. Boards often give those plans different names, which they use to engage with people. For instance, a lot of work is being done in the Borders and Grampian on the strategic direction as a framework for going forward. I think that there is a programme called healthfit Grampian. People in the Western Isles are certainly working hard on developing a service strategy. I understand the difficulties that the committee might have in getting a consolidated picture of the approach that is being taken, but variability in the approaches that people use is necessary and required.

The Convener: As you can see, I am being prompted a little by my adviser. It is not the naming that is the issue; rather, we need information in a common format so that we can consider it properly, even if the names and titles that are given to the projects vary.

Nicola Sturgeon: I will try to be helpful. John Matheson and Kevin Woods have outlined the financial and service planning frameworks within which boards operate. Those frameworks are informed by national policy, but they inevitably reflect local circumstances. A range of strategy documents in different board areas will be at different stages because of different stages of development. We can certainly consider how we can encourage or tell boards to present information in a format that is more helpful to the committee to allow it to compare and contrast. I would not want to go much further than that today. We will have to consider what is possible, and we will do that, of course, if the committee thinks that that would help future budget scrutiny.

The Convener: We are all nodding in agreement. It would be useful not just for committee members but for anyone who is interested—perhaps researchers or just members of the public—to be able to understand the material.

Nicola Sturgeon: I emphasise that, just because boards present the information in different ways, that does not mean that they are not doing the forward planning and financial and service planning that they are required to carry out.

The Convener: We are agreed on that. We simply want, so far as is possible, to be able to compare like with like across all the information that is displayed, which is quite difficult to do at the moment. That observation about the information that comes from health boards has been made both by this committee and by previous health committees.

I will move on, as I am conscious of the cabinet secretary's time. Do members have any other questions that they wish to ask? Sorry, I had forgotten about Richard Simpson, who is already down on my list.

Dr Simpson: I have a brief question on joint future, which used to be a programme promoting working together between health boards and local authority social care services. Obviously, such joint working is important, not least in shifting the balance of care so that more people are maintained in their own houses. Joint future is not mentioned anywhere in the draft budget document. I realise that it might not be totally appropriate to mention such programmes in budget documents, but joint future is not

mentioned even in any of the correspondence on HEAT targets. The programme seems to have disappeared off the map slightly. Is it now named something else? Has it been subsumed by the community planning partnerships? Is there still a national programme on joint working? Where has it gone?

Nicola Sturgeon: Joint future is about local authorities and health boards working together in the context of community planning partnerships and CHPs in order to integrate service delivery. In budgetary terms, there are a number of budget transfers to local government to support work on, for example, delayed discharges, mental health, suicide prevention and free personal care. Such budgets are provided. Obviously, there is an increasing emphasis on ensuring that both the NHS and local authority services work together to deliver seamless services.

Dr Simpson: Will we receive a report back on how those moneys are spent, given that they are just put into the local government pot and are no longer ring fenced? I understand the reason for the policy shift away from ring fencing, but will we receive a report back at any point on how transferred moneys are utilised?

Nicola Sturgeon: Obviously, local authorities report back through the single outcome agreements process. In addition, as the member will be aware, we gather statistics on delayed discharge and a range of data on free personal care, so—this goes back to my point about outputs—the performance of local partnerships on those issues is certainly heavily scrutinised.

Dr Simpson: I am particularly concerned about the choose life campaign, whose budget—as we have ascertained from inquiries made under the Freedom of Information (Scotland) Act 2002—has been cut. I am also interested to know about the national programme of joint future work, which used to examine the difficulties in undertaking joint working in caring for groups such as—this was one of the original programmes—the elderly.

Nicola Sturgeon: The joint improvement team has subsumed much of that national programme. Kevin Woods will say a bit more about that.

Kevin Woods: Joint future goes as far back as, I think, 2001—a lot of water has passed under the bridge since then—but we continue to provide support through the joint improvement team within the health directorates. The team's objective is to support partnership working through a range of projects. For instance, we continue to build on the single shared assessment work that was a project in the original joint future work. The JIT supports our wider efforts in developing community health and care partnerships and community planning partnerships. Partnership is the way that we do our business across local public services, and we try to support that centrally.

Before you ask, I am afraid that I cannot quite remember in which budget line that appears in the draft budget document.

Nicola Sturgeon: "Improvement and Support of the NHS" is the relevant budget line.

The Convener: Let me bring to an end what has been a very full and helpful evidence session, in which people have participated with their usual good humour. I thank my committee team and the cabinet secretary and her team.

As previously agreed, item 4 will be considered in private. I will give members a few minutes of respite first, as I know that they are busy this afternoon.

12:09

Meeting continued in private until 12:31.

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