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Official Report

HEALTH AND SPORT COMMITTEE

Wednesday 12 May 2010

Session 3

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HEALTH AND SPORT COMMITTEE
16th Meeting 2010, 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:

Laura Ace (NHS Lanarkshire)
Calum Campbell (NHS Borders)
Cathie Cowan (NHS Orkney)
Jane Davidson (NHS Borders)
Susan Goldsmith (NHS Lothian)
Ian McDonald (NHS Tayside)
Gerry O'Brien (NHS Orkney)
Professor Tony Wells (NHS Tayside)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Wednesday 12 May 2010

[The Convener *opened the meeting at 10:15*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning and welcome to the Health and Sport Committee's 16th meeting in 2010. I remind everyone to switch off mobile phones and other electronic equipment. Apologies have been received from Ian McKee. I welcome Joe FitzPatrick, who is attending as his substitute.

Under agenda item 1, do we agree to take in private item 4?

Members *indicated agreement.*

Subordinate Legislation

Guar Gum (Restriction on First Placing on the Market) (Scotland) Revocation Regulations 2010 (SSI 2010/153)

10:16

The Convener: Item 2 is consideration of a negative instrument. The Subordinate Legislation Committee reported that the regulations had breached the 21-day rule for subordinate legislation, but that it is content with the Government's explanation for that. Do members have comments?

Members: No.

The Convener: Are members content to make no recommendation on the regulations?

Members *indicated agreement.*

Budget Strategy Phase 2010-11

10:17

The Convener: Item 3 is oral evidence for the budget strategy phase 2010-11. We will hear from witnesses from national health service boards as part of our mid-year scrutiny of NHS board allocations for the financial year 2010-11. The committee has agreed to use the written and oral evidence from this meeting to contribute to the Finance Committee's inquiry for the budget strategy phase of scrutiny of the Scottish Government's draft budget for 2011-12.

We will have two panels of witnesses from NHS boards. I welcome our first panel, which comprises Calum Campbell, chief executive, and Jane Davidson, director of finance, from NHS Borders; Cathie Cowan, chief executive, and Gerry O'Brien, director of finance, from NHS Orkney; and Professor Tony Wells, chief executive, and Ian McDonald, director of finance, from NHS Tayside.

Mary Scanlon (Highlands and Islands) (Con): When I compared the submissions this morning, I was surprised by the variation in prescribing costs. The uplifts are 4 per cent for NHS Tayside, 5.5 per cent for NHS Lothian, 6 per cent for NHS Orkney, 9 per cent for NHS Lanarkshire hospitals and 9 per cent for NHS Borders. Among the boards represented on the panel, the uplifts for prescribing vary between 4 per cent in Tayside and 9 per cent in the Borders—Orkney is in the middle. I appreciate that drugs are a huge part of your spend. Why is NHS Tayside so efficient while NHS Borders is less efficient?

The Convener: I ask panel members to indicate to me when they want to respond and I will make a list. Witnesses should not feel obliged to speak unless they wish to.

Calum Campbell (NHS Borders): The question is good. I will try to set the context. Mary Scanlon highlights the fact that NHS Borders has the highest percentage uplift. However, when we talk about primary care prescribing in the Borders, it is important to note that NHS Borders has the second-lowest cost per 1,000 weighted population. NHS Borders also has the highest percentage of generic prescribing in secondary care, at 80.55 per cent.

NHS boards start from different places. I contend that NHS Borders has been efficient in prescribing. Our volumes are increasing, which is why our percentages are high for the forthcoming year.

Ian McDonald (NHS Tayside): As for the NHS Tayside figure, you are not comparing like with like. Our uplift of 4 per cent is for family health services and secondary care growth. In addition, a £5 million cost pressure on FHS prescribing takes the NHS Tayside uplift to 9 per cent, which is comparable with the NHS Borders figure.

Mary Scanlon: A problem is that we have figures only for one year in the submissions, so we cannot see trends from the past.

As an MSP for the Highlands and Islands, I paid more attention to NHS Orkney's submission. With my lecturer's hat on, I would give NHS Orkney six out of 10 for its submission, because it did not answer four of the questions that we put to it in our letter. I can understand that, given your answer to question 2, which was:

"What adjustment are you expecting in ... earmarked funding and ... non-recurring funding compared to levels for 2009/10?"

Your submission is dated 21 April, which is three weeks into the financial year. It is not your fault, but I am shocked that in your response, you say:

"We have no definitive information on the overall level of earmarked or non-recurring funding to be received in 2010/11".

How can you plan ahead when, three weeks into the financial year, you do not have any direction on funding from the health department in Scotland? No business could run like that. Does that present a difficulty for you?

Cathie Cowan (NHS Orkney): To be fair to the Scottish Government, it has a good relationship with us. That relationship is built on good discussions, based on the assumption that there will be no significant change to the position. We are using the 2009-10 figures to inform our budget setting. On reflection, we should perhaps have made that clear in our submission.

Mary Scanlon: I was not asking whether you have good relations with the Scottish Government—I spoke to your chairman yesterday, and I have good relations with him. I was asking about good financial management. If you thought that there would be no change, it would have been helpful if you had told the committee that, rather than saying that you

"have no definitive information".

That does not give us confidence.

Unlike other health boards—including Tayside, which was very helpful—you did not answer question 3, on your anticipated expenditure . You also did not answer question 8, which was:

"What service developments were agreed to be highly desirable for 2010-11 but were not possible to fund at present?"

You did not answer the question on financial planning for 2011-12 and beyond. You may have

good relationships and good friendships, but as you were unable to answer four questions, your submission does not give the impression of sound financial planning. I do not find that helpful.

Cathie Cowan: I apologise to Ms Scanlon for that. On question 3, if it would helpful to the committee I would be happy to submit that kind of tabular information. We have that information, by area, in monetary terms and percentage terms. Obviously, we need that information to do the projections and savings and so on. I hope that I can reassure the committee that we have that information.

Mary Scanlon: But we do not have it.

Cathie Cowan: I appreciate that it is not in the submission, but we have the information. It has been worked on for some considerable time, and has informed our budget-setting process.

Mary Scanlon: Do you also have the information for question 8? As a Highlands and Islands MSP, I would like to know what you were unable to fund. Do you have information for question 10?

The Convener: If you are about to say that you can provide that information in detail, I would add that it would be helpful if we could have it before we do our report next week.

Cathie Cowan: I can certainly do that—we have that information to hand.

The Convener: Having had that assurance from NHS Orkney, let us move on.

Helen Eadie (Dunfermline East) (Lab): My questions are directed at NHS Tayside. In your submission, you talk about a funding uplift of £12.4 million, a cost increase of £42 million, and savings of £30 million in 2010-11. You talk about net costs rather than actual costs, and you say that a saving of 5 per cent is necessary in order for you to break even. You rely heavily on reducing staff costs, through vacancy control management, and on corporate function costs. Some of the categories are rather vague, for example around £2 million in cheaper procurement of medicine is mentioned. Is your funding uplift a cut in real terms? Does saving on the skills mix mean that you are reducing services to save money?

The Convener: That is from your submission.

Professor Tony Wells (NHS Tayside): There are a number of issues in Helen Eadie's question. I will start, then Ian McDonald will come in with detail about the finances. We have tried to capture in our projections for 2010-11, which we have been working on for close to a year, what will be required in our savings programme. We have looked at all the cost pressures in the system, such as pay uplifts, drug costs and payment prices for procurement, which give the £30 million figure that is the bottom line that we have shown on our returns. We have looked at a number of areas in terms of cost reductions. We have tried very hard to keep away from direct patient services. The reason why we have highlighted corporate services, for example, is to focus on management, administration and clerical costs. Last year, we pulled out £2 million of savings from those headings, and we are targeting a further £3 million in savings this year. In the drugs budget, as Helen Eadie said, there is a savings target of close to £2 million, which is against a budget spend of over £100 million. We feel that we are trying to target waste variation and harm in the system. One of the areas in which we think there is scope for reducing waste is medicines prescribing in both primary and secondary care. I will pass over to Ian to give you detail around the percentages that you asked about.

Ian McDonald: First, the pay uplift that we have supported for 2010-11 is based on a 2.1 per cent composite uplift for mainly agenda for change staff, with a smaller uplift for medical staff. In overall terms, that, combined with the agenda for change incremental movement, comes to just short of £12 million. In addition, as I indicated previously, we have uplifted medicines by 4 per cent, which is £4 million. The combined total is therefore about £16 million. In addition, we had a range of cost pressures that we have supported across our operational unit. The biggest of the single cost pressures was the FHS prescribing cost of £5 million that I mentioned. In addition, we have some community health partnership directorate cost pressures, as well as a clinical growth pressure to ensure that we continue to meet waiting time targets. We have also supported a number of developments in our overall plan: the largest of those single developments is a mental health development, on which we are nearing financial close. The additional investment for the development, combined with bridging in 2010-11 is £3 milion. In addition, we have £1.5 million built into the contingency plan. All of that stacks up to the £12 million uplift and £42 million cost increase that Helen Eadie outlined in her question.

As Professor Wells has outlined, we embarked on an efficiency and productivity savings programme very early in 2009-10 around our projected pressure in 2010-11, based on the predicted uplift at that point in time. So, we have been working on £30 million since July or August of last year. As Professor Wells indicated, we had that risk assessed when we submitted our local delivery plan to the Scottish Government at the tail end of March, which was then signed off on 1 April by the Scottish Government, on the understanding that the 70 per cent that we had identified as being risk-assessed had a £10 million gap. We are

working around that just now in order to narrow the gap. Professor Wells has given a number of examples, and I will be quite happy to expand on any of them if the committee so wishes.

Helen Eadie: I have two more short questions. What are the "General efficiencies" that are itemised in your budget paper that come to £6 million, and what are the "non recurring measures"? Can you guarantee the committee that your savings will not result in reductions in front-line services?

Ian McDonald: The general efficiencies are just a 1 per cent target across the piece. As you will see from our paper, we have risk assessed about a third of that at this point in time. On the non-recurring issue, I will take you back to our response to question 2 on our predicted growth within the overall figure. You will see that we have a number of earmarked funds and non-recurring funds. Just because of the timing of those as they come through any given year, they will deliver some non-recurring savings opportunities. I am sorry —what was the last part of your question?

10:30

Helen Eadie: Can you guarantee that there will be no reduction in front-line services?

Professor Wells: Can I take that question, convener? As I said earlier, the philosophy that we have been pursuing in NHS Tayside is the elimination of waste, variation and harm, and part of that is about improving the quality of service to patients. In recent years, we have carried out a number of service reviews—in what we call rapid improvement events—to look at how we can improve front-line services to patients. Many of those have resulted in efficiencies through reducing the time that patients take to go along care pathways. I will mention one or two examples that might help with the debate.

Before we reviewed it, our haematuria clinic at Perth royal infirmary had a 48-day pathway for patients. That has now come down to 11 days. We have also improved our pathway in colorectal services and our stroke pathway. We have been looking at diagnostics: computed tomography scanning, for example, has a much more efficient pathway than it had two or three years ago, as has magnetic resonance imaging. Improvement in theatre efficiency also helps throughput. By doing those things, we are improving services to patients, but we are also making them more efficient. In so doing, we reduce the costs in some cases.

Helen Eadie: I take it that that means that you will not have any reduction in front-line services.

Professor Wells: The answer depends on what you mean by "a reduction in front-line services." If we are talking about, for example, the closure of out-patient clinic areas because we have made the system more efficient, that might well happen. We might well also close some wards or departments that are no longer fit for purpose or that are no longer required because we are providing more services in the community or in different ways, or because there is faster or greater throughput in a department. It very much depends on your definition of "reductions".

Helen Eadie: Thank you.

The Convener: Rhoda Grant wants to ask a supplementary question. Before that, do the other boards want to comment on Professor Wells's interesting comments on shortening the experience for patients so that you are able to make greater use of staff? Are you all doing that?

Calum Campbell: The challenge for all the boards is similar to what Professor Wells said. We have to look at all our services and try to shorten the pathway wherever possible. I will talk about NHS Borders because I obviously know it better than I know NHS Tayside. We have a fair bit of duplication in our primary care services: we have primary health care teams and we also have community teams and we have two different waiting lists. By bringing them together, we can make better use of resources and streamline services for patients. The perception might be that I am getting rid of either a primary health care team or a community team, but the reality is that I am just making a single team out of two and making better use of those resources.

Cathie Cowan: In NHS Orkney, we are utilising telemedicine through telecare, telehealth and the like. That is particularly important to those of us in remote and rural areas, where we are trying to get digital diagnostics and the like back into our central hospital. As Professor Wells and Mr Campbell said their boards are doing, we are doing lots of work to improve the patient experience by taking out the waste and redirecting it, where possible, into front-line services.

The Convener: Rhoda Grant and Richard Simpson have supplementaries.

Rhoda Grant (Highlands and Islands) (Lab): Professor Wells talked about shifting the balance of care and moving services into the community, but I notice that the table in your answer to question 3 shows no increase in expenditure on primary health care. Given that you are looking to put more emphasis on that, it seems puzzling that you are not putting any additional funding into it.

Professor Wells: Shifting the balance of care almost always involves movement from secondary care—in-patient type services—to community-

based services. The development of community-based services is, by and large, funded from a reduction in investment in acute services. Mr McDonald can give you some of the detail around that, if that would be helpful.

Ian McDonald: I apologise if table 3 is misleading. The line for "Primary Care" in that table is for primary care contracting, rather than primary care services. The area of community care that you have asked about is reflected through CHPs. That is where the growth is being picked up.

The Convener: Thank you—that is helpful.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): This question is for all the witnesses. You all talk about improving the patient journey and making things more efficient—which is great—but to whom do you tell that? I understand that local improvements will be made all the time, but apart from making those improvements within your own boards, what is the mechanism whereby best practice, say from Tayside, is relayed to the centre and then to other boards? Is every single board reinventing every single wheel all the time?

Professor Wells: A number of initiatives that have come through the Scottish Government or from boards have been rolled out across Scotland. I can give you an example of that. The patient safety initiative has had a significant impact on patient safety, hospital-acquired infections and other initiatives in acute hospitals. It was taken up by the Scottish Government and now comes under the Scottish patient safety alliance, which has been taken on by all Scottish boards. Likewise, the lean methodology that we have been using for rapid improvement has been picked up by our colleagues in the Scottish Government and is being disseminated among boards.

We very much welcome other boards engaging with us and with our experience—and vice versa. We have developed a philosophy of pursuing the best in class, not just in areas of Scotland but nationally and internationally, to see how we compare with the best, and to aspire to be the best in how we provide services.

Cathie Cowan: I can give a similar answer. There was a connection between the national productivity and efficiency work stream, which was led by Margaret Duffy at NHS Forth Valley, and the sharing of lessons by boards. We have picked up on that—in prescribing, in shifting the balance of care, in lean methodology and so on. There is a very good process in place whereby we share best practice.

Calum Campbell: I can pick up on the points that my two colleagues have just made. A good practical example is the patient safety programme, which Professor Wells mentioned. Let us take the specific example of leg ulcers. There is a lot of evidence that suggests that leg ulcers consume up to 4 per cent of the NHS budget. Think about the pain, the discomfort and the length of stay that that incurs for those patients. Just by managing that differently, as part of the programme, it is possible to take all that suffering out of the system and to shift the balance of care. If the problem does not occur, the care for patients will be more appropriate, and it will be possible to save money. The patient safety programme is an example of what can be done as we shift the balance of care appropriately.

Ross Finnie (West of Scotland) (LD): I will ask you all a question about your approach, particularly on wages costs, which is your biggest item of expenditure. I will do that by following up the question that Helen Eadie asked, about whether front-line services are being affected. I understood Professor Wells's answer—that it depends on how front-line services are defined. However, I say without picking on Professor Wells that I hope you will understand that that makes it difficult for the committee and members, who are acting on behalf of constituents, to understand how health boards are coping with the enormous pressures on them. If different boards define front-line services in different ways, it is difficult for committee members or members of the public to feel confident that when a board announces that it is making an "efficiency saving", that is not shorthand for reducing the service.

What principles do you apply in addressing the fundamental issue of your wages bill? Perhaps I should give an illustration of what I am looking for a little more explanation about. When a health board says, "Oh, well, we've frozen a post" or "We've downgraded a post", the public find it very difficult to understand that that does not represent a diminution in service. I am not asking for the detail of every single appointment: I want to know the principles that a board applies before it decides to go down the road of downgrading, realigning or whatever. At face value, it is very difficult to take that as meaning anything other than that a person's post has been cut. After all, if you did not need that grade, you would not need to qualify it, so would you simply stop it? I do not think that that is what you are saying but, on the other hand, I do not think that you have made the principles that you apply in this respect explicit, open and transparent.

Professor Wells: Mr Finnie has asked a number of relevant questions. As about 64 per cent of our spend is on staff, any budget scenario will have to take staffing into account, so we have been looking at areas of the staffing budget such as locum costs, agency nursing costs and bank nursing costs. We are trying wherever possible within the organisation to drive down exposure to

such premium rate costs, which should in turn reduce the pressure on our pay bill.

Furthermore, the skills mix within any ward, department or service should reflect the needs of the population for whom that group of staff cares. We have been and are getting more skilled at identifying the needs of patients and patient groups and aligning the staff and their qualifications and experience to meet those needs. From a number of exercises that we have carried out on this issue in different parts of the service, we know that we probably have more trained or more highly qualified staff caring for our patient population than we need for balance, so we have to restore that balance, which is what we mean by restoring the skills mix.

We have tried to look at the turnover and movement of staff in the organisation to ensure that we put the right skills mix in the right places. Of course, at any given time, that will depend on who is leaving and who is coming through the system. It is a difficult balancing act, but Ross Finnie is absolutely right: if we are considering reductions in budgets, we will almost certainly have to look at our staff establishment. That said, we will try to direct reductions away from front-line patient services wherever possible, which is why, as I said earlier, we are having a very big push on management costs, administration and clerical staff, back-room services and other provisions in the organisation.

The Convener: Do you want to come in on that, Mr Campbell?

Calum Campbell: No, I was going to make very similar points.

The Convener: Do you want to pursue the point further, Ross?

Ross Finnie: If I felt that the witnesses' silence meant that every single board was taking the same approach to the issue, I would find that interesting and encouraging. However, that is not necessarily reflected in the written submissions that we have received. Indeed, at least two boards have talked about changing the grades of nursing staff in ways that are different from the approach taken in other boards. I am interested in hearing other views on this matter, given that wages is the biggest issue. Professor Wells has given us a very articulate response. Is everyone else content not to explain more fully how they are addressing wage costs?

The Convener: I think that you have just stirred them out of their contentment.

Cathie Cowan: The picture in NHS Orkney is very similar to that presented by Professor Wells. As a relatively new team of three—medical director, chief executive and the director of finance—we have been looking at the wages bill. We have a staff headcount of 607, which we do not see changing in any significant way, but we will certainly take the locum, bank and agency costs out of the system.

I can give you some idea of last year's expenditure. We spent £2 million on locum, agency and bank staff. Let me say to reassure the committee—because this is the tack that we are taking in NHS Orkney—that we do not want to be spending that kind of money on a workforce that is not stable and permanent, as it also has an effect on continuity of care. We want to reinvest some of the money into permanence and stability and, from engaging with the community, the isles network and the like, I know that that is the message that the community wants to hear.

10:45

As well as redirecting money away from those premium rates, we will look at skill mix. I am sure that NHS Orkney is not dissimilar from other boards in the sense that we are looking to address the high tariff pay-bill costs—band 7 and above—and to do the skill-mix work that puts more staff directly into patient care.

We are aligning that work with the productive ward and productive hospital work. We are trying to streamline our care pathways and how we work so that we increase the quality, eliminate the waste and reduce the harm. A lot of the alignment work is directly associated with the workforce. Our situation is similar to that of others. You heard the numbers—£2 million, for example—for NHS Orkney; we want to see that reinvested. We have plans to do that—and to take some savings out at the same time.

Calum Campbell: I will say something relatively similar. In NHS Borders, we spend more than £1 million on bank staff and more than £1 million on agency staff. In addition to that, we have what is known as a pool of nurses who have historically been self-rostering, and we also have 250 temporary staff on our books. We are going through risk assessments to see whether we need all those temporary staff because we are interested in permanence—that is what we want in the Borders. We have historically had a 12 per cent turnover in staff. That is reduced to 8 per cent, and we are working through all the posts to see whether we really require them, given that this is a tight financial year.

We must also tie any decision to the fact that my biggest expenditure on agency staff is in theatres. Standing back, I might say that I can improve my theatre performance in that I can get an extra 15 to 20 per cent just by managing my theatres better. However, I have difficulty reconciling those

two points: managing my theatres better—starting and finishing on time, for example—and the fact that it is my highest area of agency spend. That does not fit well with my workforce plan. It is a question of permanence, reducing variation and ensuring that I have staff in post with the appropriate skill mix to deliver the care required—and, on top of that, save money.

Ross Finnie: The answers are helpful, and I understand perfectly that you want to identify your expenditure on bank and agency staff and those of a more temporary contractual nature, which includes the premium rate element—a nice phrase. However, that rather suggests that you can simply get rid of them because you do not actually need them. I am not saying that you said that, but I am trying to get a handle on the issue. If you do not need the staff, that is fine. However, if you resorted to staff on the premium rates because you needed particular skills in particular areas to deliver a certain level of patient care, I understand that you can reduce the cost by replacing them with a permanent member of staff at a different rate and avoid the premium, but I do not wholly understand how you can simply eliminate them and not affect the level of service that is delivered.

Cathie Cowan: I may not have been clear enough in my response, Mr Finnie. The head count of 607 in NHS Orkney will not materially change—in fact, we see it very much staying the same. It is a question of putting in permanent positions and taking out the premium rates.

It is not just a question of cost. Agency nurses and locum doctors just come in and go out, so there are issues with continuity and quality of care and patient safety. We want to address all those issues so, although we are saving money, we will not reduce our head count in NHS Orkney. We will do work on skill mix and ensure that the skills and qualifications of the staff reflect the patient needs into the future. In the meetings that we have had with the community, particularly about the isles network, which has caused a lot of tension in Orkney, people have said, "That is really good news. We want the same doctor and the same nurse, and we want to build that relationship."

The Convener: Why has that not happened before? It seems to me that it is easy-peasy, lemon-squeezy. I am not a director of health, but I wonder why you have been buying in services if doing so is curable.

Professor Wells: It is fair to say that we have been reducing our agency and locum costs significantly over a number of years. Locum doctors are very expensive, so we are looking at why we need to employ them. There are many reasons for that—for example, covering for sickness absence or maternity leave—but a lot of it has to do with sustaining rotas. Over recent months, we have looked very closely at the rotas that we are required to provide to ascertain how we can rationalise them and make that part of the service more efficient. We think that that can reduce the cost of locums. We are also aware that the cost of employing locums is likely to come down this year because of a better contract negotiation. It is not that we have suddenly discovered that locums are very expensive—we have known that for a very long time—but we are trying to keep that cost to a minimum. I do not think that we will ever be able to eliminate locum or agency costs, because situations will always arise in which we must cover essential services.

Cathie Cowan: I started as the new chief executive of NHS Orkney on 1 February and I think that our service models in Orkney have not been attractive. For example, in the remote and rural isles network we were trying to attract single-handed general practitioners. Now that we have come up with a hub-and-spoke model that links mainland and remote and rural services using telehealth, telecare and the like, we had 10 outstanding candidates in our last GP recruitment exercise. We are making our model more attractive because the professionals want to come to a location where there is peer review and their revalidation is not in jeopardy, and so on. Much of what we have done is about reflecting on service models and using technology. Much of what we did years ago when I was a nurse was directed at secondary care, but that position is shifting significantly. The answer to the question why we did not do something years ago is that we are aligning all the changes and developments to come up with something much better, not only to save money, but to improve the quality of care and provide continuity.

The Convener: And perhaps there have been changes at the top and new brooms have come in. Are there any new brooms among the witnesses? Cathie Cowan is a new broom, and it appears from the raised hands that several of you are new brooms. Does that make a difference in helping to get rid of old habits, Mr Campbell?

Calum Campbell: Obviously, I must say yes to that. It is always helpful to have a balance between new eyes coming in and looking at subjects and having others who have been there for a while. We must respect the culture that we come into, but bringing in new eyes helps. It is important to say that a number of us, although we are general managers, have a clinical background. Like Cathie Cowan, I have a nursing background. The values that drive the Health and Sport Committee are probably no different from the values that we hold.

The Convener: My question was really aiming at the issue of leadership. If there are good leaders across the boards—or in the Cabinet, in these circumstances—things can be done. I said lightheartedly that the answer to my question was easy-peasy, lemon-squeezy, but my question was really about leadership. If money on locums and so on can be saved now, why was it not being saved all those years before? Perhaps it is because there is a financial crunch and people are looking at what has been misapplied.

Cathie Cowan: In my 30 years in the public sector I have certainly seen a difference in the style of leadership. Very recently, we moved into a collaborative leadership model in which we in NHS Orkney look to our partners. We are doing significant work with NHS 24 and the Scottish Ambulance Service, and we are linking that to the third sector and the council. In a sense, that is about building capacity on our islands. We are aligning the workforces round about us to deliver something. We are tapping into and sharing the skills and expertise. A lot of that collaborative stuff is fairly new, as is the power shift in who takes things forward, but those things are helping significantly.

The Convener: I will let my colleagues in shortly. I do not want to hog the discussion but, as a supplementary, is that collaboration leading to more savings or is it identifying more need, which means that you have to spend more money?

Jane Davidson (NHS Borders): I was going to give you what I think is a good example from the Borders, where there are a number of different shift patterns on wards. That has grown up over time as we have thought about supporting staff through family-friendly policies. One of the leadership challenges is to work in partnership with unions and the staff to consider the impact of that. There is a big impact on patient safety given the number of handovers that happen on many wards, and there is also an impact on the financial position through agency costs, bank costs and our pool of nurses. We need to get the right people round the table to consider that and examine the number of different issues that need to be addressed. There is definitely a financial byproduct.

The Convener: Can somebody answer the question that I posed, which was about collaboration with the likes of local authorities? Is that making savings or is it causing you to spend more because you are identifying more need through social work referrals and so on, through which people tell you that something needs to be done and someone needs care?

Cathie Cowan: I would say that, at a high level, it is actually stripping out any waste from the system. I will use the example of someone with social needs who needs a home carer. We are using befriending skills from the third sector as opposed to referring the person to a community nursing team or, particularly at night, to hospital. If we have a crisis at 10 o'clock at night and we do not have any carers, we can think what else we have in the social prescription box, and not just look in the health box. We can put in a befriender from social work or the third sector to sit with the person until we sort out a care package. We can keep people at home.

In the longer term, stripping out that duplication, bureaucracy and waste will save us resources.

Ian McDonald: The example that I can give is that we have a joint equipment store for health and the local authority. Previously, both sectors purchased aids and adaptations, but we now have a single equipment store. That has removed a lot of duplication and the local evidence shows that it is stripping out costs.

Calum Campbell: Your question is a wise one. The answer has got to be that there are massive opportunities. In the Borders, we have joint services around learning disabilities and mental health. We are committed to looking at our properties jointly, and we are starting to look at our day hospitals, because some of them are similar to our day care centres. We are asking how best we can use them. There are lots of opportunities. We have taken up some of them, but there is more to be done.

The Convener: I will let in Richard Simpson, followed by Michael Matheson, Helen Eadie and Mary Scanlon, all to ask supplementaries. I am on my B list. On my A list, I have Rhoda Grant.

Dr Simpson: We have covered some of the staff issues, such as on-call rotas, the skill mix, and bank and agency staff, but vacancy control management comes up in many of the submissions. As an ex-clinician, my experience of that is that it caused delays in appointments rather than a reasonable look to see whether posts were required. It created enormous problems at every level, including the consultant level. There were examples in which consultants gave six months' notice that they were going to end their contract in a key position but a recruitment advert did not go out until the last month. It takes three to four months to appoint a consultant.

What is meant by vacancy control management and, in relation to that, can you also describe your policies on maternity and sickness leave? In one of the teams that I worked in latterly—it was not in any of the boards that are represented at the meeting—when someone went off on either sickness or maternity leave they were not replaced. In a small team, that meant that the sickness rate went up because the stress on the

other members of staff increased substantially. NHS Tayside mentions £4 million of savings on vacancy control management and NHS Borders is talking about proportionately even more—£1.1 million of savings in vacancy control.

11:00

Ian McDonald: I will pick up on the duplication of costs and talk about redeployment and the skills register. After previous service redesigns, people were placed in posts inappropriate to their skills. We have been trying to ensure, through our redeployment skills register, that, with adequate training, those individuals can be placed in vacant posts or, as in the example that we gave previously, used to address the bank nursing issue. To put some figures on this, we use in the region of 140 whole-time equivalent bank nurses per annum in NHS Tayside. We are starting to say that, on the one hand, we have the costs of the redeployment register. On the other, we have a duplication of costs as a result of using bank nurses. Now when a vacancy arises, we ask whether we have a permanent member of staff within our midst who can fill that post, thereby reducing our overall resource cost through vacancy management.

Calum Campbell: Your question is a good one, and I will try to address it in practical terms. It is a false economy to delay appointments. For example, if a board does nothing for months and months when a consultant leaves and the post has to be covered by a locum, that is, as we know, expensive. It is bad management to do it that way.

We are committed to looking at everything. As well as an organisational workforce plan, we insist on workforce plans at departmental and ward level, so that we can look at our skill mix. On top of that, as a pro-tem measure since I came in—I started in January—I have said that I am looking to get 15 per cent savings from all my backroom functions. I have given them that challenge and I expect to see significant reductions there to protect my clinical services. That is how we are attacking the issue in NHS Borders.

The Convener: Do you have any other questions, Richard?

Dr Simpson: I have another question for the A list, but I will come back to it.

The Convener: I had deleted you from the A list, but I will reinstate you.

To keep witnesses in the loop, I explain that the A list is substantive new questions and the B list is supplementaries. We are still on supplementaries.

Michael Matheson (Falkirk West) (SNP): Professor Wells, you highlighted that in NHS Tayside you feel that you have not, in effect, got the skill mix right. You gave me the impression that you feel that you may have individuals who are potentially overqualified working in some posts. Is that the case for each of the boards? Do any of you think that you have got the skill mix right? If not, are you in a similar position to NHS Tayside in that you feel that you have overqualified individuals in some posts?

Cathie Cowan: I suppose that it is about realigning the workforce using the skills. The balance of care is shifting; we are moving care into the community and with that goes a skill set that is sometimes sitting in the acute sector. In my clinical experience, the acute sector—the hospital sector—has become even more acute. Rather than the generic skills that nurses used to have, they now need skills for high dependency care and intensive care. It is about getting workforce numbers right to meet patient needs, but also about realigning the skill mix to the different parts of our organisation.

In Orkney, given the size of the board, some of our clinicians have attracted a higher grade because they have a management component to their jobs. When we start to replicate that across all the clinical areas, we get a high tariff management cost. I think that we can do something quite different. I want clinicians to be clinicians and to manage in that sense—I am not trying to differentiate—but I do not want to pay high-tariff management costs when it can be done differently and cheaper.

Calum Campbell: My answer is similar. Some posts have attracted relatively high gradings because of their management component. My challenge is to see how broad a range of areas a manager can take responsibility for—the structure is like a Christmas tree—so that they are doing work that is appropriate to their grade for the vast majority of their time, not a smaller part of it. That frees up resource for more staff at a lower grade. Sometimes, posts are graded because of the most challenging part of the job, but that might not be a major part of the job. We have to work that through, and we have to demand workforce plans to reflect the need of every department and to see whether we can join teams together to reduce management costs that way.

Michael Matheson: Professor Wells, can you give me a practical example of where you have overqualified staff working for NHS Tayside?

Professor Wells: I mentioned the issue because it is not just my judgment or that of senior management; it is based on the clinical assessment of workloads in different parts of the organisation. For example, we have looked in detail at and compared with other services the skill mix that we use in community nursing, along with considering the needs of the population being

looked after by community nurses. In some areas, we could have a different skill mix, providing a richer and more appropriate quality of service to patients. What if a significant proportion of a senior community nurse's case load is dealing with wound dressing or maintenance injections, for example? Community nurses do many of those things day and daily, but they do not necessarily have to be done by a highly qualified senior nurse. They could be done by a more junior member of staff.

I stress that things change over time. We are shifting the balance of care, so we can also be shifting the balance of workload in terms of moving from an acute hospital environment to a community environment The needs of that population might be different, or we might be able to provide for them in a different way. We talked earlier about working with local authorities. Many of our patients who might previously have been in long-term care are now cared for at home by people who are employed by the local authorities—home care staff—and that has proved to be very successful. We need to know where we are with particular patient groups at any given point in time.

Michael Matheson: If the skill mix is wrong now, how did we arrive at that point? I understand that there is a shift in the balance of care, but that has been happening for a considerable time. When I was training in the NHS 20-odd years ago, a shift in the balance of care was taking place then. Why are we still in the position where each of the health boards that is here does not have the right balance in their staffing mix? The issue has been going on for a long time.

Professor Wells: From your experience you will be aware that there is a significant lead-in time to such changes happening within the service. It takes a lot of organisation and time to move someone who is already in post for their career development, or to use our skills register to place appropriately those who are displaced within the organisation so that we do not leave them in a part of the organisation where their skills are not being properly used.

We are not looking at redundancy. We are looking at staff turnover and at how we can place staff appropriately to backfill people who are leaving the organisation. It is difficult to predict who will leave, where, and when, unless they are retiring or their leaving is planned. It is quite a complicated scenario to manage.

Cathie Cowan: In conjunction with shifts in the balance of care, technologies and treatments change. While Professor Wells was speaking, I was reflecting on my experiences as a very junior staff nurse in Glasgow many years ago. Then, patients who required treatment for an ulcer, for example, would have significant operations and their length of stay in hospital would be between seven and 14 days, depending on their age and the like. Then we got cimetidine, which is an H_2 receptor antagonist treatment against acid. That significantly changed the workload and the skill mix that was required in surgical wards. We now have antibiotic therapy. It is a matter of trying to keep abreast of the technology. We have laser therapy, and there has been a significant change from day care to out-patient care to self-care. We need to try to keep abreast of all the complexities. As Professor Wells said, the lead-in time is significant. We are working with organisational change and many other human resource frameworks because we want to be decent in working with staff.

The Convener: Do you pool budgets with local authorities when it comes to shifting the balance of care? Everybody is protective of their funding. What do you do? The duplication of aids and adaptations was mentioned. What happens if local authorities want folk to be kept in hospital so that they do not have to pay home care bills, for example? How do you deal with such conflicts?

Cathie Cowan: I suppose through our new models. We have an integrated model of community health and social care partnerships and community health and care partnerships. We are not yet pooling budgets; rather, we use an aligned budget model. However, when staff work together, are co-located, understand things, have the same assessment process and the same drive, and are geared towards achieving a single outcome for patients, many things change quite significantly and people share budgets. I came from being in a system elsewhere in which we offset health budgets with social care budgets and the like because care at that time meant a social care or a health response. With joint working, there is a completely different way of working that benefits people.

The Convener: So that is not a problem.

Cathie Cowan: Things could be better. It would be great to pool resources, but we are on a journey, and an aligned budget is the first step in it.

Professor Wells: The committee should be aware that NHS Tayside has agreed to consider with Perth and Kinross Council an integrated resource framework pilot that will address a number of issues that have just been raised to do with joint budgets and joint working arrangements.

The Convener: When does that pilot start?

Professor Wells: It has just started.

The Convener: Will it be assessed?

Professor Wells: Yes. There is a built-in evaluation programme.

The Convener: That is interesting for the committee. The issue is an old chestnut. We have tried for years—

Michael Matheson: Decades, not years.

The Convener: Yes. Michael Matheson is growing older every minute. I thought that he was quite a young man.

Helen Eadie: If I may, I want to dig a little deeper into the situation on Orkney, which illustrates that non-recurring savings are being used to balance the books and not for reinvestment. The issue there that concerns us is that although there are plans to deliver savings, savings are not actually being delivered. There was a deficit of £3.6 million in 2009-10. In the Treasury model, non-recurring savings are not supposed to be used for balancing the books; rather, they should be reinvested. That is a big worry.

It has been said that front-line services are not being cut. I have paperwork from NHS Orkney that says that it hopes to save £105,000 through having fewer nurses and a further £250,000 in staffing costs through redesign. The paperwork also says that NHS Orkney is planning to save £150,000 on the number of general practitioners and cutting locum spend, and that it expects to save £200,000 from changes in the nursing skills mix. We received that information following a freedom of information request.

The Convener: Wait a minute, Helen—I have déjà vu from last week. For the *Official Report*, will you say what you are referring to?

11:15

Helen Eadie: We are all entitled to approach all the boards with freedom of information requests.

The Convener: Oh, yes.

Helen Eadie: We have a response from NHS Orkney to a freedom of information request, from which I gathered my information.

I am worried that non-recurring savings are being used to balance the books when the intention is that they should be reinvested in the community. Such savings should be used to prevent cuts in front-line services, but the reality is that we are dealing with front-line service cuts.

The Convener: You used the pronoun "we". I make it clear that you did not mean the committee.

Helen Eadie: No—I gathered the information.

The Convener: You meant your team.

Helen Eadie: Yes.

Joe FitzPatrick (Dundee West) (SNP): It was a royal "we".

Helen Eadie: I meant my team.

The Convener: It was a royal "we"—"we" are a freedom of information person. You were not referring to committee information.

In any event, Gerry O'Brien was nodding and seemed to recognise the figures.

Gerry O'Brien (NHS Orkney): Ms Eadie makes a valid point. When NHS Orkney produced its financial strategy in June 2009, it identified a three-year framework in which it would return the board to recurring financial balance. It is unfortunate that that clearly depends on non-recurring savings to break even in each of those three years, as Ms Eadie says. Our target is to return to recurring balance in the financial year 2012-13. At that time, any non-recurring savings that were made in-year would be able to support in-year investments.

The figures that have been referred to are the consequences of changes. For example, the £105,000 saving is linked to the establishment of an intermediate care team jointly with Orkney Islands Council, which meant that we changed the structure of a ward in Balfour hospital. In effect, we closed that ward last year when the intermediate care team was established, so the figure is a residual saving from establishing the team jointly with the council and the previous cost of running that ward.

A similar position applies to the acute savings. We used to run two stand-alone wards. In the autumn months of last year, we integrated them to run as one service. Under a nursing review, which continues, we expect changes in staffing levels and the skills mix, which will generate the savings figure that we provided in response to the freedom of information inquiry.

As for the GP savings, we are fundamentally changing the model on the islands, as Ms Cowan said. We are moving away from having individual GPs on all the islands to a network of care. We aim ultimately to reduce not the number of GPs but the cost of GPs, so the heading is probably misleading. The delivery method will be more cost effective.

The Convener: You will be glad that you have put that on the record, to avoid panic in hearts in Orkney.

Helen Eadie: My last comment is more general and could be for all the boards, but it applies to NHS Orkney. Given the lack of service output data, how are efficiencies validated? That has been a big problem for Audit Scotland. You sit there and tell us the information, but how can we

be certain about it, and how is it all validated? Do you have a validation process?

Gerry O'Brien: I return to what the convener said about new brooms. A big part of our process this year is that we are trying to change our approach. That is about the process and the systems that are in place, rather than just having a number on a bit of paper. The board's chief executive, service managers and I must go along to our finance and performance committee, which is chaired by a non-executive director and which comprises non-executive directors, to show where we are in achieving all our savings targets. That committee not only asks whether we have saved the money but considers service outcomes and ensures that savings in the system have not had an adverse impact on outcomes.

The Convener: What do you find out from patients? What access do they have to you to tell you what they think of what you have done? What systems are in place for that? Patients are the people who count.

Cathie Cowan: I suppose that we have got the better together patient experience data. There have also been two recent reports on the north isles network of care focusing on, for example, our community engagement with the community in Shapinsay, where the GP is supported by nurse practitioners. In Orkney, we are very keen to have good and robust community engagement to ensure that we actually deliver the whole engagement and involvement philosophy behind a mutual NHS. I am talking not only about the kind of engagement and involvement in which people simply say, "We've told you what happens"; we carry the same approach into our board papers, in which we say, very transparently, "People have told us this, this and this and it has made this, this and this difference," or are really up front and honest and say, "We can't do this, this or this." In Shapinsay, for example, people said, "We want a single-handed GP," but in our feedback we said to them, "That would be no good for your community, for our organisation or for the wider NHS." After all, GPs need to be part of a peer-review network for revalidation and to ensure that they are exposed to clinical practice, and we need to be able to see what that looks like with regard to our appraisal system.

The Convener: How did that go down?

Cathie Cowan: There are people here today who know what the press said in its coverage. The overriding message was that NHS Orkney was changing. People are still sceptical—to be honest, I have to say that that was my first meeting with the community as the new chief executive—but I believe that the headline was "It seems that they're listening".

At that first meeting, we also gave a commitment to come back to people very quickly. After all, we are good at engaging with communities, but then we simply say, "Thanks very much," and go back to them in a year when we need to ask them something else. However, we said that we would go back to them in four weeks' time; we have met that deadline and have the documentation to ensure that we are clear about who said what at the meeting, how we responded and what we said we could do. The meetings have been chaired by one of our local councillors to give some independence. People are watching us with interest but, as I say, the press said, "We think they're listening".

Mary Scanlon: When we ask about partnership working, we always get the answer, "We're working with the council, the Scottish Ambulance Service or NHS 24". However, one of the best partnerships in whole of Scotland is that between the NHS and community pharmacists and optometrists, in which patients with diabetes or eye conditions such as cataracts are monitored until the very minute they walk into an acute hospital to see a consultant. Indeed, there is also a very good partnership with complementary medicine practitioners. Do you look constantly at the voluntary and independent sector to see where there might be excellent quality of care and the better patient pathways that have been mentioned? After all, if people can get a quick eye check in their local community, it saves them having to travel hundreds of miles to Raigmore hospital. Is there some sort of ideological opposition to working with the independent sector, which, in my opinion, has been proven in such instances to provide the best-quality eye care in the whole of Scotland?

Professor Wells: Quite the opposite. We encourage wherever possible the increased use of community pharmacy, optometry and dental services in particular and are increasingly working in partnership with voluntary sector organisations. As the chair of a voluntary sector organisation in Tayside for a number of years, I know that such organisations work very closely with people who have alcohol and drug problems, and that they work in partnership with our services to provide those patients with high-quality care.

Not only do we work in partnership with organisations outwith the NHS, but we in the various boards all work together. For example, the north of Scotland boards have collaborated very effectively in recent years to provide, for example, a new eating disorders in-patient service in Aberdeen that serves the whole of the north of Scotland. Previously, some of those young people had to go to a private sector clinic at high cost.

We are building a new medium-secure facility at Murray royal hospital in Perth on behalf of the five north of Scotland boards. We have network services with Fife and Grampian, particularly in gastroenterology and neurology services for children, which would not have been sustainable as stand-alone services within a board. There are many good examples. However, I echo your sentiments about working with independent and voluntary sector organisations. That is important to us.

Mary Scanlon: Do you agree that the optometry model is excellent?

Professor Wells: Absolutely. That is about screening out people with a potentially serious disability.

The Convener: I see that the other witnesses are nodding—I will take that point as being agreed.

We will move on. We have two more substantive questions, so we might be able to meet our timescale.

Rhoda Grant: I have listened to the evidence with interest. I noticed that most health boards were a little coy in answering question 8 in our letter to them, which was about things that could not happen because of the tight budgets that boards have been given. From listening to the evidence, you seem to be saying that management was not great previously and that tight budgets have made boards deliver services better and more efficiently. Based on what I have heard this morning, our response to the Finance Committee should be that tight funding budgets are a good thing and perhaps a little more belt tightening would not go amiss. You might want to put the record straight on that, because I do not believe that that is the full picture. It would be useful to know about developments that would have delivered better patient care or even efficiencies but which cannot be introduced because of budget constraints, and about useful projects that cannot be carried out. You seem to be saying that all is well and that you could probably put up with a wee bit more belt tightening.

Professor Wells: I will try to answer some of that, but I am sure that other witnesses will want to comment. There is no doubt that this is a challenging year for the whole NHS in Scotland. The level of cost reductions and savings that we are having to make is different from what we have been used to in the past decade. Looking to the future, the situation will not become any less challenging. We have tried to prioritise developments that we think give us the greatest return. There are always things that we would like to do—the NHS has never had a shortage of wishes in terms of innovation or development—but we are where we are. We are trying to put together a balanced approach to a challenging set of circumstances.

The Convener: Does that mean that the decisions are short term and that you cannot take a long-term view because you are having to deliver year on year? Are you having to make quick fixes, rather than take a long-term approach because that will not give immediate returns? For example, with preventive health care, you will not get returns that look good within a financial year or perhaps even a decade.

Professor Wells: In some cases, it could take a generation. You are absolutely right. However, we have not abandoned such measures. Many initiatives have come from the Scottish Government in recent years that we have invested in and will continue to invest in and which will give us returns over time in relation to the health of the population. However, we have had to put back some things in our capital and service development programmes, because we do not have sufficient resources to carry them out. Wherever possible, we are horizon scanning, using the best information that is available to us, to see what things might look like over a period of three or four years. However, some of that is supposition at the moment.

Mr McDonald might want to comment on some of the financial projections.

11:30

Ian McDonald: Professor Wells makes an important point. This is almost the first time that capital funding has been brought into the discussion. Some of what is happening is very short term. We have certainty around one-year capital allocation, but we have a longer-term horizon plan that says that capital could reduce by 45 per cent over the next five years. We have no certainty around that, but we have taken the decision at this stage, which has meant very much a partnership clinical advisory group debate on the long list of projects that we considered appropriate for our resident population. We had to risk assess those projects and say which we need to press the button on, which can be delayed and which can be delayed beyond the five-year planning horizon, if that is the way that things turn out. It has been very much a matter of prioritisation.

Ross Finnie: That is helpful. Tell us about that prioritisation. Is that an efficiency target? Is it an access target? It is a health improvement, efficiency, access and treatment target? You have opened up a new line of inquiry. What is that list of priorities?

Ian McDonald: I will give you an example. In the plan, a series of criteria will be used to prioritise projects, involving anything from health care acquired infection and the meeting of infection standards to environmental issues. All the criteria will be part of the scoring that will rank the various projects in terms of priority and show which we must proceed on. That is what I mean by prioritisation.

The Convener: We are trying to get at what has been parked. That is where Rhoda Grant was leading. What things are not going to get done, and is that because you will not get payback for a long time? The ulcer example was a good one—by getting in there early, you spend now to save later. Is that going to continue?

Calum Campbell: I will give a couple of practical examples from NHS Borders. We have recently committed to three new health centres, but I am dealing with complaints because others wanted to be in that top three and I have had to push them back. I wanted to have a new front end to my accident and emergency unit, but I am not going to get that because of capital constraints. Those are things that I would like to do. We are also exploring a combined heat and power plant option. The reality is that that would have a four-year payback. I am trying to get the costs firmed up, and if they are confirmed, we will take that forward—we will invest in it, although the payback will come four years down the line. Those are the sort of things that we are having to consider.

Ross Finnie: It is still not clear to me whether that is about access. A long list is a long list. We know that, quite properly, there are certain key points within what the Government is setting, and I am not clear where your long list fits in. Is it about access or waiting times? What is that list?

Professor Wells: A number of the issues are covered by the Government's HEAT targets. We closely monitor all our HEAT targets for compliance year on year, and all the boards have delivered on their HEAT targets in the past few years. We hope that that will continue this year. We look critically at any variation from our projected outcomes against all those targets and move to make any corrections that are required. I do not think that anyone will take their eye off the ball in terms of HEAT targets.

Rhoda Grant: Can I carry on with my other questions?

The Convener: The trouble is that we tend to get into the meat later on in the session. We will have questions from Richard Simpson and Rhoda Grant, then we will move on to the next panel.

Dr Simpson: This may be a slightly philosophical question that opens up the debate, although we are already over our time limit with this panel by four minutes, but Mr Campbell pointed in this direction. From the committee's papers, it seems to me that the efficiency gains that are being made are measured by the year. How much are you being encouraged to do the sort of things to which Mr Campbell referred and make investments for which the payback may not come for four or five years? How far forward are you looking?

The table for years 2 to 5 in NHS Tayside's paper was helpful. Are you all pencilling in the savings that you will make in year 5 from an action taken in year 1? The return might not come until year 5. If we are really going to get this right, we have to ensure that such action happens. Do we have charts that show that investing in eliminating a static waiting list now will save money? For example, there was a nine-month vasectomy waiting list when I ran that service. If you eliminated that waiting list, you eliminated pregnancies, education costs and a lot of other things.

Calum Campbell: I reassure you that we have to look at things in the short, medium and longer term. My concern is to ensure that robust plans are in place so that somebody does not say in three or four years, "You've not had your return on investment." In that sense, the further out you go, the more difficult it is to plan, so you have to be more robust with plans to ensure that you get the saving. To use your example of vasectomies, the challenge is to ask whether you can make the saving to get the benefit. You have to have such difficult conversations.

The Convener: I was going to ask about funding, but I do not think that I understand the question that our adviser has just given me. Is there a better way of funding boards so that you can make longer-term decisions? I get the feeling that we are just funding boards annually. Is there a better way of doing it—whoever the Government is—so that you can take longer-term investment decisions and know that you are secure, as far as anyone can be in this insecure financial world?

Jane Davidson: I do not know whether there is a better way, but it would be helpful to give boards a longer-term horizon, even if it is around the spending review period, because that would give us certainty and we would be able to make firmer decisions as a consequence.

The Convener: Ms Cowan is nodding in agreement. Mr O'Brien, what do you think?

Gerry O'Brien: I agree with Ms Davidson. The way that the money is allocated to the boards is as fair as it can be, but it is always helpful to have more certainty. We are in a unique situation at the moment, but anything that increases the certainty of the horizon is always helpful. It then becomes a

question of how far the horizon moves into the future, but I think that we would all support the principle.

Rhoda Grant: I have a quick question for NHS Orkney. Given that you are an island board and are probably representing the interests of other island boards this morning, how dependent are you on efficiency savings by other boards with which you contract—for example, for more specialist services? I noticed that some of your responses are similar to NHS Grampian's. Are you very dependent on other boards?

Gerry O'Brien: We have a very close relationship with NHS Grampian. What happens in Grampian undoubtedly has an impact on Orkney. We spend just over £4.5 million a year, which is quite a significant proportion of our total spend, with NHS Grampian. We have an on-going dialogue with NHS Grampian. Anything that impacts on Grampian will ultimately impact on us. The reverse is also true. Although we seek to explore telehealth and telemedicine, to develop pathways that we hope will keep people on the island, and to provide services on the island where appropriate, we have to be aware of the impact on NHS Grampian if we take a significant number of patients away from it. We also have a relationship, although to a lesser extent, with NHS Highland, which is the main provider of our ophthalmology services. What happens in Highland has an impact on Orkney. Shetland is in almost exactly the same position that we are in.

The Convener: I will stop the session here, because of pressure of time. I thank the witnesses very much.

11:40

Meeting suspended.

11:46

On resuming—

The Convener: I welcome our second panel of witnesses: Susan Goldsmith, director of finance at NHS Lothian; and Laura Ace, director of finance at NHS Lanarkshire. I know that they listened to the previous evidence session, so they will have an idea of the direction of members' questions.

Rhoda Grant: I notice from NHS Lothian's submission that it has in place plans to reduce the workforce by 700 whole-time equivalent posts. The other health boards from which we have heard have talked about workforce changes and changes in ways of working—more permanence and the like. The change that NHS Lothian is proposing seems quite radical. Who will be affected by it? What will be the impact on service delivery?

Susan Goldsmith (NHS Lothian): It sounds like a radical change, but over the past few years our workforce has grown quite a bit, in line with the increases in funding that have been available. What has not changed is activity, which has generally tended to be flat. We believe that there are still significant opportunities for productivity gain. The reduction in the workforce that we are planning for 2010-11—the current year—is not much higher than the increase in our workforce that has taken place in the past 18 months.

It is a step change. In the past few years, there has been growth in the workforce, so our organisation is used to growth. Turning the situation around, in light of the current financial position, to one of workforce reduction is difficult for managers and front-line staff, because that is not what they have been used to over the past few years. However, if we compare the number of proposed reductions with what has happened to our workforce, it does not look as challenging as it looks in black and white. That is not to say that there will not be challenges.

Rhoda Grant: Which staff are affected? From where will you cut the 700 posts?

Susan Goldsmith: We are doing much the same thing that you heard about earlier. We have set a target of a 10 per cent reduction in all our corporate departments. We are reliant on turnover, but much of the reduction has already been delivered. We are looking at our admin and clerical support staff. Last year and this year, we have invested in voice technology. We are looking at the retirals that are coming up and at our vacant admin and clerical posts.

Our natural turnover is about 700 a year, but it is not always in the right place. Part of the challenge for us is the human resources agenda and ensuring that we have the right people in the right place. That is why we wanted to be up front early in the year about the fact that we needed a reduction of 700 by the end of the year. It will take that amount of time, using turnover, to ensure that we target the reduction in the right place. We are also looking at the productivity of our nurse specialists and health professional staff. We have reams of different approaches to support managers in delivering the reduction.

Rhoda Grant: You said that you have a turnover of roughly 700 a year but not necessarily in the right places. Are you looking at compulsory redundancies, or retraining? How will you get the vacancies in the right places?

Susan Goldsmith: As you are probably aware, the NHS is absolutely committed to avoiding compulsory redundancies. We have a voluntary severance scheme, but unlike local authorities, we do not have reserves that allow us to support

much in the way of voluntary severance, so that is a challenge for us. Different systems have different levels of flexibility. Where possible, we are looking to see whether we can do anything on voluntary severance, but the financial challenges make it difficult.

We are working closely on the matter in partnership. Certainly in NHS Lothian, our partnership colleagues—our staff colleagues—are supportive of what we are trying to do. They see an opportunity to use the implementation of agenda for change and the opportunities that it brings to skill people in a different way, to upskill, and to use a different profile of workforce. We will continue to work in partnership and with our human resources colleagues to try to address the shifts across the organisation.

Rhoda Grant: Will that impact on front-line services? In a time of increasing budgets, you have been developing services and offering other things. If you are now trying to roll that back to a large extent, which services will be affected? You talked about specialist nurses, for example.

Susan Goldsmith: I am not saying that services will be affected. Let me take the example of specialist nurses. We now have a consultant contract that allows us to measure how much clinical activity we get for consultants' time, whereas we have been less focused on that with some of our other clinical specialists. We are looking at how much time they spend on front-line clinical activity. Given that we have seen almost flat activity yet there has been an increase in staffing, we believe that there is an opportunity for greater productivity. I am not saying that we will affect front-line services.

The Convener: It has just been explained to me that the new consultant contract means that you have more control over the way in which consultants' time is used. The boot used to be on the other foot. Is that correct?

Susan Goldsmith: Yes. They have clinical sessions and we have an annual job-planning process that determines, following discussion, how much time is spent on wards and in theatres, or how much clinical activity takes place. We have had that for a few years now, but we do not necessarily have the same approach for all our other clinical specialists such as our HPs and our nurse consultants. We need to develop that further, particularly as we see a shift in how we deliver services from medical staff to clinical staff. Looking at our productivity is very much part of our agenda. We will do that to avoid impacting on front-line services.

Mary Scanlon: That brings us cleanly to front-line services. Question 8 in our letter was:

"What service developments were agreed to be highly desirable for 2010-11 but were not possible to fund at present?"

Thank you for being so honest and open in your answer, but I cannot think of many services that are more front line than a new model of care for stroke patients, oncology services, strategies for palliative care and physical and complex disabilities, or antenatal haemoglobinopathy. Surely those are all front-line services.

The background to the issue is the NHS Scotland resource allocation committee funding. You comment at length on the

"gap of £69m from NRAC parity."

I read your comments on that, but will you give us the background, explain the situation, and explain why you are being forced to look at what I absolutely consider to be front-line services?

Susan Goldsmith: First, I point out that the list of things that we cannot invest in relates to new investment. There are always pressures to invest further in services. In section 8 of our submission, we gave examples of areas in which we would like to have invested more, but in which we are not in a position to invest more, other than what we can do through redesign.

Let me take the example of a new model of care for stroke patients. Looking at the pathway of care for stroke patients is one of our priorities for 2010-11. We want to see whether we can release resources internally to support the stroke service. In previous years, when more funding was available, we would have put new money into the areas that are mentioned in section 8. We are not talking about reducing those services. It is just that we cannot put in the money that we would have liked to put in.

Mary Scanlon: It is not just stroke treatment that you are not putting new money into; oncology services for cancer patients, palliative care, and the treatment of physical and complex disabilities are also affected. Given that you had planned highly desirable investments that would have enhanced the quality of care, surely the fact that those have been stopped means that, in effect, there has been a cut in front-line services.

Susan Goldsmith: I would say that there has not been such a cut. We are looking at ways of delivering services differently. We are certainly not cutting current services, but there are areas in which we would have liked to invest more. We will look at what we can do internally. An example is the work that we are doing with our partners in other health boards to provide regional oncology services. That is part of our work plan for the coming year.

We mentioned NRAC in our submission because the way in which funding is allocated to the boards is based on NRAC's resource allocation formula, which is based on population but weighted for age, sex, morbidity and rurality. If NHS Lothian had received the allocation that the formula suggested, we would have received an additional £69 million. That is largely because of population—in Lothian the population is growing, whereas in other parts of Scotland it is falling, so there is a greater disparity.

That means that we will face more of a challenge in the future, given that we spend less on our health services per head of population than other health systems because we have less resource per head of population. Although that does not stop us meeting any of our targets, it means that the extent of the challenge that we face is likely to be greater. We would argue that the fact that we spend less means that we are more efficient than other health systems, so generating greater efficiency will be a challenge for us, particularly when we face population pressures. We have a growing population and more older people, which puts pressure on oncology services, for example. We mentioned NRAC as a marker for the fact that we think that making further efficiencies will be more of a challenge for us.

Mary Scanlon: Given the problems with NRAC funding, the efficiency savings that are expected, the gap in funding of £69 million and the service developments that cannot happen, to what extent can efficiency savings continue to be made without current levels of service delivery being affected?

Susan Goldsmith: I return to my first point, which was that although there has been significant investment across the NHS, there has not necessarily been huge activity gain, so there is an issue with productivity. The committee has already heard about the various tools that boards are using, whether on skill mix or redesign, to ensure that we do not have to cut services. However, we recognise that that will be extremely challenging.

In Lothian, we are looking at how we benchmark internationally. We are part of the McKinsey tracker system, which allows us to benchmark internationally by identifying areas in which we perform less well and areas in which we perform well. We are still in the early stages of that process. We are also benchmarking inputs—how much spend there is—to find out, by comparing ourselves with other health systems, not just in Scotland and the UK but across the world, whether opportunities exist for us to improve our services despite the financial position.

12:00

The Convener: In which areas does NHS Lothian perform well and less well compared with other boards?

Susan Goldsmith: We perform well in breast cancer, and less well in areas that are problems for Scotland. We perform less well when it comes to chronic obstructive pulmonary disease and other diseases of Scotland, as they could be called. I also refer to lung cancer. There are no surprises there.

The Convener: Why have you performed well in breast cancer? The rate in Scotland is quite high. What are you doing?

Susan Goldsmith: I just have the benchmarking information at the moment, so I cannot answer that.

The Convener: It is an interesting point, though.

Susan Goldsmith: Yes, it is.

The Convener: Perhaps you could let us know.

Mary Scanlon: With regard to performance in areas that are problems for Scotland, there is no doubt that public health is the major problem. If I have read it correctly, appendix 1 to NHS Lanarkshire's submission says that "Zero base health promotion and public health budgets" are being cut by £1 million. Is that right?

Laura Ace (NHS Lanarkshire): Yes.

Mary Scanlon: Is not public health our number 1 spend-to-save investment, to ensure better health over the longer term? How have you justified that reduction of £1 million?

Laura Ace: Public health and health improvement certainly are such an investment, but that does not mean that they cannot be organised better or work more effectively in any particular service area. There is a lot of project funding in that area, so initiatives have developed that have set up their own structures and infrastructures. There is duplication between what community teams are delivering, what specialist health promotion teams are delivering and what the public health directorate is doing centrally.

The exercise aimed to examine everything together in order to establish the core objectives and what we wanted to achieve; to find the evidence for the best way of achieving that; and to consider how we could integrate more. There was a lot of difference among health promotion teams across localities, because of their history, how they had evolved and the different levels of project funding. We found that there could be more of a standard structure, with a better span, and with a mainstreaming of activities, rather than three

separate initiatives that were basically tackling the same issue among the same target population.

Mary Scanlon: Are you confident that you can cut £1 million from the public health budget in NHS Lanarkshire without having any impact on current and future health?

Laura Ace: We started the work in September 2009, and we have had very strong partnership involvement. All the models that it has been possible to use have been worked through. A full staff consultation has been undertaken, so staff have agreed the model that is being adopted. It has been implemented. Everything that we have done has been impact assessed for quality, quantity and the impact on targets. There is better structural efficiency in the delivery of the work, with a real focus on things that work rather than on things that we have done but which perhaps do not work.

Mary Scanlon: I understand that, but, with respect, I ask you to answer my question. Can you take £1 million out of that budget without having any impact on the public health of individuals in Lanarkshire, now and in the future?

Laura Ace: Our belief is that we can, in pursuing the work that we are doing.

Mary Scanlon: Thank you.

Michael Matheson: I return to your responses to question 8, on those areas that were

"highly desirable ... but were not possible to fund at present".

The two health boards answered slightly differently. NHS Lanarkshire referred to "aspirations" that it would like to develop, but cannot. NHS Lothian is specific about the services that it cannot fund.

What process do the boards go through to determine which service you will choose not to fund and in which service you will choose to improve funding?

Susan Goldsmith: We have a prioritisation process and a weighting system, whereby everything that comes forward is weighted according to a variety of measures. We use that system to agree where funding is to go, if it is available. In the first instance, funding goes to the must-dos and the things that will be a pressure, whether we like it or not. The first call is ensuring that we have financial provision for areas for which we have no choice. Thereafter, if any funding is available, we have a prioritisation process.

Laura Ace: Our experience is very similar. In the NHS, services are developing all the time but many of them are what Susan Goldsmith referred to as the must-dos. As new drug treatments are approved, they become available and are adopted for clinical use. So, £3 million in our financial plan this year is set aside in recognition of new drug treatments that are coming through the system, but the board will never debate whether it will introduce those treatments. We scan to see which treatments are coming in appropriately and they will be introduced. Similarly, the volume of GP prescriptions has been rising very steadily, year on year. This year we experienced a 4.7 per cent increase. That is the result of things such as the success of the keep well initiative in identifying people who would not previously have presented to the health service at that stage. Treatment needs change and more statins, diabetes drugs and treatments for long-term conditions are coming out.

We are not taking explicit decisions. We are just recognising that those things have happened and that funding is there for them. When we have gone down the list of the must-dos and ensured that services are safe and compliant with legislation, we reach the areas that we can prioritise by rank. When we were in a high-growth environment, prioritisation events would be held and a list of criteria would be used for assessment. Now that we are in much tighter economic times, the list of must-dos outstrips the available funding and we instantly have to look to efficiencies for the must-dos. That makes it very hard to bring in a discretionary investment, because unless people have confidence that they can deliver the required level of efficiency saving, it is like spending on a credit card without knowing when they can repay it.

Mary Scanlon: Are all boards down to the must-dos?

Laura Ace: Yes. The one area in which we made some discretionary investment in Lanarkshire was mental health. We recognised that we had such a low historic base that we had to do something to start moving that along, but it was quite a small sum. Beyond that, we could not consider discretionary investments this year because we felt that we had pushed the efficiency programme for 2010-11. We have other schemes for future years, but they will take longer to deliver. We had pushed discretionary investment to the level that we could deliver this year.

Susan Goldsmith: Laura Ace is quite right that the must-dos are now what we fund. However, the term has an almost negative connotation. As Laura has said, the money that we have put into prescribing is on an upward trend, but some of that relates to smoking cessation, which is about improving health. Although it comes under the must-do heading, it is a good thing to do.

Michael Matheson: It is helpful to get a feel for how the process operates and how spending is prioritised. With regard to the discretionary funding

elements and the weighting mechanism that you use to determine the areas to which you can give discretionary funding when you are able to do so, would each of your boards use the same weighting mechanisms?

Susan Goldsmith: The elements are very similar.

Laura Ace: We have very similar elements, but they might be slightly different in different boards.

The Convener: You actually said that together.

Michael Matheson: Can you give me a feel for what those elements would be?

Susan Goldsmith: They would be something like safety, targets, invest to save, efficiency—-

Laura Ace: Health gain.

Susan Goldsmith: —and that kind of range.

Michael Matheson: They are broadly the same. Is that because you are given some direction at national level about what those weightings should be, or are they left to the discretion of the individual board?

Susan Goldsmith: It really relates to our priorities. As a health system in Scotland, we have the same essential priorities, which are delivering the targets, health gain, being efficient and effective and providing safe care. That is the business that we are in. It would be surprising if they were different.

Laura Ace: People are keen to learn and to see whether other people have done something more effectively. There tends to be sharing between boards of how they have done things and people develop from that.

The Convener: Are there different geographical pressures in terms of public health in the board areas? Might that make a difference between the weighting and prioritising of discretionary funding?

Susan Goldsmith: Yes. For example, Lanarkshire has a big health improvement agenda and specific issues with mental health, while Lothian has pressures as a result of the fact that it has a growing population as well as an ageing population—people live longer in Lothian, so it has more people who are growing older than Lanarkshire does.

Helen Eadie: One of the papers before us has a detailed and costed saving scheme from NHS Lanarkshire, but there is no similar exposition in relation to Lothian, which I find concerning. How can we be assured that there will be no impact on front-line services? Mary Scanlon and I, along with others, have argued in the Parliament for improved IVF services in Scotland. Lothian has one of the worst records in Scotland in that regard. It is a front-line service, but people have to wait two years to access it, and, if they get beyond a certain age, they cannot get the service.

We are concerned about the costings and the impact of the savings, but also about the quality of service. How can you persuade us that you have the evidence, locally, to make the necessary savings in a way that will not result in a reduction in the quality of service?

Susan Goldsmith: I apologise for the fact that we have not sent you the details that you are talking about. I sent only a summarised list because we have more than 100 schemes. Each manager is set a target and is tasked with delivering efficiencies in a way that does not have a negative impact on clinical services. That is one of the criteria that we use to judge the efficiency proposals that are coming forward. This morning, for example, I was in a meeting on efficiency savings with a team of managers, challenging them on just that. We meet regularly to review the programme of efficiency savings.

Helen Eadie: The gap of £69 million in relation to NRAC, with regard to parity, must be a huge issue for the board. We know that NHS boards across Scotland are used to having to make efficiency savings, but in addressing that gap you must confront a considerable challenge. I imagine that that is bound to affect front-line services. Can you reassure us that it will not?

Susan Goldsmith: We have coped with that gap. The board has deployed many techniques to enable it to live within its means. It has used lean techniques and redesigned services and measured their efficiency. Up to now, we have lived within the resources that we have, which has meant that we have had to make some difficult decisions. IVF, which you referred to, did not make it through our prioritisation process, as other things were deemed to be a higher clinical priority. Having said that, because we realise that our position in relation to IVF is not a good place to be, we have made provision for IVF this financial year.

Our greatest concern about NRAC is that it will be challenging for the system to be able to shift resource into Lothian in a difficult financial situation. We do not know what the reduction in funding will be in 2011-12 and beyond, and we are concerned that it will become more difficult for us to continue to make year-on-year efficiency savings.

12:15

Helen Eadie: If the Government has sent out guidelines to say that IVF must be a priority—it is one of the Government's priorities for the health board—why do you demote it further down the line? There is clearly patient demand and the

cabinet secretary has sent a crystal-clear message, but the health boards have decided not to pay any attention to either the patients or the cabinet secretary. Where does that leave us as politicians when we want to be reassured that you are listening to both the political imperative and the public?

Susan Goldsmith: We do listen. We recognise that our waiting times are too long, but we wanted first to compare the service that we were providing with that provided in other parts of Scotland, because different levels of service are provided. We did that piece of work first. There are also difficult choices to be made. We have a lot of targets and priorities, and up until this year we were not able to identify additional resource for IVF.

The Convener: I will move on to Mary Scanlon—or do you have another question on that, Helen?

Helen Eadie: That was it, although I think that Laura Ace wanted to come in.

Laura Ace: I wanted just to speak about the NRAC formula. Lanarkshire is not as far away from parity as Lothian—we are £21 million below it. We received a small amount of additional funding this year, for which we were grateful, to start moving us towards parity. That softens things round the edges in terms of dealing with the gap. The difficulty is that the money for Lothian, Lanarkshire and the other two boards that are below parity has to come from the other boards, and it is a low-growth environment. However, in plans for the future we are relying on getting at least that small amount each year. Without that, the problems would be much worse, although we recognise that reaching parity will take a long time.

Mary Scanlon: My question links to the point that Helen Eadie made about IVF, and it also relates to mental health services. In your paper, you say that you are unable to develop weight management services. We have an obesity action plan, which allegedly brought with it an additional £40 million, as I remember it. I am aware that in Lanarkshire there is no bariatric surgery. Have we reached a point at which the finances are so tight that priority is given to meeting the waiting times targets, and treatment for mental health, obesity—including bariatric surgery—and IVF is reduced to zero?

I am aware that in Scotland about 300 operations a year are carried out in bariatric surgery and that thousands of people have been clinically and psychologically assessed for it. I know someone who has a body mass index of 66 and who has been told that she will have to wait three years for an operation. Are we in a position in which decisions are dictated by the waiting times targets, with the easy option being to leave aside anything that is not covered, even if that may be best for patient care and doing so leaves patients who need IVF, mental health or weight management treatment with nothing? Is that really where we are?

Laura Ace: To pick up on Susan Goldsmith's point, we are doing whatever we can to redesign services. Certainly in mental health, huge progress has been made, in combination with some ring-fenced funding. Whenever there is ring-fenced funding, we apply it, but there comes a point at which we cannot make a step development in a service without having the money to do so.

Mary Scanlon: People with a high BMI can only get bariatric surgery by going private. The same is true for IVF.

Laura Ace: There is not a block on bariatric surgery; it is just a slow process to get through because of the capacity in the system.

Mary Scanlon: There is a block. There are thousands on the waiting lists, but only between 200 and 300 operations are done each year. I would say that there is a block if someone who has a BMI of 66 and other complications is told to wait for three years.

Laura Ace: I meant that it is not that we will not do bariatric surgery; it is just that there are clear bottlenecks, as you said.

Mary Scanlon: There is no requirement to do the operation, because there is no Government waiting times target for it. My worry is that procedures that are essential but for which there is no Government target are considered easy options to be left aside.

The Convener: Unless Laura Ace wants to comment further on that, which I think is a matter for ministers, we will move on to the next question.

Laura Ace: Yes. As health boards, we work to the framework that we have been given.

The Convener: We will move on to Richard Simpson's question.

Dr Simpson: My question is in two parts, but the first part has almost been dealt with—

The Convener: There is no need to introduce questions as being in two parts. You know that you will get as many questions as you like.

Dr Simpson: I see that different types of investment are being delayed. The NHS Lanarkshire submission provides a detailed list of those—the more broad-brush approach in the NHS Lothian submission makes it difficult to interrogate—which include, for example,

"increased provision of insulin pumps".

Clearly, there must be some business plan that says that the appropriate provision of insulin pumps will produce significant savings because fewer unstable diabetics will come into hospital. When the service is unable to provide, or decides against, investment in such developments, surely increased expenditure will be incurred further down the line. To what extent does that happen when it is not possible for boards to make such investments?

The other part of my question is about maintenance. We know from Audit Scotland that, although the maintenance of hospitals that were built under the private finance initiative is covered—this point is seldom mentioned—for the 30-odd years for which the PFI contract runs, we have a £500 million maintenance backlog. Maintenance is an easy target for reductions. Indeed, I see that, among the priorities that it has not been possible to fund, the submission from NHS Lanarkshire includes

"priority estates work within primary care premises".

To what extent are maintenance budgets being undermined? Will that ultimately lead to a deterioration in the estate and cost us more in the longer term? I am not saying that the problem is soluble, but I want to know the panel's thoughts on the matter.

Laura Ace: On the issue of insulin pumps, we are actively in dialogue with the service to look at the business case and the forward modelling. At the moment, we still have capacity to put patients on to insulin pumps, but we recognise that, as we expand towards full implementation of the National Institute for Health and Clinical Excellence guidance, those numbers will need to increase substantially at quite a high cost. We are currently in dialogue to ensure that the highest priority cases come through in a steady stream. We are also discussing what the impact might be on other services, which might allow us to reconfigure resource. As has already been highlighted, the problem is that such impacts might happen a bit down the line, whereas the investment needs to be made up front. However, there is continuing dialogue on how to achieve what we believe we should achieve.

Dr Simpson: Do business plans and so on indicate that savings might not occur until year 2, 3 or 5? Are those written in now as part of the efficiency savings going forward?

Laura Ace: Some of our schemes will not deliver until year 3. A good example is estates rationalisation, which will take a while to achieve but will ultimately, when we do not have surplus estate, release big savings each year.

Dr Simpson: Is there a graph or grid that shows that investment in such things just now will produce those savings in the future? Are those already written in as part of the savings target for year 3?

Laura Ace: That is much easier with estates rationalisation, for which the costs are very black and white because we can see the buildings on which we might save rates and other costs. With clinical developments, the issue is more difficult. Normally, when different ways of treating people create extra capacity, huge demand from elsewhere comes in and fills the new capacity. In the past, much of that was just allowed to happen, so we saw good improvements in services. However, in today's much tighter environment, we need to be much more explicit about what is happening and much better at tracking that. We will get to the stage at which we cannot allow demand to fill the vacuum because the money is needed elsewhere to allow other things to happen. That will be a real challenge for the health service in the way that it looks at efficiencies going forward. Some of those issues have already been picked up in the lean methodology for tracking and capturing savings that was alluded to.

Susan Goldsmith: On the question of maintenance, I think that, if anything, the reverse of what was said is true. We have increased the amount that we invest in the estate because we appreciate the impact that good-quality estate has on the quality of care and on, for example, hospital-acquired infections. If anything, we have seen a reversal of what happened many years ago, when maintenance budgets were run down during difficult times and then pushed back up. When capital is tight, we are more likely to try to put the little resource that is available into things such as maintenance because of its benefits for patient care.

The Convener: I bring this evidence session to a close by thanking both our witnesses for their evidence.

As previously agreed, we now move into private.

12:25

Meeting continued in private until 13:00.

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