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Official Report

HEALTH AND SPORT COMMITTEE

Wednesday 8 December 2010

Session 3

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HEALTH AND SPORT COMMITTEE
36th 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)
Nanette Milne (North East Scotland) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Jackie Baillie (Dumbarton) (Lab)

THE FOLLOWING GAVE EVIDENCE:

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

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 8 December 2010

[The Convener *opened the meeting at 10:28*]

Draft Budget Scrutiny 2011-12

The Convener (Christine Grahame): Good morning. I welcome the hardy souls who have come to the 36th meeting in 2010 of the Health and Sport Committee. I thank members who have made it. I deferred starting until 10.28 to see whether other members would arrive.

I have apologies from Rhoda Grant, Richard Simpson, Helen Eadie and Michael Matheson, as well as from those witnesses who have been unable to travel.

I welcome the Cabinet Secretary for Health and Wellbeing, who is here to take questions with Derek Feeley, acting director general health and chief executive of NHS Scotland; and John Matheson, director of health finance in the Scottish Government.

Before we begin questions on the budget, I tell members that, because of the depleted committee and, in particular, the absence of members of the main Opposition party, I have deferred until next week consideration of amendments at stage 2 of the Patient Rights (Scotland) Bill, which we were going to take this afternoon. I think that we will require to convene on Tuesday 14 December at about 3 pm, to accommodate members who are on the Subordinate Legislation Committee.

At some point, cabinet secretary, I will be asking in loco Richard Simpson's questions, so that will explain the situation if you feel that there is an air of hostility in the questions that I direct at you—I would not wish to find my seat on the back benches whirled right out the door.

10:30

Ross Finnie (West of Scotland) (LD): Will we notice any difference?

The Convener: I do not know whether you will notice any difference, but I thought that I should put that on the record for my own sake.

Mary Scanlon will start. Because there are so few of us, you need not be inhibited about asking a range of questions this morning.

Mary Scanlon (Highlands and Islands) (Con): Oh, thank you. I have permission to ask my five questions.

Ian McKee (Lothians) (SNP): I might just go away now.

Mary Scanlon: My first question is on administration. I know that we are keen, certainly in my party, to look at reducing administration costs in the national health service. However, the Information Services Division figures for health service costs for the year to March 2010 reveal that administration costs have gone up by £32 million in the hospital sector and £63 million in the community sector, so a total of £95 million has been added to administration costs between 2007 and 2010. Can the cabinet secretary respond on that?

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): First, I apologise to Mary Scanlon, because I do not have the ISD figures in front of me. I am happy to provide more detail on the specifics of the figures after the meeting, if that would be helpful. I will frame my answer more in terms of the generality of the question rather than by reference to the specific figures.

I agree with Mary Scanlon—that is a bold opening statement for me—

Mary Scanlon: It is a good start.

The Convener: What an effect the weather is having on our attitudes this morning.

Ross Finnie: It has been worth coming.

Nicola Sturgeon: I am not sure whether Mr Finnie thinks that we should just finish now, but I presume that he does not.

I agree with Mary Scanlon that, as budgets are tightening—no doubt we will come on to the relative protection that we have given to the health budget later but, notwithstanding that, budgets in health, as they are everywhere else, are tighter than they have been—it is all the more important that we channel as much as possible of the budgets that we have available to what we refer to as the front line. I add the caveat that it is not always possible in the health service to draw a straight line between front-line and non-front-line services. For example, without going into the specifics of the figures that Mary Scanlon has provided, I point out that much of what might be termed administration in the ISD figures may be assistance to clinicians that, by improving their practice, enables them to improve the patient journey, to treat people more quickly and to get waiting times down, so the distinction is not always clear.

That said, we are committed to minimising the expenditure on administration. As an example, the projected staff figures in this financial year indicate that a higher percentage of administrative and managerial posts are being reduced than is the

case in other categories. I made it clear a few weeks ago that I want there to be a 25 per cent reduction in the number of senior managers over the course of the next session of Parliament.

The whole emphasis of health boards on meeting and, over the past few years, exceeding efficiency targets and their focus in years to come on meeting a minimum of a 3 per cent efficiency target will ensure that there is a focus on reducing administration costs as much as possible. I hope that, regardless of our different interpretations of what has happened in the past, there is a degree of common ground about the necessity of doing that in the future.

Mary Scanlon: I would appreciate further clarity on that. I would also appreciate reassurance that the administration budget is going down, as opposed to increasing by £95 million since 2007.

My second question is also—

The Convener: Before we proceed, I point out there might be many other questions on which the cabinet secretary will have to give us more detail. We are under a time pressure because, I understand, we have to consider our report next Wednesday. I just wanted to alert the cabinet secretary to the fact that any further information that she wants to give us will have to be pretty prompt—like tomorrow, I am told. Do not try to go back to Glasgow, cabinet secretary.

Nicola Sturgeon: We will ensure that your timescales are met.

The Convener: Thank you.

Mary Scanlon: That is fine. This question, too, might fall into that category.

Our report on last year's budget mentioned that we could not track the resources transferred to local authorities. I notice that there was an increase in resource transfer to local authorities of £48 million between 2007 and 2010. Given the amount of care in the community and the size of local authorities' care budget, the committee asked for more transparency in that resource transfer and for reassurance that it was being spent properly. I am happy to get that answer in writing.

Nicola Sturgeon: We can give you the breakdown of that in writing. Mary Scanlon will be aware—and, I am sure, supportive—of the increased money for free personal care that we made available to local authorities.

Another feature of the budget that we might come on to later is the £70 million change fund that we have set aside in the health budget for next year. That is intended to be the bridge towards integrated local authority and health funding for elderly social care in particular. It is important that the totality of spend is transparent, that it is tracked and that its outcomes are obvious. Mary Scanlon will be aware that a number of health boards are already doing pilot work on integrated resource frameworks. The premise of her question is a good one. We are striving to ensure that, wherever money is spent on providing care for people, whether by the health service or local authorities, the outcomes are clear.

Mary Scanlon: That is fine.

The Convener: Ross Finnie has a question on that point.

Ross Finnie: I appreciate that this is all quite difficult. In your answer to Mary Scanlon, you indicated the £70 million spend, but that goes into next year. There is clearly unanimous support in the Parliament for free personal care. Equally, there is acceptance—certainly by me—of the Government's proposition that free personal care is but a part of the total spend on the elderly, and on the elderly in the wider community.

To what extent are you able to assist members about the extent to which your own Government is committed to free personal care? I would find that a difficult statement to make, personally, without seeing it within context, and I cannot but imagine that the cabinet secretary likewise finds it difficult to make that statement without seeing the context. To what extent are you able, if not this morning then by letter, to assist the committee and Parliament by putting a little bit more flesh on to the bones of the £70 million change fund and how the pilots of the integrated service are doing? I am bound to say that the Liberal Democrats are anxious to support the Government in the matter, so having more information on that critical area of the wider spend would assist all members.

Nicola Sturgeon: I will answer that question in three parts because it is important not to mix up the different issues, and we might be doing that.

I am happy to write to the committee on the progress of the test and pilot work on integrated resource frameworks, because that is progressing well in the boards that have been doing that work. It is easy enough to give the committee a fuller briefing on that.

I am very keen that we do not have a misunderstanding about free personal care. I will talk about the £70 million change fund in a second, but it has nothing to do with free personal care. The free personal care funding increase that we have given to local authorities is separate from the change fund. As members will recall, in our first year in government, after we had looked at the report that Stewart Sutherland did as a health check on free personal care, we said that we would increase funding for free personal care by

£40 million. That did not happen in a vacuum. In return, we came to agreements with local authorities about new eligibility criteria and on guidance about waiting times for assessment and access to services. Again, if it is helpful, we can provide further information on the progress of that work. Subject to local authorities agreeing the offer that we made to the Convention of Scottish Local Authorities, there is an agreement to continue to provide free personal care on the basis of those agreements.

We deliberately set aside the £70 million change fund in the health budget to try to up the pace of change around community services. We want to see community services develop quickly in a way that, over time, allows disinvestment from some acute services. If we have community services that reduce unnecessary admissions to hospital, over time that will allow a disinvestment in the acute sector and greater investment in the community sector. That £70 million is intended to be catalyst funding to start that process. Agreements are in train between Government and local authorities about how that funding, which sits in the health budget, will be administered. It will be spent in line with local plans, agreed between local authorities and health boards, for improving community services and there will be clear governance arrangements for the use of that £70 million. Just to be clear, it is not related directly to free personal care.

Ross Finnie is 100 per cent correct to point out that a lot of our discussion about older people's services focuses on free personal care, but that is a relatively small proportion of the overall budget for older people's services. If there is a relationship, this is it: the £70 million fund is intended to get us to the position where we have a much more integrated view of all the money that is spent on older people's services, whether it is spent by health authorities or local government, so that we can use that budget in its totality to ensure that people are getting care where they should and that they are not ending up in hospital simply because the community services are not there for them.

Ross Finnie: I am grateful for that response. It was really the latter point that I was asking about; I am sorry that I gave the impression that I was confusing the £70 million and the £40 million. As Arbuthnott pointed out, if you achieve a much better integration of those services, you should see a crossover into the totality of that care and therefore, over time, you should also see a benefit in how you are able to sustain what we call free personal care. I am sure that you share my hope that that element will become more sustainable as long as the majority of that spend is delivered in a more efficient way.

Nicola Sturgeon: Absolutely.

Mary Scanlon: Will you include in your note to us information on how increased shared services and collaboration will impact on and, hopefully, include the third sector? I would find that helpful.

Nicola Sturgeon: For the change funds?

Mary Scanlon: Yes.

Nicola Sturgeon: We intend to include the third sector.

Mary Scanlon: My next question takes us back to last year's budget report; I am trying to follow through on points that we raised then. One of the main issues was telehealth and e-health. I appreciate that telehealth is now integrated with NHS 24. We were all, including Richard Simpson, delighted that, in last year's draft budget, e-health was to receive £134 million but, in the final budget, the figure was £100 million. In the draft budget for next year, that line is down by another £10 million. After our report on clinical portals and suchlike, we hoped that there would be better investment in e-health and telehealth. Why did the £134 million in last year's draft budget become £100 million and then go down to £90 million in the current draft budget? How can we track what is happening in telehealth given that it has now merged with NHS 24 and we do not know whether that budget will increase or decrease, or whether anything is happening with it?

10:45

Nicola Sturgeon: I am happy to answer that question. I will first try to explain the numbers a wee bit and then look at what we are trying to achieve with the budget and what are the priorities for e-health.

I guess that the numbers are best described in terms of the difference between inputs and outputs. We set a budget last year and, to put it simply, over the course of the year we have managed to achieve what we wanted to achieve with it through efficiencies, using existing systems in the NHS and building on them, rather than always creating new systems. We have managed to be more efficient in what we are trying to do and to achieve things for less money, which should be seen as a good thing. I am conscious that I am building up work for my officials over a short period of time, but we can certainly go through for the committee what that money has bought us over the past year.

The reduction from this year into next year is also because we think that we can be more efficient in how we achieve our objectives for e-health. Mary Scanlon will be aware of this, because she takes a close interest in these issues. We will set out the priorities for the e-

health budget for 2011-12 in a successor strategy to the e-health strategy that we have had from 2008 to 2011. What we have seen in the budget up until this financial year has been paying for the things in that strategy.

As we look ahead to a refresh strategy, we are looking to progress our priorities for e-health such as developing the clinical portal; looking at better use of e-health for management of long-term conditions; and looking at patient e-health—in other words, giving patients more access to their own health records online. In broad terms, those are our e-health priorities. We think that the budget that we have set for next year will allow us to progress those priorities.

The Convener: I have a supplementary from Richard Simpson on that, which you might have already answered in a different way. He wanted to ask what the underspend was for 2009-10 on telehealth and telecare and what you are predicting as the underspend for 2011-12.

Derek Feeley (Scottish Government Acting Director General Health and NHS Scotland): We did not separately identify a spend on telehealth and telecare in the budget. The only specific contribution that we made was the money that went to NHS 24 to sustain the Scottish centre for telehealth. The amount was £1 million and it was spent in full. You cannot really separate out telehealth and telecare from the overall £100 million.

Nicola Sturgeon: On the overall budget, which Mary Scanlon's questions were geared towards—Mary Scanlon has already given you these figures—the budget bill for 2010-11 had this budget line at £134 million and we have restated that at £100 million. I do not know whether in effect that is what Richard Simpson means by "underspend". If that is what he means, the reason why we have been able to do that is the reason that I gave to Mary Scanlon: we have been able to achieve what we wanted to achieve for less money.

The Convener: The £34 million did not go somewhere else.

Nicola Sturgeon: No.

The Convener: I understood that. That is why I prefaced Richard Simpson's question by saying that you had probably already answered it in a different way. You are saying that to use the term "underspend" is not the correct way to approach this.

Nicola Sturgeon: No. We have managed to achieve what we wanted to achieve for less money than we thought. A lot of telehealth is about information technology systems and so on. You can get a lot of efficiency gain out of those things if you go about it in the right way. This is not about reducing our ambitions for e-health; it is about trying to deliver those ambitions as efficiently as possible.

The Convener: Thank you for clarifying that.

Mary Scanlon: The reduction of £34 million is significant. I would certainly be pleased to see that all the outputs that were planned had been achieved with a lower budget.

You would expect me to talk about the island boards. I hope that my calculations are nearly right—I have taken the total budget and divided it by the population. On average, NHS Orkney receives £1,540 per person; NHS Shetland receives £1,556; and NHS Western Isles receives £2,173. That means that every man, woman and child in the Western Isles receives £617 more NHS funding than people in Shetland do and £633 more than people in Orkney do. I also note that the Western Isles has a bigger increase this year as well. What is the underlying reason for such a difference in the three island authorities?

Nicola Sturgeon: Before I answer that question in the way that I think is the right way to answer it, can I just be clear that those per capita calculations are based on the figures in the draft budget document?

Mary Scanlon: Yes, they are.

Nicola Sturgeon: I direct Mary Scanlon and other members to footnote 2 on page 120 of the draft budget, which says that the health board allocations are indicative, which is always the case in the draft budget, and that final allocations will be made once the budget is finalised. The final allocations are made on the basis of the NHS Scotland resource allocation committee formula. NRAC has not been applied yet to the board allocations in the budget document; if you calculate the percentage increases, you will find that all the territorial boards have an increase of 3.2 per cent. Once we apply NRAC, the average increase will be 3.2 per cent, but those that are below their NRAC parity will get more than that and those that are above their NRAC parity might get slightly less. It is when we apply NRAC that rurality, remoteness, deprivation and all the other things that determine how we split the cake among health boards are taken into account. Therefore, you should not base your observations on the current figures, because they are indicative figures until we apply the NRAC formula to them.

Mary Scanlon: That probably takes me to my last question.

Nicola Sturgeon: Cool.

Mary Scanlon: You will be delighted.

Comparing last year's draft budget to this budget, I went through the boards in the Highlands and Islands. In last year's draft budget, NHS Grampian's figure was £12 million more than it actually got; NHS Highland's was £9 million more; NHS Orkney's was £0.5 million more; NHS Shetland's was £1.1 million more; and NHS Western Isles's was £1.6 million more. Would that be because the figures in the draft budget were calculated prior to the NRAC formula being applied?

Nicola Sturgeon: Yes. In the draft budget, we just take the overall increase for health boards and apply that consistently. I know that you were meant to have David Bell here this morning. I read his written evidence last night, and he makes the point that we have given all health boards the same increase. He comments that that is a bit strange. Well, we are not going to do that. It is just that, in the draft budget, we give just the indicative figure. Once the budget is finalised, we apply NRAC to that, so all the health boards will end up with a slightly different figure based on their NRAC share.

Mary Scanlon: Do you have to apply NRAC at a particular time? Would it be possible in future to apply NRAC prior to the draft budget?

Nicola Sturgeon: We can certainly look at doing that.

The Convener: Cabinet secretary, I think that John Matheson wants to comment.

Nicola Sturgeon: I will bring him in in a minute. We can certainly look at doing what Mary Scanlon suggested, although John Matheson may be about to say that we cannot. However, I am sure that we can. NRAC is partly just about applying a formula, but there are some judgments that I have to make about the boards that are beneath their NRAC parity. I must make a decision about how far and how fast, without destabilising boards that are above their NRAC parity, we can move them towards parity. It is not sensible to make that decision until we get to the finalised budget. I do not anticipate that the overall figures in the draft budget will change, but they could. That is why we tend to leave that judgment until later on.

Mary Scanlon: Well, they did change significantly in the past year.

Nicola Sturgeon: No, I mean the global figures for health.

Mary Scanlon: I appreciate that.

Nicola Sturgeon: Obviously, the global figures would have an impact on my ability to decide how fast we can move below-parity boards towards parity.

John Matheson (Scottish Government Health Finance Directorate): I have just a quick point, picking up on Mary Scanlon's point. A technical adjustment was made to capital charges in 2010-11. The Treasury adjusted the way in which capital charges were calculated, and the interest on capital charges and building assets was removed and taken back to the Treasury. That is why, for every individual health board, you will see a reduction from the original budget to the restated budget. The total across Scotland was £125 million. That was neutral, because the money was taken back and the expenditure was removed as well.

Nicola Sturgeon: So, as well as the effect of NRAC, that technical adjustment will have changed the figures later in the year.

Ian McKee: I hear what you say, and that obviously solves one of the problems with the briefing that we got about the same amount of money going to health boards. However, the committee has found it quite difficult to scrutinise what happens to the £8.6 billion, which is a large portion of the health budget, that goes to terrestrial health boards. Although I appreciate that adjustments are made through NRAC and various other factors, there are other factors. For example, I am sure that some health boards are more efficient than others in reducing waste in a particular year. Do you make a judgment not just on factors such as inequalities and rurality but on whether health boards have played ball in previous years? If you do not, you are giving an incentive to health boards to make only the savings that they have to make, knowing that they will have to make some more savings in the next year.

Nicola Sturgeon: First, on your point about scrutiny, the NRAC changes that are made to the figures are important to an individual health board but, overall, they are made at the margins, so I do not think that they make scrutiny too much more difficult.

We do not decide health boards' allocations on the basis of the size of the efficiency target that they meet, but we monitor and manage the performance of health boards against the efficiency targets that we set for them. Until now, the target has been a minimum of 2 per cent, and most boards have exceeded that, some by a considerable margin. Boards are not allowed to be inefficient because we scrutinise carefully how they spend their resource and make sure that they do it as efficiently as possible.

Ian McKee: I suppose that I am asking whether a health board that does fantastically well and squeezes out inefficiencies will feel vulnerable the next year?

Nicola Sturgeon: No, they will benefit from that, because we do not take efficiency savings away from them. The boards retain the money, so any board that is more efficient than we ask it to be gets to keep the extra money for reinvestment. There is no perverse incentive in that system, but there would be if we were clawing back the efficiency savings. If we were doing that, you could say that it is not in their interest to make the efficiency savings, but when they get to keep the money, that is not the case.

Ross Finnie: Cabinet secretary, I draw your attention to table 8 in the Scottish Parliament information centre briefing paper. It analyses the very question that Ian McKee has just asked, and sets out the efficiency savings that the boards have achieved as a percentage of their budget, by which you can set the 3 per cent target that you have laid down as an average for the year.

I want to press you on that. Table 8 can be read in a variety of ways. We could say that those boards that achieved more than 2 per cent savings did terribly well. If we were being more sceptical, we might say that those boards needed to make a lot of efficiencies and that they have scope to make more savings. When the health boards came before the committee earlier in the year, the degree of astonishment with which finance officers and chairs of boards declared that they had unearthed savings that could be made underwhelmed the committee, although they seemed to be very excited by it.

Some of those figures are extremely good but, in many cases, they are so good that 3 per cent would not really represent a great challenge. Do you have any mechanism whereby your officials are able, as Ian McKee suggested, to look at where there are difficulties or where there might be some clear scope for the boards to make themselves efficient irrespective of financial pressures? I am talking about sheer efficiency, better use of resource and better management.

11:00

Nicola Sturgeon: I do not speak to many health boards that claim to find making efficiency savings easy. Over the past few years there has been more of a deliberate focus on efficiency. I suspect that during the first years of the efficient government programme, boards found relatively easy pickings in terms of efficiencies, because that focus had not been there. Although none of the boards describe it as easy to find such savings, it is perhaps easier at the start than it becomes later on.

That takes me to a second point. We cannot assume that because a board has overshot its efficiency target one year, it will find it easy to do the same the following year. It may have taken all the easy pickings out of the system, so it will get harder to make savings.

An inevitable feature of an organisation such as the health service is that not all boards are the same. They are not all starting from the same position—rightly or wrongly, some boards will have done things much earlier than other boards. They are not the same in terms of the populations that they serve, the spread of those populations and the type of services that they have to deliver.

The nature of the efficiency savings that a board such as NHS Highland might be able to make could therefore be very different from those that NHS Greater Glasgow and Clyde might make, just because of the different circumstances. There will always be varying patterns between boards.

It is therefore right for the Government, based on our assessment, to set a minimum efficiency savings target and to encourage boards to exceed it if they can. That is what we have done in the past. All boards met those targets and many boards, as table 8 in the SPICe briefing shows, exceeded them.

Efficiency savings on a year-in, year-out basis become, by their very nature, harder to make. The low-hanging fruit is picked in the early years and the agenda becomes more difficult. During the next few years, our efficiency savings will necessarily require to come from much more fundamental redesign and reform of service delivery, unlike the easy savings that might have been made in earlier years.

To give some illustrations, if boards could cut emergency admissions by 10 per cent, they would save £16 million. If we could reduce inappropriate referrals to out-patient clinics by 10 per cent, we would save £70 million. Reducing the average length of stay in acute hospitals to the mean would save £7 million. If all boards reached the upper quartile of performance, we would save £74 million.

Those are efficiency savings, but they are also about delivering better quality care. They illustrate very well the fundamental relationship between efficiency and quality, but they demonstrate that we are getting into tougher territory on efficiency. Perhaps that is a good thing, because it forces us to redesign services in a way that is better for patients.

Ross Finnie: I am grateful for that. Can you confirm—or otherwise—whether reductions in the number of senior managers, which you have targeted, count towards or are included in efficiency savings?

Nicola Sturgeon: No. We will track that separately.

The Convener: Before I ask a question I will welcome Jackie Baillie. She has taken away my Richard Simpson script, with which I was a bit uncomfortable.

Ross Finnie: It was marked "secret".

The Convener: Yes, it was marked for my eyes only.

I will ask about the difficult issue of protecting front-line services, which raises difficulties of definition, for a start. Andrew Walker makes an interesting point about that in his submission. He states that talking

"about 'frontline services' risks implying anything that does not involve frontline care has no value",

or, to put it in my own words, lesser value. He makes the point that

"public health, training, research, evaluation and collecting data to monitor the performance of the NHS are all vital"

and that they might even contribute to efficiencies. He uses the example of

"the Scottish Medicines Consortium, providing evidence-based advice to the NHS to ensure decisions about millions of pounds of spending represent demonstrably good value."

That would not be protected as a front-line service, however, and he uses the word "ring-fencing" with regard to protecting front-line services. He makes the interesting point that you are boxing yourself and NHS boards in, when more flexibility would deliver a better NHS and make the efficiency savings that we all know are required in the present circumstances.

Nicola Sturgeon: Andrew Walker makes an interesting point. It is an area that I struggle with. Anyone who does not struggle with the division between front-line and non-front-line services does not understand the health service, which goes back to a point I made to Mary Scanlon. We can argue that most things—if not all—that are done in the health service in some way, shape or form contribute to the delivery of front-line services. The NHS administrator who takes the burden of paperwork off the NHS consultant is helping that consultant to reduce waiting times, for example. The distinction has limited validity. I try to avoid using that terminology when I can, although I am not always successful. I must be honest and say that I slip into it sometimes because it is the easiest shorthand to use for an argument that one might be trying to make that point-of-care services—I prefer that terminology—should be protected as much as possible.

I will try to clarify what I hope is a misunderstanding. We are not saying that boards should not be trying to deliver point-of-care services more efficiently. The efficiency savings target does not apply only to functions that we would describe as non-front-line. Some of the examples that I gave earlier about reducing emergency admissions and length of stay are front-line in terms of care, but if we deliver those services more efficiently, we free up money for reinvestment.

I accept that the terminology is not the most helpful. Most people who find themselves using it are doing so as shorthand to illustrate a bigger argument.

The Convener: Do you have concerns that making a stable, good patient experience the touchstone and protecting it will deplete other areas that would save money and therefore make the patient experience a better one? Do you see what I am saying? Using the money more efficiently would deliver more bodies on the front line.

Nicola Sturgeon: We must make sure that how efficiency savings are being made guards against that. I was trying to illustrate in my answer to Ross Finnie that, as we move forward, the efficiency agenda is inextricably linked with the patient experience and how we deliver services.

I have always been conscious that what I am about to say is much easier to say than it is to do, but that does not make it wrong. Health boards must have an absolute relationship in their minds between efficiency and quality. We sometimes think of efficiencies as cuts, but that is wrong. Managed wrongly, efficiencies could equal cuts, but a service that keeps someone out of hospital or reduces the length of their stay in hospital, is providing more efficient and better quality care. The big challenge for us—a challenge that I am determined that we will meet during the next few years—is to keep that relationship between efficiency and quality front and centre in our minds, and get away from the notion that they are enemies; they are not. Efficiency and quality should go hand in hand.

Ian McKee: As you know, the Scottish Medicines Consortium is renowned worldwide for its assessment of whether new drugs are effective and cost-effective, and whether they should be used in the health service. It has suggested that other new services, guidelines and so on that put cost pressures on boards might not be subject to the same degree of continuing scrutiny with regard to, first, whether it is worth introducing a new service, guideline or strategy and, secondly, whether it is worth continuing with current ones. Is that a reasonable criticism?

Nicola Sturgeon: That is an interesting point. I read the submission made by Andrew Walker, who, as one of its members, is obviously a big enthusiast of the Scottish Medicines Consortium. He is right to be, of course—

The Convener: You slipped that under the radar, cabinet secretary

Nicola Sturgeon: I hope that he does not read the *Official Report*.

The SMC is a huge success story of which we all should be very proud—I certainly am. Although it has not removed the difficult decisions that need to be taken about drugs, it gives us an independent and robust system in which people can have confidence. We should certainly be open to the idea of constantly looking at how we can improve the evidence base for other decisions that boards have to take, given that they frequently have to grapple not only with decisions about new drugs, new technologies and new ways of doing things, but with how to balance decisions about investment and disinvestment to allow them to make these transitions. This is difficult territory and if we have a tried-and-tested method in one area we should always look at whether it can be applied in others.

Just to retrieve Andrew Walker's opinion of me, I am happy to say that I am more than happy to consider his suggestion.

Ian McKee: It is perhaps a bit unfortunate even to imply that he is biased in that sense—

Nicola Sturgeon: For the record, let me make it clear that I was not implying that.

Ian McKee: The suggestion has a great deal of merit, given the problem encountered by many new services and strategies in the health service that what is right for the masses is sometimes not right for the individual. With bowel screening, for example, you have to screen 1,000 people for 10 years just to save one life and yet screening that number of people gives rise to false positives, risks with regard to colonoscopy and so on. Any measures that are introduced need to be constantly re-evaluated and I am not 100 per cent sure that that will happen.

Nicola Sturgeon: Bowel screening is, of course, another big success story. I am not saying that it uses exactly the same methodology as the SMC, but the United Kingdom national screening committee, on whose advice we base all our decisions on new or extended screening programmes, looks very carefully at evidence about and the cost-effectiveness of screening. For example, it wants more evidence about the cost-effectiveness of screening for heart abnormalities in young people, which is something that has been lobbied for, and we are introducing a pilot to try to contribute to that evidence base. I think that that suggests that such considerations are already being taken into account in certain decisions. I guess that I agree with you and Andrew Walker that we need to strive constantly to make every health service decision on treatments, technologies, screening programmes and so on as evidence-based as possible, and that evidence must cover clinical effectiveness and cost-effectiveness.

Ian McKee: You have touched on this issue in previous responses, but we find it very difficult to examine the health budget when information on health board spending is not presented in a consistent way that allows us to compare health boards and really get to the nub of the £8.6 billion spend on health board activities. Does the Government plan to produce that information in an easily understandable way that will allow the committee to compare one board with another?

Nicola Sturgeon: As I said last year, I am not just happy but keen to look at how we can make that information available to the committee in a more helpful way. I would argue that how health boards spend their allocations and what they achieve with them is already subject to very close scrutiny by Government and parliamentarians in terms of their performance against the HEAT—health improvement, efficiency, access and treatment—targets and all the other targets that we set for them. I listened to what the committee said last year and, of course, you produced your own report on the spending plans of individual health boards. I am keen to consider that and—to address another point that Andrew Walker raised—see whether we can provide that information to the committee in a more helpful way.

11:15

The Convener: Are you ready to come in, Jackie?

Jackie Baillie (Dumbarton) (Lab): Absolutely.

The Convener: I did not doubt it. You are on.

Jackie Baillie: Thank you very much, convener. I am grateful for the welcome. I apologise on behalf of colleagues who were keen to put questions to the cabinet secretary, but I am sure that she will not mind if I do so in their stead.

The Convener: I have already put their apologies on the record.

Jackie Baillie: I am sorry if I repeat anything that has already been asked, but I want to be clear in my mind that, as a result of UK budget consequentials, there have been real-terms decreases of £113.5 million in capital expenditure, £190 million in revenue and £95 million in the budget for NHS and special health boards.

Nicola Sturgeon: I do not think that any of that is correct. We might well be talking at cross-purposes, so I will try to explain the position.

The revenue budget increases by £280 million, which is the total amount of the consequentials flowing from UK Government decisions. As a result, we have completely fulfilled our commitment to pass on all the consequentials in what is a real-terms increase in that budget.

The reduction in the capital budget is proportionately slightly less than the 25 per cent overall reduction in next year's Scottish Government capital budget. You are right, though, that there will be a real-terms reduction in the capital budget for the health service and that that, again, flows from decisions made by the UK Government in its budget and comprehensive spending review.

If you take the total health budget and make an absolutely valid alteration to take account of the fact that this year's budget was artificially inflated because of a one-off set-aside to deal with pandemic flu that, in the end, was not required and was not available for any other purpose, you will see that the overall health budget has been maintained in real terms.

The member was not at the meeting when I talked about the NRAC formula that will be applied later to board allocations. The average real-terms increase for territorial health boards is 3.2 per cent, although that will change slightly at the margins when the NRAC formula is applied. We have applied differential efficiency requirements to the special health boards. I do not want to return to our earlier discussion about the use of terms such as "front-line" and "non-front-line", but I point out that, although we have applied stretching efficiency targets to those either partly or wholly delivering non-direct-patient care to release more money for territorial boards, we have not applied the same targets to those delivering direct patient care, such as the Scottish Ambulance Service, NHS 24 and the Golden Jubilee hospital.

Jackie Baillie: That response was very helpful. You might not be able to provide this information just now, but I wonder whether you can give us a breakdown of the £280 million in formula consequentials.

Nicola Sturgeon: What do you mean by breakdown?

Jackie Baillie: Well, how do they arise? What spending decisions taken at a UK level have resulted in a proportion of money coming to Scotland?

Nicola Sturgeon: We get the global, consequential figure. That is £280 million that flows from the increase to the health budget. We do not get a breakdown. I dare say that you can work it out from the Department of Health budgets, but that is a global sum; there is no further breakdown of that.

Jackie Baillie: Okay. So you do not work that out to see what decisions have been made and how the budget consequentials have arisen.

Nicola Sturgeon: The £280 million comes from the increase to the Department of Health revenue budget. That is what it flows from.

Jackie Baillie: Indeed. What I am trying to get at is that there are increases in different areas. Although our priorities might well be different to the UK Government's priorities, what I was driving at was whether you had considered, as part of your thinking, what it had allocated additional money for.

Nicola Sturgeon: We will always look at that. For example, I am sure that people will ask—if not today, at some point—about the cancer drugs fund. The £200 million for that in an English context leads to roughly £20 million in consequentials, which will be included in the £280 million. The Department of Health has also done something broadly similar—although in practice it is not that similar—to our £70 million change fund. Of course we will look at that, but we will take decisions on spend that are right for our circumstances. Those decisions will sometimes follow what is done south of the border. One of the things that I would not want to follow is the vast amount of money that they are using for an administrative shake-up of the health service south of the border, which will be flowing through in consequentials to us. I do not want to use that money to, in effect, privatise the health service in Scotland in the way that they are arguably doing south of the border. Our priorities will differ, but of course we always look at what they are doing there.

Jackie Baillie: Okay. Thank you for that response. Can I take you back to the figures that I started with? My understanding is that they came from the SPICe briefing—I want to be absolutely clear. Although I understand what you are saying about how the figures can be interpreted, starting with the same factual bottom line—

Nicola Sturgeon: It might help if you told me where the figures are in the SPICe briefing.

Jackie Baillie: In fairness, having arrived late—

Nicola Sturgeon: If we cannot source them immediately, we will perhaps come back to you on the detail.

Jackie Baillie: Okay. It would be fair to understand where the challenge lies. We all accept that there is a real challenge facing the health service. If we have a shared understanding about where we are in real terms, that would make life easier in the debate that needs to happen. I will look at that while someone else asks questions.

Can I ask one final question in this slot? I am sure that you will give us more time, convener.

The Convener: I always do.

Jackie Baillie: The cabinet secretary helpfully mentioned a 3.2 per cent increase in the budget for health boards. We had a briefing from the Royal College of Nursing some time ago that suggested that health boards had new burdens along with that money. For example, the budget line for prescription charges had been transferred to health boards. The RCN estimated that the increase was more like 1.8 per cent. I ask for the cabinet secretary's comments on the RCN's views.

Nicola Sturgeon: I have seen its briefing and it is right that we very deliberately decided at the start of the year to put the money for prescription charges into board allocations. Without wanting to quote any individual boards, I think that they will welcome that, because it provides an efficiency incentive around prescribing: if they can reduce costs around that, they have the excess to reinvest. That makes sense. It allows them to be much more in the driving seat in how the budget is used.

Also in there—I think this was one of the things that the RCN deducted—was the £70 million change fund. We have already had a bit of a discussion about that, but that is money that is very clearly to the benefit of health boards. If, for example, that money can be spent in a way that reduces avoidable admissions to hospital, that allows boards to free up resources that they can reinvest. I would argue that all that money is there and is usable to the benefit of the overall health board allocation.

On the overall board allocation, you are right in the sense that we have protected health; however big the challenge is in health, it is a lot smaller than it would have been if we had not taken the deliberate decision to protect the health budget. As a result of that protection, the share of the total Scottish Government budget that now goes to health has increased. I can probably tell you exactly how much it has increased by: it was 32.4 per cent and it will go up to 33.9 per cent.

As David Bell, I think, says in his written evidence, this is a very good financial settlement for health. However, there are inflationary pressures on the health budget—I have never shied away from this—that mean that the situation will continue to be challenging. Some of the obvious inflationary pressures are the increase in VAT that is about to kick in, the change to national insurance thresholds, and inflation around pay and supplies, the biggest component of the latter being inflation in drug costs. We have given boards an increase in their basic allocation that covers those key inflationary pressures.

In addition, there is an efficiency savings target of 3 per cent for boards, which amounts to £220 million. That is money that boards then have available to invest in service development and redesign. I would never say to any health board that the next year and beyond will be anything other than challenging, but this is a good financial settlement for the health service and it is a much better financial settlement than would have been possible had we not taken the decisions that we have. If anybody wants more detail in relation to the SPICe briefing, we are happy to provide that in writing.

Mary Scanlon: I have a supplementary question on a point that you have raised twice today, cabinet secretary, on the potential £16 million savings as a result of a 10 per cent cut in emergency admissions. At a recent Scottish Care conference, they said that they had 5,000 empty beds, some of which could be used for rehabilitation, where appropriate, for people who had had falls. They said that they can provide that at one fifth of the cost—

Nicola Sturgeon: Sorry, who said that?

Mary Scanlon: Scottish Care. Shona Robison spoke at the conference.

They can provide those beds to rehabilitate people to get back home at one fifth of the cost of doing so in the acute sector. Would you consider using those beds in order to make the £16 million savings?

Nicola Sturgeon: The partnership that must work if we are to make the efficiency savings is principally between health and local authorities. The latter work closely with the independent care home sector, whose umbrella organisation is Scottish Care, so that relationship also has to work.

There is scope for what you suggest, and it makes sense for there to be discussions between the health service, local authorities and organisations that can contribute to ensuring that we are configuring services and providing the right services in a way that allows us to treat more people better in the community and reduce the need for them to go into hospital. I will not comment specifically on the cost being one fifth of the acute sector cost, because I have not seen the figure and I do not know what lies behind it. In response to the general thrust of Mary Scanlon's question, I expect those conversations about how we best provide good community care for people to be taking place.

Mary Scanlon: Andrew Walker's submission has had a good airing, but David Bell's submission

is excellent, too, although we will obviously not be able to ask him questions.

I will wrap together my final two questions. I was slightly shocked by the second paragraph on page 6 of David Bell's submission, which states that between 2004 and 2009 the

"gap between the average Scottish salary and someone working in the hospital sector increased from £4343 to £7223 per annum."

So, the gap between the salary of someone who works in the NHS and the average Scottish salary has almost doubled. I would have liked to ask David Bell a question on that. Can the cabinet secretary respond on that point?

My final question is on the KPMG report for the Centre for Public Policy for Regions. In the third-last paragraph on page 37, it concludes that

"higher spending in Scotland in the NHS since 1999 has not delivered greater improvements in life expectancy; healthy life expectancy or reduced mortality rates faster than in England."

It also says that

"decisions on priorities or reduced spending should be made on a sound evidence basis."

Obviously, the cabinet secretary has not been responsible for health since 1999. However, as an economist, I would be concerned about those points.

David Bell's submission states that

"health care costs can be contained without jeopardising quality"

and that

"public debate ... has been woefully inadequate."

Does the cabinet secretary feel that we have a sound evidence base? Will the investments that we are prioritising in the NHS improve life expectancy, although that has not happened to date, and reduce mortality rates?

11:30

Nicola Sturgeon: There was a lot in Mary Scanlon's latter question, but let me deal first with the first one. You would have to ask David Bell about the figures around salary levels. I am not questioning those figures, but I do not know what he bases them on.

Mary Scanlon: There is quite a difference.

Nicola Sturgeon: Absolutely. I probably had the same reaction as Mary Scanlon when I saw those figures. David Bell will probably usefully be able to explain a bit more about that.

The only observation that I would make—I suppose that it could be made about the private sector, too—is that when we take the average salary of somebody who works in a hospital, we are taking a broad spectrum of people, from those who do valuable administration work through to the highest paid consultants. I do not know whether we will get on to distinction awards, but it is an issue in that area as well. As I said, a very broad spectrum of people work in hospitals, and averages never tell the whole story.

Mary Scanlon: I just found the gap quite shocking.

Nicola Sturgeon: Sure. Off the top of my head, I cannot remember what time period David Bell referred to.

Mary Scanlon: It was 2004 to 2009.

Nicola Sturgeon: That period covers things such as the new consultant contracts and agenda for change, so we have had a lot of salary reform in the health service that may have had a bearing on some of those figures.

Mary Scanlon's second question was huge, but I will try to do it justice in as short a time as possible. You asked whether we have a sound evidence base. In terms of what we deliver for the money that we invest in the health service, we can always get better at evidence and how we measure outputs but I think that we have a fairly sound evidence base.

The evidence base is far less sound—I think that the Nuffield report that came out some time ago demonstrated this—in comparisons between the different countries of the UK. We tend to talk about the same things, but beneath the surface we find that we measure them very differently in some respects. In my view, it is therefore very difficult to make robust comparisons between Scotland, England, Wales and Northern Ireland. There is an argument for looking at how some of that could be standardised. For academic interest, if for nothing else, we have good cause to look at that information. Increasingly, we diverge very much in how we do things, so it would be interesting to see whose approaches are working better. However, I do not think that we have an evidence base that is robust enough to do that just now.

Life expectancy in Scotland is improving across all socioeconomic groups. It is improving faster in the more affluent groups than it is at the bottom, which means that we have a widening gap. That is an issue for us—it always has been—but we should not forget that the picture is improving. Obviously, the differences in spending on the NHS between, say, Scotland and England are driven by aspects such as rurality and our big remote population, which Mary Scanlon is well aware of. Again, we have to be cautious about making bald comparisons.

My key point is that it is not just spend on our national health service that determines life expectancy. That underlines the importance of our seeing the bigger picture in all this, as the Government is trying to do. For example, our spend on early years education arguably has as big an impact on somebody's life chances and life expectancy as our spending on the health service has. So, there is a big point in there, but I do not think that we can answer it just by reference to how much we spend on the health service.

The Convener: You touched on the great inequalities in life expectancy in Scotland—sometimes just from one side of a hedge to the other—and, indeed, in quality of life. Andrew Walker raises those issues. I am not his spokeswoman, but he makes an interesting point about what we mean by inequalities. He asks whether

"we mean inequalities ... in spending on services"

or a number of other things, such as life expectancy and quality of life. One of the questions that he raises, which is worth following through, is: what HEAT targets relate to inequalities, how has the NHS performed against those targets and what is the expected impact of the draft budget on future performance?

That is a fairly detailed list, so I will leave it before you while we get the information together. Addressing health inequalities is a huge task, but it is of great concern to the committee that, if we are not moving or the gap is getting wider, the task is not being addressed.

Nicola Sturgeon: There are different parts to that question. Our budget is equality impact assessed, so we directly assess it for the differential impact that it has on different groups.

Another part of your question was about what we mean by inequality. For me, fundamentally, it should be concerned with the equality of outcome for people, whether in terms of their health, their life chances or, crucially, not only life expectancy but healthy life expectancy. The Government's overall strategic objectives are couched in those terms.

I am sure that nobody wants me to sit and read out a list of HEAT targets. The health improvement targets are the ones that are specifically geared towards inequality. By their nature, they will be achieved over a longer period of time than some of the treatment or efficiency targets. I think that the information is in the SPICe briefing, but we can certainly go through where we are with all the HEAT targets this year. I have just issued guidance to health boards on their local delivery plans for next year, and the HEAT targets will performance manage boards again next year. However, I am happy to provide more information on progress towards all the HEAT targets and, in particular, the health improvement ones, although I think that that information is in the SPICe briefing.

The Convener: I have a bit of a daft-lassie question: what is the responsibility of the territorial boards for improving the public health of the people within their catchments? People tend to think of that as a Government-level issue, but what level of responsibility do the boards have?

Nicola Sturgeon: It is huge. Their responsibility is not exclusive, for reasons that are obvious, but it is primary. All boards have public health directors who are clearly focused on improving health and reducing health inequalities. Many of those HEAT targets are about population health improvement and, in some cases, are specifically targeted to the more deprived areas.

It is not an exclusive responsibility because, as is increasingly recognised, health boards have to work with local authorities in particular to achieve public health improvements. Take NHS Greater Glasgow and Clyde as an example. Linda de Caestecker, the director of public health in NHS Greater Glasgow and Clyde, is now a joint appointment between the health board and Glasgow City Council in order that they collectively carry out the responsibility that they have for improving population health.

The Convener: To get back to that awful expression "front-line services"—or patient experience or whatever we call it—is public health a front-line service?

Nicola Sturgeon: It is difficult to answer that question with a yes or no. Of course public health is a front-line service in the sense that one of the things that the health service has got better at over the last number of years, not only under this Administration, is seeing its role as much wider than just treating people when they are ill.

We talk now about a health-improving health service, which means that the service is much more focused on its responsibilities for improving health, starting with its own staff. The health service is the biggest employer in Scotland and it can lead by example in how it improves the health of its staff. It now sees its role as much more about improving health than it ever has done. If we do not see its role in that way, the burden of ill health on the health service will continue to grow at a time when we want to reduce it by improving people's health. To use the terminology that none of us likes, it is probably as front line as it gets.

The Convener: So health improvement would be an NHS board budget that you would expect would not take pressure. You would want to see it protected.

Nicola Sturgeon: I am sorry, but I tried to clear up that matter earlier on. We have protected the health budget in overall terms, and we expect boards to work within their budgets to protect the quality of the services that they provide to patients, which includes their health improvement work. Do not get me wrong: I am not saying that health boards cannot be more efficient in how they provide those services to patients. We are not saying that front-line services are immune from making efficiency savings.

The Convener: I will put things simply. I am trying to say that the people at the other end should not notice the difference.

Nicola Sturgeon: That is a very good way of putting it.

The Convener: I was not trained for that; I had only Richard Simpson's script.

Is Jackie Baillie ready to come back in?

Jackie Baillie: I will come back—

The Convener: I am sorry. Ross Finnie has a question. Jackie Baillie is a welcome visitor, but she will appreciate that I do not want to offend the deputy convener.

Ross Finnie: I am glad that we have sorted that out.

The Convener: You have made a fuss by indicating that you want to speak, so you had better ask a question.

Ross Finnie: I am pleased to see Mr Feeley accompanying the cabinet secretary in his new role as acting director general of NHS Scotland, but I am sorry that I cannot ask him in that capacity about the state of the orange roughy stock. I am sure that he would have been delighted to elaborate on that but, thankfully, I cannot ask him that question.

The Convener: Mr Feeley is smiling. Obviously, he wants to tell us about that.

Ross Finnie: I suspect not.

Cabinet secretary, I would like to get a better feel for where you and the Government genuinely believe that there will be pressures in the health service. I return to the earlier answer to Jackie Baillie, who mentioned the 3.2 per cent increase in the NHS and special health boards budget. You properly indicated that the £70 million change fund was in there, but you hope that it will result in an improvement. I am not questioning that, but I understood from your answer that that might not be within the immediate year, although that might not be the case.

Nicola Sturgeon: It will be.

Ross Finnie: That is helpful.

You also indicated that it was perfectly proper of you to provide the funding for prescription charges. That is quite proper, but there are two sides to the equation. There is the additional cost, which you are providing for.

We are dependent on improvements from the change fund. Without them, if there was no change, we would go from a 3.2 per cent increase to a 1.8 per cent increase. I am not criticising the change fund for that; that is simply a fact that tends to illustrate that there is an overall pressure. I do not think that you are denying that. The cuts are a pressure. In the Government's view, where are the pressures most likely to occur in the health service?

Nicola Sturgeon: I am not trying to be argumentative; that is not in my nature.

Ross Finnie: Indeed not.

Nicola Sturgeon: Even if we take an increase of 1.8 per cent, that is not a cut; it is a 1.8 per cent increase. We must see that positively when we put it in the context of other Scottish Government budgets that are being cut because of the financial situation that we have been given by Westminster, and I know that people will see it positively.

Ross Finnie: I appreciate that, but I also put it in the context of the slightly above-average rate of inflation that, regrettably, despite your best efforts, particularly with respect to drugs, there still is.

11:45

Nicola Sturgeon: I take that point.

I will not repeat what I said earlier but, for illustration, the £70 million is funding that the health service will be able to use dynamically to free up money for reinvestment. It is not valid to take that money out of the equation. However, even if we do, and even if we take out the cost of abolishing prescription charges, the boards will still have in excess of £100 million extra to cover other inflationary pressures—such as increases in national insurance, threshold changes, the VAT increase, pay inflation and price inflation.

We are all aware of the demographic pressures on the health service and we are all aware of the pressures—good pressures, in my view—to redesign services. Upfront investment is often required to redesign services, which takes me back to why the £70 million is important. Some pressures relate to the cost of drugs that can already be prescribed, but new drugs coming on to the market can also present cost pressures. Furthermore, new technologies become available all the time; they, too, will present cost pressures.

Within its allocation, the health service has funding for the identifiable pressures that I have listed. However, it also has to make efficiency

savings of a minimum of 3 per cent in order to free up additional resources to meet all those other pressures and to allow it to continue with redesign work so as to deliver better services for patients. None of that will be a walk in the park for the health boards. There are real challenges. Now, I am not saying that we should welcome all those challenges, but we should welcome some of them. We should be encouraging boards to consider how to redesign community services in order, for example, to reduce hospital admissions. Not everything that we are doing is proving necessary because of the tight financial circumstances; there are some things that we should be encouraging anyway.

The Convener: I was mumbling under my breath that a bit of grit on the pavements would reduce hospital admissions. That is a personal bugbear at the moment.

Ross Finnie: I am certainly not going to ask a supplementary question on that.

Nicola Sturgeon: Thank goodness for that.

Ross Finnie: Indeed. I would like to pick up on the latter part of the convener's first question, which was on the priorities. The issue was referred to in the briefing from SPICe, and, curiously enough, the priorities are also brought together—although not as comprehensively—in Andrew Walker's paper, starting on page 3. I understand that you have studied the paper very carefully, cabinet secretary. No doubt you have also anticipated my question.

The committee has been exercised. The Government has talked about a minimum of 24 priorities but, in the budget document, only three of those priorities meet the qualification of being specific, measurable and time limited. That leads to a difficulty: the priorities cannot easily be linked to a line in the budget. Issues also arise to do with how we can express HEAT targets.

I am not asking you to go through those, but it is difficult for the committee to correlate between the budget commitments and the priorities. Could the committee receive information in a form that would allow us, when scrutinising the budget, to relate it to the Government's stated priorities?

Nicola Sturgeon: The short answer to that is yes. I would like us to consider whether we can provide such information, whether in the draft budget or separately—I am sure that that would be up for debate. We should provide information that more easily allows the committee to join the dots between the budget lines and the priorities. In my performance management of the health boards, I am able to do that. Obviously, it is desirable that the committee should be able to do so as well.

I am not sure that it is as simple as just identifying a budget line that equals a HEAT target. Let me give you an example off the top of my head, which, for that reason, may not be the best example. Let us consider the target to reduce waiting times—the 18-week referral-to-treatment target. There are probably several budget lines that contribute to boards' ability to meet that target: there is direct money for reducing waiting times and access support but, to return to a subject that Mary Scanlon raised earlier, the health budget and improvements in technology will also help to reduce waiting times.

Several budget lines feed into every HEAT target and—I am thinking through this as I answer the question—maybe we need to provide information to reflect that. My officials will hate me for what I am about to say, but possibly before the end of this week we could try to highlight the specific budget lines for every HEAT target—

The Convener: I feel the officials stiffening and their smiles turning to gritted teeth.

Nicola Sturgeon: Derek Feeley is whispering to me that he wishes he could go back to fishing.

Ross Finnie: Can you confirm that your officials are still breathing?

Nicola Sturgeon: He is planning his route back to fishing as we speak.

To be honest, I do not think that it will be particularly complicated to take the main HEAT targets and, although it will not be absolutely comprehensive, identify the two or three key budget lines that feed into them.

Ross Finnie: The fishing allocation regulations were a lot simpler than that, I assure you. [*Laughter*.]

More seriously, such information would help. We are not pretending that there is a simple and direct correlation, but if we are to have narratives that set out priorities to which we all sign up it is not unreasonable to see a path that shows how the expenditure is tied up.

Convener, I have a different question, but you may want to come back to me later.

The Convener: I hope to finish at about 12 o'clock, but if it is just one more question you can go on.

Ross Finnie: For the benefit of the committee, cabinet secretary, will you talk us through the pay policy, particularly with regard to the high earners in the NHS? You mentioned the distinction bonuses. Are other bonuses still being paid in the health service? I am not wholly familiar with all the arrangements, despite efforts to discover them.

Nicola Sturgeon: I will first set out the Government's pay policy in broad terms. Let me say, for explanation purposes, that the Government's pay policy applies in a direct sense only to those whom we directly employ—that does not include NHS staff, who are employed by the NHS—but we expect our pay policy to provide the framework for pay settlements elsewhere in the public sector. We have a pay review process in the health service. That is under way, so I will not pre-empt it.

Our general view is that we should have a pay freeze for all staff who earn more than £21,000. For staff who earn below £21,000 the Government's pay policy has proposed two things: first, the living wage of £7.15 an hour, which most staff in the NHS already earn; and secondly a minimum increase of £250. We have also said—this is important for a host of different reasons, economic as well as social—that we are committed to continuing the policy of no compulsory redundancies. Those are the broad parameters of the pay policy.

On higher-paid staff in the health service, I will deal later with consultants and the issue that I think lies behind the question. Higher-paid staff in the health service who are not consultants are covered by the pay freeze element of our pay policy, although we have the review process for doctors and dentists just as we have it for the wider agenda for change staff.

I have made my views on distinction awards clear to the committee previously, and I will do so again. I do not think that it is right or fair to use terminology that people associate with bankers to apply to distinction awards, because they are different. The system is not a bonus system in that respect; it is a merit system.

Nevertheless, when we have tight financial circumstances, we must consider carefully a merit system that rewards about 3 per cent of the entire NHS workforce. Last year, I decided to freeze the distinction awards budget. This year, I have decided to go further than that—pending the Doctors and Dentists Review Body's review, which will report in the middle of next year—so no new awards will be made next year. In this financial year, awards that have been freed up by retiring consultants have been awarded to new applicants. That will not be the case in the next financial year, when a freeze on the system will apply and distinction awards that are currently held will not increase in value.

Some say that we should just go ahead and abolish distinction awards. I have made changes around the margin, but my view is that we must be mindful of our competitiveness throughout the UK. If we allowed too big a divergence in the systems in different parts of the UK, we might harm our competitiveness. We have given evidence to the DDRB review that argues for fundamental reform of the system. I hope that the DDRB review will agree with us, but we will see what it comes up with.

The only other system is the corollary to the distinction awards system—the discretionary points system, which is managed by health boards. As with distinction awards, we have frozen that system this year.

Ian McKee: I hear what you say and I support you strongly. It is a pity that the previous UK Government would take no action. We have made progress by having a review. Two points concern me a little. I gather that you suggested in your evidence to the Doctors and Dentists Review Body's review that the awards scheme could be opened to other NHS employees. Does a body that was established primarily to examine the pay of doctors and dentists have the scope to expand its inquiry to consider other health service employees who could benefit?

I understand that distinction awards have two broad purposes. One is to augment the pay of someone who is of international standing and who could be poached by another body, to attract people from overseas to work in our health service or to attract people to be academic general practitioners, for example. A university salary is much lower than that of a GP, so it is difficult to attract people into that specialty. As that award augments pay, it is reasonable to reflect it in pensions.

However, the vast majority of distinction awards are to recognise some form of good service. Whether or not we agree with that—I put that to one side for the moment—it is totally unreasonable that, because someone has done good service at one time, their pension is augmented by a large sum of money for the rest of their life. Most distinction awards or bonuses—whatever we care to call them in the outside world—are lump sums for a particular year's good performance. People not only receive a lump sum—which is rarely, if ever, removed—but continue to benefit in their pension. Have you considered reforming the pension element unilaterally?

Nicola Sturgeon: Our evidence to the DDRB is not in front of me, so I will not attempt to quote it—I will give you the gist. I am not arguing that the current system should be opened up to everybody in the health service. The gist of my argument is that if we are to have a rewards scheme, it should not be available only to one relatively small part—in percentage terms—of the NHS workforce. As we all know, the modern NHS is multidisciplinary. If a rewards scheme is to operate, it should be

designed to be available to the NHS workforce generally and not just to a small part of it.

If a reformed scheme is to be put in place, a further principle that must underpin it—given the financial climate—is that it should be more cost effective than the one that we have now.

Some of the evidence and the thinking that we are feeding into the DDRB review is around the second point that you made about the fact that if there is to be a reward scheme, it could perhaps involve payments for extra special contribution or service, rather than being an on-going, pensionable payment, as applies to distinction awards.

In general terms, I agree with both the points that you made.

12:00

Ian McKee: The other element of my question was whether you think that a body that has a long history of considering only doctors' and dentists' pay has the breadth and scope of experience to cope with what is being suggested.

Nicola Sturgeon: I will not pre-empt the outcome of the DDRB review, and I do not know that a new system would necessarily be administered according to the same arrangements that we use to administer the distinction awards system. The arrangements would flow from the kind of system that was put in place.

Jackie Baillie: I will stick with workforce issues—workforce planning is the subject of a difficult debate at the moment, with significant implications for the budget. Has the cabinet secretary reflected on the number of places for student nurses and midwives, on which she is due to notify the Scottish Further and Higher Education Funding Council shortly—according to the last response that I got. Has she also reflected on the number of places for doctors in foundation training programmes?

Nicola Sturgeon: I am considering those matters at the moment and I will shortly make a decision on the nurse and midwife student intake. As Jackie Baillie and others will be aware, their numbers have held steady over the past three years, whereas there was a reduction under other Administrations.

We have to make complex judgments about workforce supply and demand, ensuring that the student intake every year provides sufficient nurses and midwives for the needs of the NHS in three, four and five years' time—but without having an oversupply that could lead to nurse and midwife unemployment, which we do not want. I will soon make known my decision on that.

Similarly, I have not yet reached my decision on junior or student doctor intake. At a very basic level, the same supply and demand considerations are at play, but there is the additional consideration of the work to modernise the medical workforce and the shift from service delivery by doctors in training to a trained doctor-delivered service. The shift is to be effected over a period of years and all the key stakeholders are enthusiastic about it. There will be a larger trained doctor workforce, involving a mix of consultants, specialty doctors and others, with less of the service being delivered by doctors in training, who will be focusing on their training. Over time, to ensure that the arrangements stay in sync, there will be fewer doctors in training. There is a bulge coming up, which also makes it important to get the timing correct.

There are slightly bigger factors at play for those decisions, although I will make the final decisions soon.

Jackie Baillie: I absolutely understand the complexity. I also understand that junior doctors—certainly those to whom I have spoken—have been told that there is likely to be a reduction of 183, specifically. I do not know how they arrived at that figure. Given that that has been the basis of e-mail communication, there is concern among those who are already in the system about whether there is any contingency to manage the fact that there are to be 183 fewer places. Some reassurance about that would be helpful.

Nicola Sturgeon: Absolutely. The figures that they are coming up with are not figures that are based on decisions that I have taken. Over previous months, there has been a consultation about how we get the supply of junior doctors in sync with the demand for trained doctors. There has been growing demand in recent years and in some specialties, such as emergency medicine, we have a bulge of trained doctors coming out of the system, due to implementation of the modernising medical careers programme. We need to ensure that there are opportunities for them.

There are complex decisions to be made, but I am glad to say that the British Medical Association is fully involved in the work. The central consideration is getting the timing of the shift correct, so that we manage everything in a way that is right.

Jackie Baillie: I acknowledge—and I am sure that you would, too—that there is currently an oversupply because health boards are not recruiting people, particularly nurses and midwives, and that, despite the guarantee, people are unable to access jobs. Getting the numbers right is important.

For clarity, can you confirm whether efficiencies have already been assumed in the budget figures that have been given to health boards? I ask that because whether the increase is 3.2 per cent or 1.8 per cent—let us assume that it is 1.8 per cent in terms of available cash—it will still feel like a cut because efficiencies need to be made to deal with the pressures that you have described in relation to VAT, national insurance contributions, the pay-as-you-earn system and so on. The scale of the challenge is quite considerable.

Nicola Sturgeon: I cannot remember if you were present when I was having a discussion with Ross Finnie about how boards in different parts of the country will be in different positions in terms of their efficiency programmes, but the point is that there will be differences between boards. To repeat what I said earlier, the allocation that we are giving to boards covers some of the key cost pressures, such as VAT, national insurance, PAYE and supplies inflation. The 3 per cent efficiency savings requirement is over and above the 3.2 per cent increase. That is what boards will need to make either to deal with other pressures or—although I am not sure that we should necessarily make a distinction between these two elements—to fund the service redesign that will enable them to deliver services more efficiently and to a higher standard than previously.

I have never tried to say that the relative protection that we have secured for the health budget within the overall budget will make things easy. However, boards have been given a good settlement, which has given them the bedrock on which to build. They have a good record on efficiency savings, and every penny of efficiency savings stays with the board for reinvestment. That is an important point to stress.

Jackie Baillie: The health budget has taken the biggest hit in relation to capital budgets, which is entirely a consequence of the reduction in capital spend from the formula consequentials. How will you manage the pipeline of capital projects? It has been suggested to me that those that are legally committed will proceed but those that are at the stage of the final business case or the outline business case will naturally be much lower down the pecking order. Is that so? Managing expectations is an issue, as you cannot conceivably fund everything.

Nicola Sturgeon: We have a reduced capital budget. There is no getting away from the fact that, when the Scottish budget is 25 per cent less than it was last year, no part of the Government can be immunised against the impact. There are priorities that must be funded from the capital budget, either by necessity or by choice. The items that are necessities are those to which a legal commitment has been made or virtually been made and those relating to essential maintenance, which no one would advise that we skimp on. The item that some might argue is a matter of choice—although I would argue that it is a necessity—is the Southern general hospital in Glasgow, which we have committed to maintain as a priority.

Beyond that, we will continue to engage in discussions with health boards about their other capital aspirations and how we work with them to try to meet those aspirations over a period of time. As John Swinney said in his budget, we have decided to give revenue support to non-profit-distributing models of capital funding. We have said to NHS Lothian that that is how the new sick kids hospital is likely to be funded, which is preferable to the project not happening. It is positive about that proposal and we are in discussions about how we can make progress on that. We are also in active discussions with other health boards about how—without sugar-coating the issue—we can achieve as many of the capital aspirations as possible within the non-profit-distributing model. We will have to consider the timing of certain projects, but I want the capital and infrastructure improvements in the health service to continue in the way in which they have in the past years. Incidentally, the list of legally committed projects, which will be going ahead, is quite long.

Jackie Baillie: It would provide reassurance to people in various health board areas if that list could be published. I do not think that it has been—certainly, I have been unable to find it.

We might have had a debate about various funding models before. However, that is less of an issue for me now, and I am more concerned about whether the proposal will cause delay. I expect that, in the normal course of things, it will do.

Nicola Sturgeon: I am answering in general terms, and it is important to do so, but in some cases, that might be the case. Although a delay in a project is never a good thing, it is better than a project not happening at all. I have said to health boards that we want to work to minimise any delay to projects that they think are important. That is the way in which we will proceed.

I thought that the list of legally committed projects had been published—in response to a written question from you, in fact—but I might be wrong about that. I will check to see whether there is any reason why that could not be published.

Jackie Baillie: I think that you were going to release the answer shortly, cabinet secretary.

Nicola Sturgeon: It must be very shortly, then, as I have seen it.

The Convener: I thank the cabinet secretary for her attendance at this long meeting.

Meeting closed at 12:12.

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