The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 8 November 2011

Session 4

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HEALTH AND SPORT COMMITTEE
10th Meeting 2011, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Jim Eadie (Edinburgh Southern) (SNP)
*Mary Fee (West Scotland) (Lab)
*Richard Lyle (Central Scotland) (SNP)
*Fiona McLeod (Strathkelvin and Bearsden) (SNP)
Gil Paterson (Clydebank and Milngavie) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Derek Feeley (Scottish Government)
John Matheson (Scottish Government)
Dennis Robertson (Aberdeenshire West) (SNP) (Committee Substitute)
Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy)
Dr Andrew Walker (Adviser)

CLERK TO THE COMMITTEE

Rodger Evans
Douglas Wands

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Tuesday 8 November 2011

[The Convener *opened the meeting at 09:33*]

Interests

The Convener (Duncan McNeil): Good morning and welcome to the 10th meeting this session of the Scottish Parliament's Health and Sport Committee. As usual, I remind committee members and members of the public to turn off all mobile phones and BlackBerrys. We have received apologies from Gil Paterson, who is unable to attend and is being substituted by Dennis Robertson.

I ask Mr Robertson whether he has any relevant interests to declare.

Dennis Robertson (Aberdeenshire West) (SNP): Yes, convener. Prior to the election in May, I was a client services manager in social care. Indeed, I have 30 years' experience of working in social care, predominantly in the joint futures crossover between health and social work.

The Convener: Thank you. I take the opportunity to invite everyone at the table, including our clerks, to introduce themselves. The man with the big loud voice is Duncan McNeil, the committee convener.

Rodger Evans (Clerk): I am one of the committee clerks.

Douglas Wands (Clerk): I, too, am a committee clerk.

Mary Fee (West Scotland) (Lab): I am Mary Fee MSP.

Mary Scanlon (Highlands and Islands) (Con): I am Mary Scanlon MSP.

Richard Lyle (Central Scotland) (SNP): I am Richard Lyle MSP.

Derek Feeley (Scottish Government): I am Derek Feeley, director general, health and social care.

The Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon): I am Nicola Sturgeon, Cabinet Secretary for Health, Wellbeing and Cities Strategy.

John Matheson (Scottish Government): I am John Matheson, director of health finance.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I am Fiona McLeod MSP.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am Richard Simpson MSP.

Jim Eadie (Edinburgh Southern) (SNP): I am Jim Eadie MSP.

Dennis Robertson: Good morning. I am Dennis Robertson MSP.

Bob Doris (Glasgow) (SNP): I am Bob Doris MSP.

Dr Andrew Walker (Adviser): I am Andrew Walker, committee adviser.

The Convener: I thank everyone for that.

Subordinate Legislation

Scotland Act 1998 (Agency Arrangements) (Specification) Order 2011 (SI 2011/2439)

09:35

The Convener: The second item on our agenda is consideration of a statutory instrument. As the Subordinate Legislation Committee has made no comment on this order and as members have raised no issues with it, does the committee agree that it does not wish to make any recommendation to Parliament on it?

Members *indicated agreement.*

Draft Budget 2012-13 and Spending Review 2011

09:36

The Convener: Agenda item 3 is scrutiny of the 2012-13 draft budget and the 2011 spending review. I welcome to the meeting Nicola Sturgeon, Cabinet Secretary for Health, Wellbeing and Cities Strategy; Derek Feeley, director general, health and social care, and chief executive of NHS Scotland; and John Matheson, director of health finance and information at the Scottish Government.

I invite the cabinet secretary to make some brief opening remarks.

Nicola Sturgeon: Thank you, convener. I welcome this opportunity to discuss the budget. We live in a time of severe financial constraints. Nevertheless, the Government strongly recognises the importance of the national health service and our budget decisions protect NHS spending by allocating more than £1 billion extra to the health revenue budget in Scotland over four years. That fully meets our commitment to pass on to the NHS in Scotland the full benefit of the Barnett resource consequentials arising from the United Kingdom health settlement. As a result of that commitment and at a time of real-terms reductions in the Scottish Government's overall budget, our territorial health boards' core budgets for delivering point-of-care healthcare services have been protected in real terms for each of the next three years.

However, as a result of UK Government decisions, the capital budgets available to the Scottish Government will fall by around 36 per cent in real terms by 2014-15 compared with 2010-11, and that move will obviously have an impact on the health capital budget. However, key projects such as the new south Glasgow hospital have been secured and the Scottish Government is delivering a number of initiatives to ensure that the total available capital resources are utilised as effectively as possible.

As I said, the health budget has received the full health revenue Barnett consequentials over the spending review period. In 2012-13, that amounts to £249 million; in 2013-14, £293 million; and, in 2014-15, £284 million, lifting the resource budget to more than £11 billion in 2012-13 and, in 2014-15, to a record £11.6 billion. In 2012-13, the overall health budget will be increased by £214 million to £11.6 billion, £8.8 billion of which will be the core allocation for territorial and special health boards. Over the next three years, the funding for territorial boards will increase by 2.9 per cent, 3.3 per cent and 3.1 per cent. As I said earlier, we

have protected territorial health board budgets in real terms. To improve efficiency and to further support front-line services, we have again set a differential efficiency target for special board services that do not deliver direct patient care.

There will remain an on-going focus on delivering efficiency savings and increasing productivity, building on past success in doing so. Of course, it is important to stress that all efficiency savings that NHS boards make are retained by them for reinvestment in front-line services.

Our priority for the budget is to continue to address the significant health inequalities that exist in Scotland. We will extend a programme of inequalities-targeted, high-risk primary prevention to all NHS boards' activities from 2012-13. We are investing £30 million in and establishing new approaches to detecting cancer early. We are determined to continue to implement the healthcare quality strategy in partnership with other stakeholders. We will work in partnership across health and care services to deliver world-leading healthcare services. To help deliver that goal, we have invested a further £10 million in the change fund so that it will amount to £80 million in 2012-13 for NHS boards and partner local authorities to invest to redesign services for older people.

As I said earlier, capital budgets have been hit significantly, but nevertheless the decisions that we have taken allow us to maintain a high level of investment in NHS infrastructure. Contracts have been signed and construction has started on major developments, such as the new south Glasgow hospital, the Royal Victoria hospital replacement in Edinburgh and the new emergency care centre in Aberdeen.

In addition to the core capital budget, the delivery of a £750 million pipeline of projects through the non-profit distributing model and the hub initiative will allow key projects to be developed and delivered across the spending review period and beyond. Expenditure plans for sport and Commonwealth games delivery remain a key priority. The Government is working in partnership with Glasgow City Council, Commonwealth Games Scotland and the 2014 organising committee to ensure that the games are the outstanding success that we all want them to be.

So, in short, despite the biggest reduction in public spending imposed on Scotland by any UK Government, this Government is committed to delivering on health. We have passed on in full the Barnett consequentials to health, delivering an extra £1 billion over the period 2011-12 to 2014-15, and we are taking steps to maximise our capital budget with over £2 billion of capital investment through traditional capital, NPD projects and hub funding, and a transfer from resource funding to capital funding. Improving our health and improving our health service are top priorities for the Government, and I believe that they are reflected in this draft budget.

The Convener: Thank you very much, cabinet secretary. We go to Mary Scanlon for our first question.

Mary Scanlon: Over the past four years we have had efficiency savings for health boards—in fact, many health boards exceeded the targets that were set. Cabinet secretary, you said that boards are retaining and reinvesting that money. In my opinion, the efficiency savings brought discipline to the financial management of health boards. Therefore, it comes as a bit of a surprise to find that there are no efficiency savings targets this year. Will that discipline now be removed? There are no health improvement, efficiency, access and treatment targets, either, beyond this year. It is the efficiency savings—which I have found highly impressive—and the HEAT targets that have allowed this committee to examine the spending and priorities of local health boards. Why did you decide that there would be no efficiency savings this year and, indeed, no HEAT targets for efficiencies?

09:45

Nicola Sturgeon: I thank Mary Scanlon for that question. She is right to say that there is no centrally determined efficiency savings target for 2012-13 and beyond—in the current financial year, that target was set at 3 per cent. However, I stress that that is not to say that health boards will not require to deliver efficiency savings. As I said, efficiency savings will be retained locally for reinvestment. I give Mary Scanlon the absolute assurance that the discipline that has been required of health boards will continue to be required.

I say openly that, for 2012-13, I expect health boards to deliver efficiency savings in the region of 2.5 to 3 per cent. Beyond that year, the figures to an extent will depend on pressures that emerge and that currently are not known precisely. For example, we do not know the extent to which pay will be a pressure on budgets when we come out of the period of pay freeze. However, there will be an on-going requirement on health boards to deliver efficiency savings in order to balance the books and to deliver good financial management.

A final point, which is important and which applies regardless of whether there is a centrally set target, is that the overarching responsibility on health boards, beyond meeting particular yearly targets for efficiency savings, is to be as efficient

in the delivery of healthcare services as possible. That is an on-going requirement, and my officials and I will scrutinise carefully health boards' performance against it. We will ensure that the committee has any information that it needs to perform that scrutiny role, too.

Mary Scanlon: You expect efficiency savings of 2.5 to 3 per cent, which is not unreasonable and which are similar to the efficiency savings over the past four years. Why, when those savings were explicit, are there suddenly no explicit efficiency targets this year? I do not understand the difference. If you expect those savings, why do you not just say publicly what you expect and what you want the boards to deliver? In previous years, we have had lists of the efficiency savings in many health boards, which was helpful to the committee's scrutiny. If you expect those savings, why is that not explicit?

Nicola Sturgeon: I thought that I had just made it explicit in a very public forum. The central Government position is as I have stated, and it reflects the past experience of performance against efficiency savings targets, as well as the differential positions that parts of the public sector will be in and what different parts of the public sector will do to ensure that they continue to be efficient.

I have made clear my general expectation for the health service for 2012-13. Next year's draft HEAT targets are explicit about NHS boards having to continue to operate within their agreed revenue resource limit and capital resource limit and to meet their cash requirement. That necessitates continued discipline and a focus on efficiency savings in order to meet those explicit financial targets.

I repeat that although principally and in the immediate sense efficiency savings must be made to allow that good financial management, the obligation remains on health boards to deliver healthcare services efficiently in the interests of good patient care—let alone good financial management—and we will continue to scrutinise health boards carefully on that.

Mary Scanlon: This year, there is an emphasis on preventative spending. Will you set any HEAT targets—

Dr Simpson: I am sorry to interrupt, convener, but can we ask supplementary questions on efficiency before we move on to a new issue?

The Convener: Given that Mary Scanlon opened up the issue, it might be useful to take supplementary questions on the theme, if the cabinet secretary is happy with that. Obviously, the committee must be careful to use its time effectively.

Dr Simpson: I have a brief question on efficiency savings. I understand exactly where you are coming from, cabinet secretary, but will you drive from the centre a reduction in variation as part of the efficiency programme? For example, dermatology services are under huge pressure because of increased referral rates, but NHS Lanarkshire and NHS Forth Valley have excellent programmes that have reduced the time from referral to out-patient consultant appointment by huge amounts. Optometry is another example—I know that the Government has funded developments on that. Will you require health boards to ensure that good programmes such as those are rolled out as part of the efficiency programme, and how will you do that?

Nicola Sturgeon: The short answer to that is yes. The efficiency and productivity programme, which I know that you will be familiar with, which gives overarching guidance to health boards on what they should be looking at in order to drive efficiency savings, is very explicit about the need to drive out waste variation in the delivery of services. We will monitor that directly from the centre.

The elimination of variation is an implicit part of the patient safety programme and the quality strategy. It is about efficiency being driven by quality considerations and motivations.

Dr Simpson: Will you publish some stuff on that to indicate the progress being made in areas in which you want to make it?

Nicola Sturgeon: Yes, and I am happy to provide the committee with whatever information it wants on that.

Dennis Robertson: My question is also on efficiencies. I know that you are looking into partnership working in relation to social care and health. What are your targets for releasing beds within the NHS by removing bedblocking and working with community occupational therapists, for instance, in social care? Do you see that happening right across the board?

Nicola Sturgeon: I will answer that question in its component parts. On delayed discharge, we currently have a target of having no discharges delayed beyond six weeks. By and large we have been meeting the zero standard on that, although I openly acknowledge that partnerships in particular parts of the country have had more difficulty than others in meeting it. I recently set out a very clear direction of travel on that target, which is about reducing the six weeks to four weeks and, ultimately, to two weeks. I also signalled a change of culture and outlook on that. Whether the target is six weeks, four weeks or two weeks, that is very much seen as a maximum. We encourage local partnerships to look at and reduce—I do not

particularly like this terminology, but I will use it for want of a better term at the moment—numbers of bed days lost overall to delayed discharges. The reason that I do not like that terminology is that it makes it seem as if the drive to reduce delayed discharges is all about efficiency in the health service, when it is actually about improving people's quality of life. That is the direction of travel on delayed discharges.

More generally, we want to ensure a continued shift from acute care to community care. As we have discussed in this committee and in the chamber on many occasions, that involves a reduction in acute beds. It is a shift in thinking for all politicians to see that, as long as it is done appropriately and with the correct investment and expansion of community services, reducing the number of acute beds is a good thing.

Obviously we are working towards better integration of health and social care and better integration of budget governance and accountability to gear up the health service and local authorities to deliver better the changes in practice that will allow that shift in care to happen.

The Convener: The broader issue of efficiencies was discussed last week and generated some excitement about whether all we are left with is some efficiencies shifting from the acute sector into the community; the whole question of configuration; and whether health boards will be free, as the British Medical Association called for last week, to make closures appropriately and when it is justified without getting us politicians overexcited. You have had to intervene in the past. Are you stepping back from that? Will health boards in the broader sense be allowed to pursue their efficiency agenda without collective political interference? Will they get that freedom back again?

Nicola Sturgeon: I do not accept that health boards are subject to political interference for its own sake. I suspect that colleagues around the table would agree with that. In the health service, we have in place fairly sound, fairly robust and fairly well used processes for when a health board wants to change service provision. Different processes are applied, depending on the scale of the change that is proposed. In cases of major service change, there is consultation, an independent scrutiny panel—which some people round the table have experience of—is sometimes set up and, ultimately, ministerial approval is or is not given, as the case may be. I will continue to apply those processes in a way that I consider is appropriate. I do not think that it would be right to issue a blanket edict that said, "Health boards cannot change services—end of story," or one that said that health boards have a free hand to do whatever they like. All proposals for service change must be judged on their merits according to the circumstances.

When I, as health secretary, look at a proposed service change to determine whether it should get my approval, what I consider more than anything is whether it will enhance the quality of the service that is being provided—will it make that service better or more convenient for patients, or more accessible to them? That must continue to be the process that is applied, but in the health service change is inevitable; it is a good thing. We all recognise that we still admit too many people to hospital who could better be treated in the community. If we are to get that right, that implies a shift away from the acute sector into the community, which will involve difficult decisions for us all—for me, as health secretary, and for you, as local MSPs. We must develop the ability to take those decisions on their merits and we must be prepared, on occasion, to take decisions that might be controversial.

The Convener: I understand and accept that what we do with the budget is more important than its size—I think that it was John McLaren who made that point—but we have taken evidence, so we recognise also that we have health inflation, an ageing population, increasing demand, a no compulsory redundancy assurance and a pay freeze, although we do not know for how long that can be sustained. Something has got to give. It will be the older buildings, will it not? Health boards will have to make the best of the situation, as well as aiming to improve people's experience of the health service and maintain quality, but given that there are constraints in all the other areas, will that not lead to a reconfiguration of how services are provided?

Nicola Sturgeon: I do not accept the big-bang analysis that there is a sudden need to up-end the health service. I do not believe that that is the situation that we are in. Money is tight—we will no doubt get into more of the detail of that later—and I have made it and will continue to make it clear that health boards need to manage that with an eye firmly on quality of care, which will involve stiff challenges. Improving efficiency and quality of care means continuing to improve services in the community, reducing the length of hospital stays, reducing the number of inappropriate admissions and ensuring that people do not stay in hospital for longer than possible.

I visited the new Forth Valley royal hospital in Larbert yesterday and saw in action its clinical assessment, acute assessment and short-stay approaches, which are about getting patients through the whole patient pathway in hospital as quickly, efficiently and appropriately as possible. Those are the kind of high-quality efficiency changes that I want to see, so I do not accept that

the process is all about going on a massive rush to shut hospitals. Yes, there will be changes over the course of time in the current configuration of our hospitals. That has always been and always will be the case but, as Richard Simpson's question brought out, a lot can be done to reduce waste and variation and to get patient pathways properly configured so that health boards can deal with the financial challenges in a way that prioritises quality, which is what I want to focus all health boards on.

The Convener: So neither you nor your officials have had any discussions with health boards about possible reconfiguration of services or closure of hospitals.

10:00

Nicola Sturgeon: As Duncan McNeil probably appreciates, it does not happen in that way. On an on-going basis, health boards will look at the configuration of services that they provide. For example, in Greater Glasgow and Clyde NHS Board just now there is a proposal about Lightburn hospital—I have not yet made a decision on it, so I will not say too much about it—and there are some proposals on changes to the Royal Alexandra hospital that have not yet got to the point of a decision. That is only in NHS Greater Glasgow and Clyde. NHS Grampian has also been looking at the configuration of its maternity services.

Those are things that health boards do on an on-going basis and they are right to do so. Decisions about where services go must be made on a sound basis and each issue must be decided on its merits.

Richard Lyle: My questions are on the same theme as Mary Scanlon's. First, is it the case that the Scottish Government plans no longer to publish efficiency outturn reports? Secondly, we always read in the papers that the NHS has too many managers and that they are being paid too many bonuses. What is your view on what is currently available in the Scottish NHS?

Nicola Sturgeon: The health directorates will continue to publish efficiency outturn reports that will be available for scrutiny by the committee. It is important that that information is available.

About a year ago I set a target to reduce the number of senior managers in the health service by 25 per cent by the end of the parliamentary session. Figures for the first year's delivery of that target, which were published a couple of months ago, show that we are on track to do that.

We have had a pay freeze. There has been particular focus on pay restraint among those on higher levels of pay and we have tried to protect those at lower levels. The group that has not had a pay freeze are those earning under £21,000. I have also taken action, over the past two or three years, to constrain the cost of consultant distinction awards. For the first time, that budget is due to decline next year rather than rise, because of the steps that we have taken.

We will continue to take appropriate measures to ensure that the NHS is appropriately managed by people who are qualified, skilled and able to do that job. The NHS is a large, complex organisation so it needs to be well managed, but we must ensure that management costs are proportionate and that we direct as much of the budget as possible towards point-of-care services. That is what everything in our budget is geared towards.

Richard Lyle: Can you remind me of the budget for consultant awards this year?

Nicola Sturgeon: I think that this year it is £26 million—

Dr Simpson: It is £24 million.

Nicola Sturgeon: It goes down to £24 million next year. Beyond that, we have kept the figure at £24 million for the remaining two years of the spending review but, as you know, there has been a recent review of distinction awards by the review body on doctors and dentists remuneration. The outcome of that review and decisions that ministers take will influence that budget for future years.

Dr Simpson: On pay, convener.

The Convener: Richard Simpson has devised a cunning trick to get in on every question. I am not falling for it.

Dr Simpson: It is not a cunning trick.

The Convener: We were on efficiencies. We had a bid earlier from Jim Eadie to pick up on the cabinet secretary's comments on change funds.

Jim Eadie: The draft budget includes change funds for older people's services and for early years. Can you clarify whether the figure of £80 million that you mentioned in your opening remarks applies to only the older people's services change fund or to both change funds?

Nicola Sturgeon: That figure is for the older people's services change fund.

Jim Eadie: Do you have a figure for the early years change fund?

Nicola Sturgeon: The Government has centrally set aside £50 million in the budget over three years, but the health service will also be expected, through the work that it already does on various early years initiatives, to contribute to that fund. I will get you the precise figures in a couple

of seconds, if you want to go on to your next question in the meantime.

Jim Eadie: That would be helpful.

Nicola Sturgeon: I will get you the figures.

Jim Eadie: Sure—that is no problem.

Like committee members, you are probably aware of the interest that the third sector has shown in the change funds, particularly given the potential and the opportunity to leverage in additional moneys and to bring about the shift from acute services to care in the community, to which you referred. Will you provide a little more of the Government's thinking on the change funds' role in bringing about those changes?

Nicola Sturgeon: The role of—after starting this sentence, I realised that it would sound a bit trite. The role of the older people's services change fund is explicitly to deliver change in how older people's services are provided. I am clear that that means that the fund should not simply replace existing spend or result in additional spend that does not deliver change—at the end of the period, we should not have all the traditional spend plus additional spend, yet not have changed services.

We have a close overview of how the change fund is operating. The Government is scrutinising all the local partnership plans. Local outcomes to drive the spend are being agreed in partnership. The change fund is not an end in itself—it is the bridge into the more integrated health and social care environment that we intend to reach. In that environment, we intend to have national outcomes that will drive not just change fund spend but the totality of the health and social care spend on older people's services.

You mentioned the voluntary sector. We have been explicit about that sector's role in determining the change fund's use. The more closely involved that sector is, the more productively the money will be used.

In the change fund, 20 per cent is set aside for providing services that support carers. I know that the committee has a lot of interest in carers' contribution. If we do not support our carers properly, they will be unable to perform their role. That is an important earmark in the change fund.

Jim Eadie: I was interested in what you said about evaluating the older people's services change fund. I suspect that the question of how the funds will work on the ground is best directed at health boards, but can you tell us more about how the health directorates will oversee the funds' operation and evaluate their success, to ensure that we achieve the outcomes that you have talked about and make progress towards the objective of bringing about the shift, to which the change funds are important?

Nicola Sturgeon: The early years and early intervention change fund is at an earlier stage of development than the older people's services change fund. Governance, accountability and performance management in relation to the early years change fund are still being developed. Angela Constance, the Minister for Children and Young People, will have direct oversight of that fund. The health directorates will feed into that with the data that is required for monitoring.

The experience and learning from the older people's services change fund give us a lot to build on in later change funds. As I said, the health directorates scrutinise plans in detail. The plans come from local partnerships, so it is right for ownership of them and responsibility for delivering them to lie locally. However, we have taken a direct scrutiny role to ensure that the proposed spend does not just replace existing spend and that it has the potential to deliver the change that is the objective. We will look carefully at plans' ability to deliver agreed local outcomes. That will feed into the wider work on health and social care integration and on setting national outcomes.

We have close oversight of the change fund. That is correct, because the fund is a key route to the shift in the balance of care and the redesign of older people's services that are crucial if we are to be well placed to deal with the rising number of older people that we are projected to have over future years.

Jim Eadie: Will your department issue guidance to local authorities, health boards and the local partnerships that you mentioned?

Nicola Sturgeon: We already issue guidance on the older people's services change fund. The guidance for 2012-13 is either about to go or has just gone to local partnerships. There was guidance last year and there is guidance this year. As I said, the early years change fund is at an earlier stage of development, but I expect that a similar model will be followed for it.

Jim Eadie: What is being done to ensure that the third sector is actively involved in the design of the change fund priorities, not just the delivery?

Nicola Sturgeon: The guidance on and the design of the older people's services change fund builds in the role of the voluntary sector from day 1. Obviously, we keep a close eye on how that is working in practice in local partnerships. I am conscious of the fact that it is the easiest thing in the world for me, as Cabinet Secretary for Health, Wellbeing and Cities Strategy, to say that the voluntary sector should be involved in something like this, but we need to ensure that it actually happens on the ground. The 20 per cent that has been set aside for carers will help with that.

Jim Eadie: My point is that the change fund is not something that should be done to the voluntary sector but something that it should be actively involved in designing.

Nicola Sturgeon: That is the point that I am making, too. The change fund was set up by the Government, but the use of the change fund depends on local discussions, in partnership principally with the health service and local authorities. We are striving to ensure that the voluntary sector is integrally involved at the early stage of deciding how the change fund money should be used, what the commissioning strategies are and what plans are put in place for the use of the change fund.

Jim Eadie: That is helpful, thank you.

The Convener: Bob Doris will develop the points around preventative spend, but there are a couple of general questions—

Nicola Sturgeon: I am sorry convener, but I promised that I would give Jim Eadie some information when I dug it out of my briefing folder, and I now have some rough figures. The health service contribution to the early years fund will go from £35 million to £38 million and then to £41 million. That is money that will be spent right now by the health service on a variety of approaches to improving early years services. By channelling it through the change fund, we intend to ensure that it is used more strategically, as part of an overall resource.

The Convener: I have some general questions on the change funds and the £500 million that is available over the spending review period.

Does the £80 million that you mentioned in your announcement today increase the £500 million?

Nicola Sturgeon: I suspect that I will confuse everyone if I try to break down the £500 million just now, so we will provide you with the details later. The £500 million is the totality of money between the three change funds over the spending review period. The older people's services change fund, in this financial year, is £70 million. Next year it will go to £80 million. The year after that, it will also be £80 million. The following year—the third year of the spending review—it will be £70 million. All of that is part of the £500 million.

The Convener: So the £500 million that was announced has not changed. Over the spending review period, the £500 million has not increased.

Nicola Sturgeon: The older people's services change fund is part of that £500 million. There are three change funds. The £500 million is made up of the older people's services change fund, the early years change fund and the reducing reoffending change fund.

The Convener: Why did you set the amount at £500 million? Has it been estimated what benefits will be gained from that investment?

Nicola Sturgeon: Just in case there is a slight confusion, I point out that the £500 million is not a health figure, it is a cross-Government figure. Not all of that money comes from health and not all of it goes on things that are specific to health. The two change funds that are most relevant to this committee's remit are the ones that we have been talking about: the early years change fund and the older people's services change fund. That £500 million is a result of a decision that was taken across the Government.

The Government recognises that we need to do much more in terms of prevention. That £500 million is not the totality of our preventative spending. In the health budget, for some considerable time, we have spent a significant amount of resource on what would be considered to be preventative measures, such as the keep well programme, smoking cessation, alcohol brief interventions and healthy weight strategies.

10:15

The £500 million is intended to up our game by setting a clear direction for shifting more of our spend into prevention rather than reaction. The benefits of that will vary, and will be measured differently across the three change funds. For example, we will measure the benefits from the older people's services change fund by looking at whether we reduce delayed discharges and unnecessary hospital admissions, and whether we increase the proportion of older people who spend the last six months of their lives at home rather than in an institutional setting. Those types of measurements will be set for each of the change funds so that we can measure the impact of that spend over time.

The Convener: I do not underestimate your capabilities in working with your Cabinet colleagues, but I presume that if you are getting a slice of their budget, there will have to be an argument. We heard about that from John McLaren's account of his debate with the UK Government. When you ask for a slice of someone's budget, they ask what is in it for them and what savings they will get.

When the figure of £500 million was debated with the other cabinet secretaries in the Scottish Government, was there a calculation of what benefit there would be for their departments and portfolios in five, 10 or 15 years' time? Or was the figure just plucked out of the air?

Nicola Sturgeon: I think that there is a slight confusion. The £500 million does not come from

other people contributing to the health budget; it is not just me getting a slice—

The Convener: It is the health and social care budget, which we are heading towards anyway. It is £500 million of Government money—

Nicola Sturgeon: But that is not what it is for. Part of that £500 million is the reducing reoffending change fund. Elements of it come from and will benefit the health budget over a period of time, but I make it clear that we are not taking £500 million out of other people's budgets and putting it into the health budget. I wish that that was the case, but it is not quite like that.

The Convener: It is money shifting.

Nicola Sturgeon: It is money across, for example—

The Convener: For the purposes of my question, let us forget about the social justice agenda. There is a smaller budget that will directly impact on health. What is that number if it is not £500 million?

Nicola Sturgeon: It covers the change funds for older people and early years, but much of the money is already health money that is now being spent in a more preventative way. I take your point—you are asking me what the benefit of it is.

The Convener: It is the benefit—

Nicola Sturgeon: At this stage, I do not think that we can quantify in pounds and pence exactly what the benefit will be, although we intend to do that over a period of time.

On the older people's services change fund, for example, we face rising demand from the ageing population that we need to constrain. It is not necessarily about saving money, but about reducing the rate at which the pressure on the health service increases. We do that by getting more people treated and cared for in their own homes in the community through preventative and anticipatory care measures, as opposed to a situation in which hospital admissions continue to increase as a result of that rising population.

The Convener: So we are slowing down the production line rather than reorganising the production.

Nicola Sturgeon: That is a comment about the older people's services change fund. The early years change fund is much more about fundamentally changing the nature of demand over a period of time. If we can deal with problems at a much earlier stage of a child's life, we will reduce the burden—if that is not a horrible word to use—not only on the health service but on the criminal justice system, social care services and the education system in later years.

The Convener: But there are no estimates about what we would save in that process.

Nicola Sturgeon: We are not saying, "Here's £500 million" and—

The Convener: It is not £500 million that is going into children's services. How much is going into the children's change fund?

Nicola Sturgeon: It is £50 million from Government, plus the health service figures that I gave earlier.

The Convener: Apart from improving the quality of those children's lives, what is the estimated saving for Government five, 10 or 15 years down the line?

Nicola Sturgeon: I am not in a position just now to quantify that in pounds and pence, for two reasons. First, we need to get the change happening in order to allow that type of quantification to happen. Secondly, it is not the case that we will go so far and no further. That is a general point; it does not matter whether we are talking about the £500 million or the individual change funds.

The £500 million and its component parts are very much seen as the first stage of a greater shift to prevention. We want that shift of resources into prevention to increase in future years. The more we spend on prevention, the more we will save across the entire range of Government services in 10, 20, 30, 40 and 50 years' time.

The Convener: We will come to prevention, but what is it? What are we investing in? Is it truly preventative work or is it just managing demand?

Nicola Sturgeon: I do not think that it is either/or. We need to do all of that. Primary prevention is encouraging younger people to be healthier, eat healthier and live a more active life. Our detect cancer early initiative also has a preventative element. It is not preventing people from getting the disease, but it is detecting it earlier so that they can take action to improve their chances of survival. Prevention is a general term that covers an entire range of health and other interventions.

Mary Fee: Cabinet secretary, you talked about the role of the third sector in the change fund. If the third sector is to be an integral part of the change fund, is that a way of balancing the delivery of care and giving the voluntary or third sector a more proactive part in delivery?

Nicola Sturgeon: That is an important question and I do not want to simplify it, but the short answer is yes. There is a bigger role for the voluntary and third sector, particularly around social care and community care delivery and I do not think that we have always fulfilled that

potential. The methodology of the use of the change fund is definitely intended to redress that balance and bring the voluntary sector, and the third sector generally, further into the discussions around how we deliver care and their role in that.

Mary Fee: Would you expect a certain percentage of care to be delivered by the third sector?

Nicola Sturgeon: No, I would not put a particular percentage on it. In any given circumstance or situation, we need to look at who is best placed to deliver a service; sometimes it will be the statutory sector—either the NHS or a local authority—but it will often be the voluntary sector, perhaps in partnership with one of the statutory agencies. That is the way to look at it. I would not put a percentage on it, but I think that the voluntary sector has a bigger role to play than it has had previously. The only percentage that we have set around the change fund is the one that I mentioned to Jim Eadie, which is that 20 per cent of the change fund will go on services to support carers.

Mary Fee: You said that the early years and early intervention change fund was still in development. At what stage will more information on that be available to the committee?

Nicola Sturgeon: We will provide as much information as we can as quickly as possible. As I said earlier, Angela Constance will have ministerial oversight of that change fund, although as health secretary I and my department will be very closely involved in it. It will draw closely on the experience so far of how the change fund for older people is administered, but we will certainly undertake to ensure that the committee gets as much information on it as quickly as possible and certainly before the start of the financial year, when that change fund comes into operation.

Bob Doris: I suspect that the convener slid towards preventative spending in a chunk of his questioning, but I will develop the matter.

I understand the challenges in quantifying the cash-releasing benefits of preventative spend, because there must be data and evidence that the health outcomes are starting to work for the people whom you want to impact on before you can then reconfigure or downscale certain provisions.

I will develop the issue of the quality health outcomes of preventative spend. For many years, the tone of Harry Burns, the chief medical officer, was that we had to be patient because outcomes could be five or 10 years down the line. However, in more recent years he has talked about achieving results as the clock is ticking and we go through some of the preventative spend measures.

For example, he mentioned family-nurse partnerships and directed our attention to factors such as the birth weight of children that could be helped by positive intervention through preventative spending. He also suggested that, if the situation were monitored quickly enough, we would see a fairly quick turnaround in infant mortality levels.

Harry Burns did not mention this but, a few years down the line, we could monitor referrals to children's panels to find out the impact of positive early intervention and, as far as older citizens are concerned, we could look at the number of people presenting to accident and emergency departments with chest pains and heart problems to see the impact of preventative spending interventions in the community. What thought have you given to collecting data—and, indeed, to deciding on which data you want to collect? After all, unless you decide on the data that you need to monitor positive health outcomes, you will never be sure what you are analysing. Any information that you might have in that respect would benefit the committee.

Nicola Sturgeon: You are absolutely spot on. As I said earlier, the early years fund is still in development and part of that work is very much about the outcomes that will drive it. The issue raised in your extremely valid point about family-nurse partnerships has been built into the evaluation of the pilot and, again, forms part of our work on the matter. We can provide the committee with more detail on how the family-nurse partnership programme will be evaluated and how decisions on roll-out will be made.

With regard to older people's services and the older people's services change fund, I referred earlier to some of the local outcomes that will have been agreed to inform spend in the programme's first year. As we move towards a nationally integrated system, we are looking to set very clear outcomes that will not need five, 10 or 20 years to be measured. Instead, they will focus on, for example, delayed discharges, reducing hospital admissions and increasing the number of people who get to spend the last period of their lives in their own homes. Those are quick things that can be measured. In the fullness of time and as we develop these programmes, I will be happy to give the committee real-time information about all this. We will have short-term and medium-term objectives for all this preventative spending. Obviously, certain impacts will take a lot longer to manifest themselves but, that said, it is only right to have clear outcomes for all the different timeframes.

Bob Doris: How will the £500 million funding for preventative spending filter down through health boards? How will you drive change? We know that

boards will be required to agree outcomes with local authorities and the voluntary sector before they will be allowed to spend the money, but what role will the Scottish Government play in driving through change in this area?

Nicola Sturgeon: The best way of answering that question is with reference to the change funds. Only one of three change funds—the older people's services change fund—is operating and, although the other two funds deal with different issues and therefore might not be identical, I expect them to draw quite heavily on that experience. As I said to Jim Eadie, we are scrutinising all the local plans to judge whether they are genuinely changing service delivery and whether those changes are capable of meeting the locally set outcome measures. That approach will allow us to monitor whether the outcomes have been delivered not only in any given year when spend is agreed, but over a period of time and I expect the same approach to be taken to the other change funds.

Bob Doris: I asked about Government influence because you said in your opening remarks that you wanted to tackle health inequalities. Given that preventative spending is core to that aim, how will you ensure that health boards target those resources in the areas of greatest deprivation such as Calton, Possilpark and Springburn in Glasgow? As you are also responsible for cities, are you expecting to see more preventative spending in the most deprived parts of Scotland where health inequalities are greatest?

Nicola Sturgeon: Particularly with early years, you would expect a focus on those kinds of areas. After all, that is where you are going to have the biggest impact on inequalities.

We have talked about where the £500 million has come from, where it is going and so on. Although it represents a definite statement from the Scottish Government about upping our game on prevention, it is not the sum total of our work in this area. For example, the health service's keep well programme, which was introduced by the previous Government, was continued by this Government and is about to be mainstreamed, is deliberately targeted at areas of greatest deprivation where the risk of cardiovascular disease is known to be higher.

That is preventative spend in action. It is not encapsulated within the £500 million, but it is preventative spend and there are many other examples of preventative approaches in the health service.

10:30

Bob Doris: I have a final, very short question about when health boards work in conjunction with their partners in the voluntary sector, local authorities and other agencies. Is it the case that, when I speak to Greater Glasgow and Clyde NHS Board and ask where they have prioritised their share of the £500 million, I should be expecting that to be top-heavy in the most deprived areas of the health board, or they will not be doing their job properly?

Nicola Sturgeon: Remember that the £500 million is not one big fund; it is three different change funds. The general answer to your question is, yes; you should be able to see a link between that spend and tackling inequalities. However, if you take the older people's services change fund, for example, there will not be the same relationship—not that there will be no relationship, but there will not necessarily be the same relationship—between areas of deprivation and an older person being inappropriately admitted to hospital as there would be between deprivation and a younger person not having the best life chances. I advise a bit of discretion about the different components of that £500 million and I also advise the committee to keep a very open mind to the fact that there are other examples of preventative spend outwith those three change funds that make up the £500 million.

Bob Doris: What about the early years fund, specifically in terms of preventative spend in deprived areas?

Nicola Sturgeon: Again, if Harry Burns were sitting here he would be saying that, in terms of prevention, we will have the biggest impact in the investment that we make in the early years.

The Convener: There are issues—Bob Doris touched on them—about the local government budget being set against the health budget, who owns the budgets and so on. Earlier, someone referred to the concern that local government and the health boards already have substantial influence. I am sure that you are aware of such issues, but is the Scottish Government exercising oversight in ensuring that the budgets are being used effectively?

Nicola Sturgeon: What budgets are you talking about?

The Convener: I am talking about the local government budget, and people around a table talking about projects such as living well and whether they will invest in them. The local authority has to contribute something from its budget and the local health board has to contribute something from its budget, and there have been barriers to that. Are the barriers lower now?

Nicola Sturgeon: I think that they are lower, but they are still there. I will confine my answer to older people's or adult services. One key driver

behind our integration agenda is the need to get away from the situation in which the different agencies jealously guard their own budgets. For example, an older person in hospital is the health service's budgetary responsibility, but if they are in a community setting, where often they should be, that is the local authority's responsibility. Local government and the health service often try to pass the buck between themselves. I want us to reach a system for older people's services, certainly in the immediate term, where the money that goes into that budget loses its identity as health money or local authority money. The point is that it is money to look after older people. That should be the driving factor in how that money is spent.

The Convener: I think that lots of us agree with that, but we still see the barriers.

Nicola Sturgeon: Getting rid of them is the challenge.

The Convener: Last week, we had evidence from the Royal College of Nursing, the British Medical Association and Unison, which are very interested in the integration agenda. I believe that they are in discussions about whether integration as it is currently planned will cause upheaval and internal problems and take our focus away from delivery. Is the Scottish Government intent on pushing ahead with that agenda? Is there anything that we can do short of integration to reduce some of the ensnarement problems?

Nicola Sturgeon: We are intent on solving some of the problems you have just outlined—perennial problems that have dogged this debate for a very long time and which have led to older people not getting the best care that they can get.

I want to solve those problems. We are taking time and having good consultation with a range of groups, including the RCN and social work directors, because we want to come up with a way of doing this work that minimises upheaval, as people describe it. It is not about structural change for its own sake; it is about what we are trying to achieve.

I have mentioned national outcomes a few times. I want our approach to be outcome driven. We must consider what we are trying to achieve for older people and then work back from that, to identify the changes that we need to make to enable that to happen, in a way that minimises structural change. I hope that before the end of this year we will come to the Parliament with our thinking on exactly how we want to take the approach forward. I am not interested in structural change that diverts people's attention over the next few years if I can avoid it.

The Convener: Richard Simpson has a question.

Dr Simpson: Convener, the cabinet secretary has opened up the area of integration, which I was not intending to ask about. Do you want to bring in another member to pursue the issue?

The Convener: I am giving you the opportunity to ask a question.

Dr Simpson: I have one or two technical questions, cabinet secretary. Can you give us your idea of the NHS deflator for next year's budget? We know that the NHS deflator is always larger than the gross domestic product deflator.

Will there be performance-related pay and bonuses for any staff in the budget for this year or next year, outside the distinction award system?

You are proposing to put £750 million into the non-profit distributing model. When the public-private partnership and private finance initiative models were being used—we will not debate the distinctions between them—it was recognised that the models involved additional costs and that interest rates were higher than the normal capital charges for public procurement, so local boards that were carrying through PPP or PFI schemes were given some compensation. Do you intend to give some compensation for the inevitably higher costs of borrowing under the NPD model?

I want to ask about inequalities, too, but the convener might want the cabinet secretary to respond to my technical questions first.

The Convener: We will give the cabinet secretary or her officials time to respond to the three or four questions that you asked.

Nicola Sturgeon: I will do my best. I tried to note down Richard Simpson's points, but he should let me know if I miss anything.

On what Richard Simpson described as the NHS deflator, I said that the board uplifts during the next three years will be 2.9 per cent, 3.3 per cent and 3.1 per cent. I think that we all accept that inflation in the health service is a bit steeper than inflation generally. However, it is not possible to come up with a fixed percentage in that regard, because the nature and extent of pressures on the health budget vary from year to year.

For example, in this year part of the inflationary pressure on the health service came from increases in VAT and national insurance costs. As far as we know, those issues will not create additional pressures next year, because they are already in the baseline for boards.

As I said, pressures vary. In 2012-13, we estimate inflationary pressures to be £27 million in relation to pay, in the region of £70 million to £80 million in relation to drugs and around £34 million in relation to non-pay issues. We seek to give boards uplifts that cover the pressures, which then

put boards in a position of needing efficiency savings to deliver care efficiently and develop services. I will not go into further detail just now unless you want me to do so, but I can provide figures for the subsequent two years.

Dr Simpson: That would be helpful. Your answer was most helpful. Of course, there are calculations on the pressures from demographics, which I know are difficult calculations.

Nicola Sturgeon: They are difficult and they vary, but a ballpark estimate would probably be about 1 per cent for demography, technology and so on. Such pressures are more changeable and, to some extent, more gradual—they generate less immediate cash pressures than pay or drug costs do. We can give you some fairly detailed information on the issue.

I think that your second point was about pay.

Dr Simpson: It was about performance-related pay and bonuses other than distinction awards.

Nicola Sturgeon: We have a pay freeze for all staff, other than those earning under £21,000, for whom there is a £250 uplift. The other change, which is not NHS-specific and will not necessarily affect that many people in the NHS, is the increase in the hourly living wage. Other than that, we have—as we have had for the past couple of years—a pay freeze within the NHS, which will continue in 2012-13. John Swinney said that he does not expect the pay freeze to extend beyond 2012-13, but obviously we need to wait and see what happens.

You mentioned distinction awards, which I have already covered. Do you want me to say any more about them?

Dr Simpson: No. That is fine.

Nicola Sturgeon: You mentioned NPD projects. As I think has been made clear, in general terms the Government will provide revenue cover for NPD projects of around 85 per cent of the revenue cost, although it will vary depending on the different components of the revenue cost. Again, if you want more detail on that, I am happy to provide it.

Dr Simpson: If you could, that would be helpful.

I want to move on to the equalities issue. Two issues arise from the preventive spend, which you announced in a press release yesterday, of £200 million to cover alcohol, smoking, children's weight, physical activity and the keep well programme. First, is any of that new spend or is it simply the budgets for those areas going forward? Secondly, you said that you are going to mainstream the keep well programme. Do you mean mainstreaming it across all health boards in all areas? Will there be a general health check for people aged 45 to 64? If so, I would love to know what the evidence base for that is, because I cannot find it. I could understand it if the check is to be focused on deprived areas, but if it is going to be mainstreamed so that everybody has that sort of health check, beyond what their general practitioner would normally do for them, it would seem to be a waste of money, as there is no evidence base for it. Identifying waste is one of the things that the committee is trying to do.

Nicola Sturgeon: I will take the keep well points first. When we talk about mainstreaming, we mean across all health boards, but not across all general areas; the programme will continue to be focused on deprived areas. The spend for it, which you will see in the level 4 figures, is £11.4 million a year.

We have said previously—I think this is what you are getting at—that we want to look at moving to universal health checks. I take your point about the evidence base, which is why we have said that we want to have a trial before we make such a move. We are currently undertaking some economic modelling work to look at the potential scope and size of a trial to determine the evidence for it.

Dr Simpson: I am really concerned about this, because good general practice has been providing that sort of general check since the Conservative contract back in 1992, which formalised things. I am slightly surprised by your answer.

Nicola Sturgeon: I hear that. We have life begins at 40, the NHS 24 web-based health check—

Dr Simpson: That is an acceptable internet thing. The recent UK Parliament Public Accounts Committee report on tackling health inequalities was scathing of the previous attempts to mainstream, and so far, we in Scotland have not been successful in tackling health inequalities by ensuring that the gap is getting no narrower.

I will make the same point that Bob Doris made, but in a slightly different way. What specific efforts will be made to support the deep-end practices—the 100 most deprived practices in Scotland? It seems to me that we have equity of provision across Scotland at the moment, whereby everybody has the opportunity to go to a GP and get a 10-minute consultation. However, that is absolutely no use in deprived areas because of complex and multiple comorbidity, which means that the time needed for primary care is much greater. Apart from the equally well pilots, which will continue for another three years, what specific efforts are being made to reinforce the opportunity for patients to consult for much longer in those practices?

10:45

Nicola Sturgeon: I am hugely supportive of the deep-end work. We want to work with the Scottish general practitioners committee and the Royal College of General Practitioners to consider how we build on that work and take it forward. It is fair to say that the deep-end practices are generally supportive of mainstreaming the keep well approach. They are an integral part of how we do those things.

Unless anyone desperately wants me to, I do not want to get into issues about the GP contract. However, as the health service elsewhere diverges significantly from our model in Scotland, opportunities will open up to consider how in Scotland we configure our contractual arrangements to prioritise work on health inequalities. That might well dovetail with the deep-end work.

A study is under way in Glasgow on the impact of comorbidity. We will look to draw on such work.

Dr Simpson: That is helpful. Given the separation that we have achieved, which looks as if it will get significantly greater, my party would support consideration of the opportunity for a variation in contract in Scotland, which would be welcome.

Richard Lyle: I have three questions, some of which Richard Simpson touched on.

What is the current cost of public-private partnerships to health boards in Scotland? Let us remember that, although hospitals were built using PPP, for some of them, we borrowed a couple of hundred million pounds, but the cost over 30 years will be nearly £1 billion. The money comes out of health board budgets and will continue to do so for the next 30 years.

Nicola Sturgeon touched on the point that social work departments and hospitals should work better together and should not work in silos with their own budgets. What will the Government do to encourage social work departments and hospitals to work together more to reduce bedblocking and release elderly people who are in hospital because the social work department does not have a care package in place to get them out?

In the previous session of Parliament, the SNP minority Government did away with a lot of ring fencing in local government, through John Swinney and the Convention of Scottish Local Authorities working together. What will you do to remove ring fencing? What do you feel about ring fencing in the NHS?

Nicola Sturgeon: I do not have with me the total PPP revenue cost to health budgets, but we can provide that. It is significant. I am not giving away any secrets when I say that some of the early PFI contracts did not provide value for taxpayers' money. That is a fact of life and it is reflected in the overall cost. We will provide that figure to the committee.

I have covered the point about integration quite a lot already. We are doing a range of things to encourage closer working, but the most important one, as a precursor to more formal budgetary and governance integration, is the change fund. That involves money coming from health budgets to be spent on redesigning services in the community to provide services there for older people that either prevent them from going into hospital in the first place or allow them to come out of hospital more quickly than at present. I have gone into a fair bit of detail on the change fund, which is a crucial part of the approach.

The arguments on ring fencing in the NHS are not always identical to those on ring fencing in local authorities. It is horses for courses, and it depends on the objective that we are trying to achieve. As the member will see from the budget, we ring fence various budget streams centrally because we think that the funding needs to be devoted to a particular objective. For example, we have ring fenced the main funding around alcohol misuse.

On other issues, in next year's budget, for example, a proportion of the money for reducing waiting times, which has previously been ring fenced, will be un-ring fenced and put into health boards' baseline budgets. The reduction in waiting times has happened—they are now at much lower levels than previously. Health boards have an on-going obligation to keep waiting times low but, given where they have got to, we think that it is appropriate to release a proportion of the money into health boards' baselines to give them greater flexibility in how they spend it.

My view on this particular question is very much that there are horses for courses.

Richard Lyle: Basically, you agree that, following the success of the ending of ring fencing in local government, which was done by the minority SNP Government in the previous session, you are doing something similar in relation to health boards, to encourage them to succeed as well.

Nicola Sturgeon: I support absolutely the approach that we took with local authorities. However, we must be mindful of the fact that local authorities have different accountability arrangements. They are directly elected bodies. Health boards—notwithstanding our direct election pilots—are directly accountable to me, and I am directly accountable to you and to Parliament. The line of accountability is different, and that will

sometimes lead to different approaches to ring fencing.

We ring fence only for a purpose. As I have just demonstrated with the example of the waiting times money, where we think that ring fencing is no longer the correct approach, we take a different approach. Generally speaking, there has been an attempt in the past couple of years to minimise the proportion of resource that we ring fence centrally and to put as much as possible into health boards' baseline budgets, to allow them greater flexibility. We have also taken an approach that we call bundling, whereby the totality of three, four or five individual ring-fenced budgets remains ring fenced, but there is greater flexibility to move money around within those budgets. The trend has been towards greater flexibility for health boards in the management of their total resource.

Dennis Robertson: I am going to try to link preventative spend, equalities and integration. You have already answered several questions about the quality of care being paramount, with regard to our older people. Are there any specific programmes within sheltered housing, residential care and nursing care to ensure that we are doing all that we can in relation to the prevention of trips and falls, such as adequate lighting, colour and contrast, and with regard to the provision of appropriate rehabilitation for people with arthritic problems and sensory problems?

As we have heard today, there has been a tremendous emphasis on the third sector taking up the cudgels in the community. The problem is that third sector organisations are being asked to do even more at a time when their budgets are being squeezed. Where is the money coming from to enable the third sector to do the work that we are outlining today?

Nicola Sturgeon: I have already outlined the role of the voluntary sector and the potential benefit to the voluntary sector of the change fund. I recognise that, just as it is for everyone, life for voluntary sector organisations is rough and tough at the moment. They do a fantastic job, in the face of that.

This comment is probably more directed at the health service than the voluntary sector, but I will always challenge the notion that better quality care always means more expensive care. Often, the reverse is true. If you treat someone appropriately in hospital and they do not end up getting an infection and spending longer in hospital than they need to, that is better quality care, but it is also more cost-effective care, because it does not add a burden to the health service.

I take every opportunity to hammer home the view that efficiency and quality go hand in hand—they are each other's best friend. That is one of the key guiding principles that will get us through the difficult financial times.

On your specific questions about older people, we have a prevention of falls strategy, which I can share with the committee. Preventing falls—whether at home, in hospital or in care homes—is a key part of improving the quality of older people's services.

I have asked the chief nursing officer to lead a programme of work on the implementation of the dementia standards in acute settings and on ensuring that acute hospitals deliver against the standards on care for older people. I have often had concerns—as I have said openly—that the care that older people get, particularly in acute hospitals, is not always what it should be. A wealth of work has been done on improving the quality of care for older people, and I am happy to share as much of it as the committee would find helpful.

Dr Simpson: Can you tell us where we are with the implementation of the falls strategy? I know that it is early days yet.

Nicola Sturgeon: Yes, we can provide a detailed report on that.

Dennis Robertson: You spoke about removing barriers between the various agencies, which I would certainly welcome. The joint future initiative did not work particularly well, because everyone wanted to press their own agendas. There is a lot of expertise in the third sector on different areas of health and social care, but those areas do not seem to come together. Do you have anything specific in mind that involves bringing them together and telling them to work together?

Nicola Sturgeon: We will do that through the plans on integration that we will outline in the not-too-distant future. The key elements are integrated budgets, integrated accountability and integrated governance. If the NHS can keep someone out of hospital by investing in a community service, our budgetary arrangements should allow that NHS resource to be used in that way rather than the NHS saying that a local authority should invest in a particular service—or vice versa. It is about budgets losing their NHS and local authority identities and becoming part of a budget for older people's services. That is key to the type of integration that has been attempted in the past, which has not worked as well as it should have done.

Dennis Robertson: Do you have a timeframe to measure that, to ensure that the strategy is working? Will you appoint someone as a champion to examine it as an overall package?

Nicola Sturgeon: It will be first and foremost for local partnerships in the new integrated framework to drive that change locally. I hope to make a

statement to Parliament before the end of the year in which I will lay out much of the detail, which will then go out for further consultation. It is important that we get this right, while avoiding—to go back to the convener's point—structural upheaval that will divert everyone's attention for a long period of time.

Mary Scanlon: Just in case I do not get in again, I have three short questions that I will merge into one.

First, Audit Scotland produced an excellent report last month on the potential of telehealth. It said that telehealth was efficient and effective, that it had tremendous potential, but that it had never been a priority for health boards. As you know, the Health and Sport Committee produced a good report on telehealth in the previous session of Parliament. What priority are you giving telehealth?

My second question relates to the workforce; I raised the same issue last week. I noted that staffing in the NHS had reduced by 3,910 in the past 21 months, and I was surprised to note that, of that figure, 1,747 were nurses. I was not sure why we had to get rid of so many nurses in order to make efficiency savings. Some clarity on that point would be helpful.

My third point is on mental health and preventative spend. Very few of us around the table would not agree that putting more money into mental health in the early stages would be helpful. We received a paper from NHS Greater Glasgow and Clyde today that stated:

"although the allocation towards mental health in terms of services is clear within the budget, it is not clear where the resource will be available for multi-agency delivery of activity to promote and protect positive mental health in a preventative way."

The commitment may be there, but our biggest health board does not know where the money is coming from.

I ask the cabinet secretary to respond to those three questions on telehealth, the loss of nurses as part of workforce reduction and mental health.

11:00

Nicola Sturgeon: I am not sure whether Mary Scanlon managed to merge three questions into one, but I will respond to all three.

Before I do so, with Mary Scanlon's permission, I will come back to Richard Lyle's point. I now have the figure for revenue spend on PFI in the 2010-11 accounts, which are the latest accounts. The figure is £177.4 million.

Like everybody, I read the Audit Scotland report on e-health with a great deal of interest. We have made good strides on e-health. We have not got as far as I would have wanted us to get, but I do not accept the suggestion that it is not a priority. It is a big priority, and I intend to ensure that it is seen as such at all levels and in every part of the health service.

We recently published our new e-health strategy for the next three years. It builds on the 2008-11 strategy and takes a strategic approach to the development of e-health. One criticism that has been made of our progress on e-health—it has some validity—is that we have adopted pilot approaches that have been shown to work but the rolling out and mainstreaming of those across the health service has not been particularly good.

The e-health strategy has five strategic aims: first, to maximise efficient working practices for staff; secondly, to support the public to communicate better with the health service and to manage their own health; thirdly, to contribute to integrating care and supporting people with long-term conditions; fourthly, to enhance the availability of information for healthcare workers; and, fifthly, to improve medicine safety. There are obviously a number of deliverables underneath the strategic aims.

As members know, we have also given NHS 24 responsibility for the Scottish centre for telehealth. That is beginning to bear fruit by giving a strategic focus to work in this area. If I may put it this way, we say with some justification that on telehealth we have not done as much as we should have done, or as quickly as we should have done it. I want to pick up the pace, because the potential is massive.

NHS 24 has been doing a lot of work in a European context and has been looking at funding and collaboration opportunities. It would say that the rest of Europe sees us as a world leader in telehealth. While we are, with good reason, sometimes hard on ourselves, we should remember that we are probably further down the road than any comparable country. That is a good thing.

We also have the delivering assisted living lifestyles at scale—DALLAS—demonstrators. DALLAS is funded by the Technology Strategy Board, Scottish Enterprise, Highlands and Islands Enterprise and the Government to look at assisted living at home at scale.

All those developments are exciting and I hope that they give the clear message that e-health is very much a priority.

On staff numbers, it is a fact that, across every staff group, there are more staff in the NHS today than there were when this Government took office. The only exception is nursing, where the number of staff is slightly below the level that we inherited.

However, taking into account primary care nursing, which is not included in the ISD Scotland statistics, I am pretty sure that nursing is also above the inherited level.

I understand people's anxieties and worries about an NHS workforce that is changing its size and shape, but much of what we have been talking about already are things that change how health services are delivered. I am thinking of more prevention, treating more people in the community and other developments such as the fact that we have the lowest average length of hospital stay and the highest day-case treatment rate ever. It is inevitable that those things change the shape and size of the NHS workforce. I have made it clear, and I will continue to make it clear, that those changes have to be linked to the quality redesigns of services. As the health secretary, I will continue to scrutinise very closely staffing levels and the mix of staffing levels in the health service.

Mary Scanlon's final point was about mental health. I am not sure what our largest health board has said in its submission, but I can assure her that I will look carefully at it.

The budget makes clear our commitment to mental health issues. Our new mental health strategy, which is out for consultation—the consultation period closes in January—is designed to build on our successes and to bring together our work on mental health improvement and service delivery. All that work focuses very much on prevention—on keeping people healthy—but also on ensuring that the right services are in place for people when they need them.

Dr Simpson: The Calderwood report on information technology and the e-health financial strategy recommended that most of the relevant money should be distributed to health boards. The previous and current Administrations have been very much in favour of not having a centralised system and not making the mistakes that were made with the huge centralised English IT system, but I am slightly concerned—I think that Harry Burns shared my concern when we took evidence from him—that the additional dispersal is a step too far.

What control will you retain to ensure compatibility and integration and to ensure that people who move from one health board to another do not face different systems, all of which would create a problem for the information base, which is a theme of your work strategy? How will you manage that?

Nicola Sturgeon: All that is encapsulated in the e-health strategy. The experience south of the border suggests that it was right not to try to create a big-bang IT system. However, that does not mean that we should have 14 approaches to e-health systems. Several health boards came together to procure and develop the patient management system, for example, from which other health boards have learned.

We must ensure that unnecessary duplication does not take place and that systems are compatible and able to be integrated. All the work is about integrating systems, so I assure Richard Simpson that that is at the centre of thinking on e-health.

Dr Simpson: It is clear from its reports that the ISD has difficulty in getting information on some matters from some health boards. I presume that that relates at least in part to having different data collection and IT systems. Do we have a handle on that?

Nicola Sturgeon: The issue relates largely to the historical systems that health boards and GP practices have used. As we move forward on the agenda, we will ensure compatibility, integration and the ability to extract data. Our ability to extract and use patient data is one of our key advantages in life sciences, which relates to how we develop services for patients. Those aspects are critical to developing IT systems.

The Convener: I have a negative point. Your priorities are often judged according to the budgets that you allocate. The budget for e-health will reduce over the piece.

Nicola Sturgeon: Implicit in the e-health budget is lots of procurement. The budget will simply reflect efficiencies that we think we can get in procuring systems. A reduction genuinely does not reflect any declining priority.

Richard Lyle: Cabinet secretary, we have—

Nicola Sturgeon: I am sorry—I am looking at the budget and I do not think that the e-health budget will reduce. It will stay steady.

Dr Simpson: The figure is down from the previous projection of £140 million this year.

Nicola Sturgeon: Sure, but the budget will stay steady over the spending review period.

The Convener: The budget is flat.

Richard Lyle: We have talked about budgets that will reduce and we have spoken quite a lot about health issues. Can we speak about sport? You said in your opening statement that the draft budget for sport would increase sharply in the next few years. Is that attributable mainly to the excellent Commonwealth games, to which I am sure we all look forward, or will that funding be used for other initiatives?

Nicola Sturgeon: The core sport budget will stay broadly steady over the period. It will deliver

our wider sport ambitions, such as improving participation, our community sports hubs, the active schools programme and working with the Scottish Football Association on the McLeish report on football.

You are absolutely right—the reason for the sharp increase in sports funding is the Government's contribution to the Commonwealth games. We are trying to ensure—not so much through direct funding, but through the legacy programmes—that the games are more than simply a few days of sporting competition and that their longer-term benefits go wider than Glasgow.

Richard Lyle: I am sure that everyone hopes the same and that we will have an excellent games. However, when the games are over, will all the excellent facilities that have been built be transferred to Glasgow City Council or sportscotland to ensure that the people in those areas receive further enhanced benefits from them? Bob Doris mentioned areas in Glasgow that have quite a bit of deprivation and I am sure that the people who live where the facilities are being built are looking forward to using them. Can we ensure that everyone gets a chance to do so and that the facilities will not be left derelict, as has happened in past games—although not, I should add, in Scotland?

Nicola Sturgeon: I absolutely agree with the thrust of your question. A fair chunk of the Commonwealth games sporting facilities exist already, although new facilities are being built.

In the east end of Glasgow, the impact of and huge benefits from investment in the games will come not only from the new and fantastic sporting facilities that are shooting up at a rate of knots but from wider regeneration in the area. More generally, though, we want to use the legacy plan to spread longer-lasting benefits. If, as we are determined to do, we pull off a good plan, we will probably be the first country to do so as part of a Commonwealth or Olympic games. It is a big challenge, but we are seriously determined to meet it.

Of course, we still have to address the issue of diversion of lottery money for the Olympics. If we had access to that money, we would invest some of it in the legacy plan. The funding for the games has been taken care of but, if we had that lottery money, we would be able to expand our legacy approach—although I stress that we are absolutely determined to secure a good legacy from the games.

Richard Lyle: That is excellent.

The Convener: The committee looks forward to discussing the issue with the minister and visiting some of the sites, hopefully in the near future.

Richard Lyle appears to have triggered a number of questions about sport.

Dennis Robertson: I had intended to ask about e-care, which might have some linkage with the sports agenda.

The Convener: I am sorry, Dennis. Please ask your question.

Dennis Robertson: I am aware that video consultations form part of the efficiency programme and that health boards such as NHS Grampian are trying to encourage that approach to prevent patients from having to fly in from Orkney or people in my Aberdeenshire West constituency having to travel for two hours to Aberdeen royal infirmary. Does the cabinet secretary hope to bid for funding to ensure that the connectivity exists to further the use of video consultations? After all, if the connectivity does not exist in certain areas, we will not be able to proceed with the measure.

Nicola Sturgeon: Although the connectivity issue falls slightly beyond my health responsibility, it will be vital in this area. As you know, the Government is committed to broadband and ensuring such connectivity and we and the UK Government have been discussing—and will no doubt continue to discuss—funding in that regard.

Dennis Robertson: But what about the quality of care for patients and saving patients from having to travel those distances?

Nicola Sturgeon: Indeed. Every time that I visit one of the island boards in particular, I see fantastic examples not just of how videoconferencing is used to prevent health staff from having to travel to conferences or meetings. Indeed, Derek Feeley has just reminded me that when we visited Orkney we saw a patient having a consultation with his consultant down the line and his local healthcare team speaking to the healthcare team in Aberdeen. That approach is being used to great effect in many health boards, and ensuring that all boards have the ability to videoconference where appropriate is one of the key priorities that NHS 24 is pursuing after taking on responsibility for the Scottish centre for telehealth.

11:15

Jim Eadie: I have a couple of points on sport. First, you mentioned the core sports budget. I just want a reassurance and a commitment that that budget will be safeguarded in order to fund the valuable projects that you mentioned—the community sports hubs. There is a very good example of that in my constituency, whereby the City of Edinburgh Council, through Edinburgh Leisure, collaborates with sportscotland to make sports facilities available to the community. The

health benefits of that are immeasurable. A commitment on safeguarding the core sports budget over the period of the spending review would be helpful.

My second point concerns an issue that falls outwith the health spend but which is most definitely a health issue: cycling. What discussions have taken place or could take place between you and the Cabinet Secretary for Finance, Employment and Sustainable Growth to maximise the budget that is available for cycling and cycle pathways? That is a sustainable transport issue, but it is also most definitely a health issue, with definite health benefits for people who engage in that activity.

Nicola Sturgeon: The core revenue budget will remain protected at £34.3 million per year over the spending review period. There is some fluctuation in capital, but obviously capital in general has been hit hard. However, within that, I think that we have secured a good capital settlement for the core sports budget. We aim to deliver at least 100 community sports hubs across all 32 councils by 2014, and the sports budget is integral to the delivery of that.

There has been a lot of work on and investment in cycling, but I do not have the detail of it to hand here. I am happy to provide that detail later for the benefit of the committee. The Cabinet Secretary for Finance, Employment and Sustainable Growth is a keen cyclist, as am I. He cycles more often than I do, but I am sure that we can have some productive discussions around what more we can do on cycling. The benefits of cycling to health, wellbeing and the environment are well known, so I am more than happy to come back to the committee with a bit more detail around what we are doing and what more we might be able to do. I am sure that the Minister for Commonwealth Games and Sport would be happy to discuss that in more detail as well.

Jim Eadie: I think that the committee will welcome your commitment to have that discussion with your cabinet secretary colleague.

Nicola Sturgeon: I am happy to do that.

Mary Fee: I want to ask about the sports budget and the early years change fund. Given that we have growing levels of inactivity and obesity in our young people, I am delighted that the sports budget will increase over the next few years, although I accept that that is mostly down to the Commonwealth games. Will any of the early years change fund money be used to deliver sporting initiatives that are targeted at the young? If so, will that money be diverted into the sports budget?

Nicola Sturgeon: It would not be diverted into the sports budget. I will try to answer the question as fully as I can, but I am sure that you will appreciate that the decisions on actual spend, just as in the case of the older people change fund, will be for local partnerships to take, based on their local arrangements. The most honest answer that I can give you is that I am sure there is potential to use some of the early years change fund money for physical activity and sport, but whether it is used in that way would be driven by local decisions. However, the money would not be diverted into the sports budget, which is very focused on the kind of things that I have been talking about.

Your general point about the relationship between health outcomes later in life and young people eating healthily and living an active life is very well made. You know the emphasis that we give to child healthy weight through the HEAT targets for health boards.

The Convener: We have covered quite a lot in our approach to the budget themes. However, there is still the question of how long it takes to evaluate initiatives, which we have mentioned. On the debate about evidence, we have had Harry Burns being evangelical and saying just blooming get on with it.

Nicola Sturgeon: You have heard him as well, then.

The Convener: We have indeed. On the other side, there are people who say, "No, we need to evaluate and do studies"—although they are mainly people who get funding for carrying out those studies. The question that arises is: when is it appropriate to roll out initiatives? Is there a balance to be struck? We need to get that on the record.

Nicola Sturgeon: There is a balance to be struck. We are pretty rigorous about evaluation. I have already mentioned family-nurse partnerships and their evaluation being built in from the start. Let us take another example. We often hear the question, "Where is the direct evidence that the keep well programme leads directly to reduced risks of cardiovascular disease and improved health outcomes?" We can point to the fact that it has a proven track record in engaging people in deprived communities and to the referrals of people on to statins or smoking cessation services. We can also point to the evidence that those interventions have particular outcomes, but we would probably struggle to say that we have the evidence at this stage that keep well, in and of itself, directly delivers the benefits that we want. However, probably all of us feel strongly that implementing the programme is the right thing to do—I know that I do—and I think that the evidence on that will emerge.

That is a good example of a case in which we would be wrong to sit back and wait for evidence.

If we think that something will work and there is plenty circumstantial evidence that it is the right thing to do, we should get on and do it, and the evidence will accrue over time. Therefore, depending on what we are talking about, there is a balance to be struck.

Dr Simpson: I want to ask about early years provision. I am concerned about midwives. Because many midwives who are qualifying now will not get employment after their protected period, you have cut the intake by around 40 per cent, from 180 to 100. However, the birth rate has gone up over the past few years. The number of births was static last year, but it has risen by almost 10 per cent, from 54,000 to 58,000. We know that there are many complex situations and that people have drug, alcohol or smoking problems and other important prenatal problems that are looked at in family-nurse partnerships in a small way. I have a concern about midwives, which has been added to by the recent helpful answer to a question that I asked, which showed that huge variations exist. There are twice as many midwives in Dumfries and Galloway as there are in Lothian, for example. I accept that workforce planning is the most difficult area, but how will you ensure that the prenatal and immediate postnatal phases in the early years programme are properly handled when the number of midwives is being substantially reduced and such variations exist?

Nicola Sturgeon: We are about to do some data collection work on the number of midwives that there are to ensure that we have an absolutely firm handle on exactly what the current position is.

The reduction in the student intake last year to which Dr Simpson referred was made in full consultation with the Royal College of Midwives. There is an annual exercise, and I take into account all the factors in conducting it. Dr Simpson is right to point to the increasing birth rate, which is a vital factor to take into account. I am mindful of that, and will continue to discuss with the Royal College of Midwives and others the appropriate levels to set.

Dr Simpson is right: workforce planning is not the easiest thing in the world. It is an art more than a science, but the more we get it right, the fewer problems of all sorts we will have later on.

I have been pretty cautious about reducing intake numbers, although I will not go into too much detail on that. Perhaps I have been more cautious than others would have wanted me to be. Perhaps they might have wanted a bigger reduction, but I think that we should err on the side of caution. The birth rate trend that we are seeing now would not have been predicted two or three years ago. We need to ensure that we keep all of that fully in mind.

Dr Simpson: Let us take one more example. In some areas, very good multidisciplinary teams are tackling drug and alcohol problems in the prenatal and immediate postnatal phases, but not everywhere has such teams. Harry Burns has made the point that, if we are genuinely going to have a big influence with early years interventions, we should be able to see that very quickly in the birth-weight figures. However, we will not see that if we do not have multidisciplinary teams in every area. I know that driving such things is not easy, but should we have such teams in every health board area within a couple of years?

Nicola Sturgeon: We certainly should. Driving those things is not easy, but it is an absolute must. I am glad that all members of the committee have Harry Burns's voice ringing in their heads as loudly as I tend to have it ringing in my head on a daily basis, because he is right. Unless we get those things right now, we will continue to live with the problems that we currently live with. We need to do lots of things, and sometimes we will need to do them without necessarily having all the evidence to hand, simply because we will need to take the fire and do them. The best practice in areas should be replicated throughout the country.

The Convener: As members have no more questions, it remains for me to thank the cabinet secretary and her colleagues very much for their attendance and the evidence that they have provided.

As we have previously agreed, we will take the next agenda item in private.

11:26

Meeting continued in private until 12:44.

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