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Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 1 May 2012

Session 4

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HEALTH AND SPORT COMMITTEE
14th Meeting 2012, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Jackson Carlaw (West Scotland) (Con)
*Jim Eadie (Edinburgh Southern) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Fiona McLeod (Strathkelvin and Bearsden) (SNP)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Laura Ace (NHS Lanarkshire)
Derek Feeley (NHS Scotland)
Marion Fordham (NHS Western Isles)
Paul James (NHS Greater Glasgow and Clyde)
Craig Marriott (NHS Dumfries and Galloway)
John Matheson (NHS Scotland)
Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Tuesday 1 May 2012

[The Convener *opened the meeting at 09:30*]

Alcohol (Minimum Pricing) (Scotland) Bill: Stage 2

The Convener (Duncan McNeil): Good morning and welcome to the 14th meeting of the Health and Sport Committee in 2012. I remind everyone present to turn off their mobile phones and BlackBerrys as they can interfere with the sound system.

Agenda item 1 is stage 2 consideration of the Alcohol (Minimum Pricing) (Scotland) Bill. I welcome to the meeting Nicola Sturgeon, the Cabinet Secretary for Health, Wellbeing and Cities Strategy, and her Scottish Government colleagues: Marjorie Marshall, economic adviser, public health; Donald Henderson, head of public health division; Edythe Murie, principal legal officer, health and community care; and Matthew Lynch, assistant Scottish parliamentary counsel.

We move to the first group of amendments. Amendment—[*Interruption*.] I apologise—that was a good start. Much of what I am about to say was covered in our pre-meeting briefing, but apparently I should also put it on record.

For stage 2 proceedings, members should have the bill, the marshalled list and the groupings. Our task is to consider all the amendments and agree to each provision in the bill. I will call the member with the lead amendment in each group to open the debate on the group by moving the lead amendment and speaking to all the amendments in the group. I will then call any members who have lodged amendments in the group to speak to all the amendments in it and, after that, I will call any other members who wish to speak on the group, taking the cabinet secretary last if she has not lodged an amendment. Finally, I will invite the member who opened the debate on the group to wind up and to indicate whether they wish to press or withdraw the lead amendment.

Any member present may object to the withdrawal of an amendment. In the event of such an objection, we will proceed straight to the question on the amendment. In other words, there will be no division on the question whether an amendment may be withdrawn. If a decision is required, we will follow the normal procedure.

When we reach amendments on the marshalled list that have already been debated, I will ask the member to move or not to move the amendment. If the member who lodged the amendment does not move it, any other member present may do so.

Finally, I remind the officials accompanying the cabinet secretary that they may not speak during the proceedings.

Section 1—Minimum price of alcohol

The Convener: The first group of amendments is on calculation of minimum price. Amendment 3, in the name of Richard Simpson, is grouped with amendments 4 to 10.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Despite the number of amendments in this group, my proposal is relatively simple and is designed to simplify the formula MPU x S x V x 100, set out in new paragraph 6A(3) of schedule 3 to the Licensing (Scotland) Act 2005, as inserted by section 1(2) of the bill. Under that formula, the minimum price per unit is multiplied by the strength of the alcohol and volume in litres times 100. My amendments seek to simplify that by putting in place a formula that focuses on units alone and multiplies the minimum price per unit by the number of units.

It is current Scottish and United Kingdom Government policy that the public should be educated on the number of units that they drink and be made aware of whether their drinking is within safe limits. Interestingly, those limits vary enormously across Europe. I feel that the bill's more complex approach will not help public education. Moreover, for trading standards to be able to monitor any of this, there will need to be a relatively complex calculation on every container and bottle displayed on every shelf in every shop in Scotland.

In evidence, Professor Timothy Stockwell told us that, with its 5,500 products and monopoly system, Canada was finding it difficult to manage minimum unit pricing. I acknowledge that, in that country, minimum unit pricing is not set at one level but varies and that, in that respect, the system proposed for Scotland is simpler, but it is not as clear as it should be.

Although the bill refers to units, it contains no definition of what a unit constitutes. That anomaly would be addressed by including in the bill the standard definition of a unit—used by, among others, the chief medical officer—as 10ml of pure alcohol. That would set an exact standard for all information about units on a label and will be essential if we are to prevent retailers or manufacturers from introducing their own idea of a unit, which might differ from the standard unit and would simply confuse consumers.

By the end of 2012, 81 per cent of bottles or containers containing alcohol will include

information on the number of units, under a voluntary measure introduced by the alcohol industry. I have suggested that we should encourage the inclusion of information on bottle labels about the units of alcohol to give consumers more knowledge about the number of units in what they drink. If we changed the formula in the bill to the one suggested in amendment 3, that would encourage people to take note of the number of units in the drink that they are consuming. That would sit well with the aims of health organisations and the Scottish Government's current approach. Moreover, as the cabinet secretary knows, considerable research shows that consumers are unaware of the amount of alcohol in a product. Setting out the number of units of alcohol on the label will address that lack of knowledge.

In conclusion, the amendments seek to set out the definition of a unit and a simpler formula. They should be agreed to, as they would deliver minimum unit pricing in a straightforward manner that would help not only consumers but regulatory enforcers.

I move amendment 3.

Jim Eadie (Edinburgh Southern) (SNP): I contend that these amendments would have the opposite effect to that stated by Richard Simpson. He said that their purpose was to simplify the proposal in the bill; however, given that they would result in the bill having more than one calculation for the minimum price, they might well be a recipe for confusion for the public and retailers and have the unintended consequence of increasing the burden of regulation, particularly on small businesses. Any regulatory process should be clear and consistent. The bill achieves that clarity and consistency and these amendments do not and, for that reason, I oppose them.

The Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon): I think that I understand what Dr Simpson is trying to achieve with these amendments; as he said himself, he wants to simplify the process of calculating the minimum price where the number of units of alcohol is marked or labelled. At the outset, I must agree with him that we have a job to do in educating the public further on units of alcohol and the amount of alcohol that they are drinking. Indeed, I think that there is consensus on that point. However, as Jim Eadie suggested, I do not believe that these amendments would achieve the simplification that Dr Simpson wishes to see.

First, there is no statutory requirement to mark or label the number of units in a product. Normally, it is the declared strength of alcohol that is marked or labelled in accordance with the law. That is why the formula in the bill includes strength in the calculation and why there is a power that enables the Scottish ministers to make an order that allows declared strength to be relied upon. For alcohol that does not have its declared strength marked or labelled, the actual strength is to be used in the formula.

Another reason why I do not believe that the amendments would succeed in simplifying the system is exactly the point that Jim Eadie made: the amendments do not delete the existing formula in the bill; they simply add an alternative formula. That means that we would end up with two formulae in the bill—the one that is already prescribed and the one that the amendment would insert. I contend that that would make the basis on which the minimum price is calculated more complicated and more, not less, difficult for retailers and the public to understand.

Although it is important and necessary to include the formula in the bill—I believe that we have come up with the most robust formula possible—to an extent, the issue of calculating the minimum price for any particular product is one of implementation. We have already said, and I repeat today, that we will work with the industry on the implementation of minimum pricing and will help to produce whatever will assist those who sell alcohol to calculate the minimum price and, in so doing, assist those whose job it is to ensure that the minimum pricing provisions are being adhered to.

I consider the formula in the bill to be as robust as it can be and my strong preference is for that method to remain the method in the bill of calculating the minimum price. Therefore, I urge the committee to reject amendments 3 to 10.

Dr Simpson: The cabinet secretary and Jim Eadie have raised an issue that is of interest. Nevertheless, it is important that there be a clear definition of a unit, and that is not the case at the moment. There is still potential for units to be different for different manufacturers—that is a possibility and that issue was not addressed sufficiently in the rebuttal.

Moving towards a system that is simple to enforce, as a generality, is another point that was not addressed in the rebuttal. For those reasons, I will press my amendment.

The Convener: The question is, that amendment 3 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

McNeil, Duncan (Greenock and Inverclyde) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Lyle, Richard (Central Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

Abstentions

Carlaw, Jackson (West Scotland) (Con)

The Convener: The result of the division is: For 3, Against 5, Abstentions 1.

Amendment 3 disagreed to.

Amendments 4 to 10 not moved.

Section 1 agreed to.

After Section 1

The Convener: Amendment 11, in the name of Richard Simpson, is in a group on its own.

Dr Simpson: As the cabinet secretary knows, the Labour Party remains doubtful of the likelihood of minimum unit pricing delivering the levels of change that we all want to see in Scottish society's approach to the consumption of alcohol. Amendment 11 seeks to ensure that, as far as possible, the effect is measured and distinguished from existing trends and from any changes that arise from United Kingdom policies and general societal changes, so that the effect of minimum unit pricing is singled out.

We will come back to that in due course, but Labour's red line on the issue, as was indicated at stage 1, relates to the windfall to the industry that will arise from minimum unit pricing. The University of Sheffield modelling is clear that the windfall is likely to be substantial, with around £140 million accruing to the industry as a whole annually in Scotland from a minimum unit price of 50p, the largest proportion of which will accrue to the supermarkets. Unfortunately, the Government has not asked anyone to examine the likely industry response. Indeed, in evidence to us, the University of Sheffield came close to expressing regret that that important question had not been posed.

09:45

The Institute for Fiscal Studies, in an important report, was clear that one possible outcome is that the industry will redesign its price structures, using the windfall to reduce the price of premium brands or other types of alcohol that are sold above the minimum price. I agree that that is a possible scenario, but I add two further ones. The overwhelming majority of the increase in consumption in the period up to 2005, when consumption began to flatline or reduce, was in relation to wine. There has been a 23 per cent increase in wine consumption and wine prices have risen substantially. From the most recent analysis, we know that minimum unit pricing will have little effect on wine. The first scenario is that that significant culture shift in Scotland might be encouraged further if wine prices above the minimum unit price are reduced using the windfall. The second scenario is a substantial increase in advertising using the windfall, which is a significant possibility.

In passing the Alcohol etc (Scotland) Act 2010, the Parliament decided to amend the then minority Government's approach to a social responsibility levy, from a polluter-pays approach in which the levy was to be on pubs and clubs to a more general levy on sales. The Government proposes a partial alternative through its public health levy, but that applies only to shops whose rateable value is over a certain amount and which sell tobacco and alcohol.

My amendment 11 does not prescribe exactly how the windfall is to be recouped to the public purse; it sets out only that it should be recouped. Given that budgeted expenditure on alcohol is flatlining in cash terms in the next few years—and therefore reducing in real terms—I strongly urge the Government and colleagues on the committee to agree to amendment 11 and to use the funds to further tackle alcohol problems. If the Government does that and comes up with a credible assessment of whether a minimum unit price achieves its modelled objectives, as we said in moving our reasoned amendment at stage 1, it will have our support for the entire bill at stage 3.

I move amendment 11.

Bob Doris (Glasgow) (SNP): I will say a few words about why I cannot support Richard Simpson's amendment 11.

The first reason is that powers are already available should any Government or Parliament wish to recoup money from supermarkets or whoever.

In the previous session, the Scottish Government proposed a large retailer supplement, with the aim of recouping some of those profits in financially difficult times. That involved not primary legislation, but a statutory instrument. Unfortunately, the measure was opposed by the Labour Party.

In April, the public health supplement was implemented, which will raise £95 million across 240 of the largest stores that sell alcohol and tobacco in Scotland. That amount will be recouped over the next few years. A Labour member of the Local Government and Regeneration Committee, John Pentland, said that he "reluctantly" supported the measure, so that was hardly enthusiastic. The Government has taken a consistent approach to recouping profits appropriately.

Also, the power to implement a social responsibility levy is still in force should the Government and Parliament choose to use it. That is perhaps a debate for another day.

Therefore, I have given three examples of current legislation, outwith the bill, that could be used should the Government or Parliament choose to recoup potential profits.

The University of Sheffield says that the profits will accrue not only to supermarkets or the off-sales sector, but to the entire sector, so that potentially includes further business for the on-trade.

Because the power to recoup money already exists in legislation should the Parliament decide to do so, and because of the other comments that I have made, I believe that Labour's approach is riddled with inconsistencies every step of the way. For those reasons, I cannot support Mr Simpson's amendment 11.

Gil Paterson (Clydebank and Milngavie) (SNP): I will give an example and pose some questions that I hope Richard Simpson will answer when he sums up.

I am interested to know how Richard Simpson would define profit. The normal process is to consider the cost of an item and what it is sold for and to build into that any overheads. A company such as Morrisons has the capacity to run a big campaign and headline it for seven days. If it goes to Tennent's in Glasgow, just up the road, and buys a container of beer, it might get 25 per cent off the base rate because of the quantity. If it runs out near the end of the promotion, it might go back and get a pallet load in order to keep faith with its customers, in which case it will pay 25 per cent over the base rate because the extra quantity was not in the contract and it is merely a pallet load.

Meanwhile, Joe Bloggs, who runs a corner shop nearby, goes to the wholesaler to buy exactly the same product and he sells it at double the price that Morrisons charged. I wonder how the profit would be measured. Would it be calculated on the price at which the product is sold or would it be the real-world profit—the bit that the retailer is left with? How could we segregate the profit on one or 100 drink lines on the shelves from the profit on 1,000 other lines, and how could we identify the costs in relation to the alcohol? How would we establish the profit if the manufacturer or wholesaler puts the price up and the retailer, because of market forces, absorbs that price rise? How would the proposed measure impact on profit?

I have been in business for a long time—too long, to be honest—and I do not think that the proposal is physically possible or workable. I am not in the business of protecting supermarkets—I would like to do the opposite—but I find the proposal utterly and completely unworkable.

Jackson Carlaw (West Scotland) (Con): I have some sympathy with the principle that underpins Dr Simpson's amendment 11. I believe that there is widespread public support for a more convincing and determined approach to alcohol and the problems that it creates and, by virtue of that, for the bill. Nonetheless, there is considerable disquiet among members of the public that one consequence of the bill might be a significant windfall profit for retailers.

I sympathise with the points that Gil Paterson made, and I note the points that Bob Doris made, although I have mixed feelings about some of the measures that have already been put in place and how they apply.

In moving his earlier amendment, Dr Simpson acknowledged that it is impossible for us to know how industry will react to the legislation—that was clear from the evidence; nonetheless, he seeks to make an amendment to the bill that anticipates that it will react in a particular way. It might react in that way, or it might not.

As Gil Paterson identified, the proposed measure might be difficult or impossible to implement, and in any event it might fall short of what would subsequently be required in the face of a particular industry response. We should acknowledge that. In addition, everybody anticipates that there will be a declining level of profitability if the bill works.

My preference is that we seek to work positively with industry, which I hope will rise to and meet the challenge, which goes beyond the Scottish Parliament's bill, by working in partnership to tackle the broader cultural issues to do with alcohol in Scotland. I hope that the industry, in partnership, will be prepared and willing to set an example by assisting in abstinence or rehabilitation programmes that might be of benefit to people who suffer the consequences of alcohol use.

Therefore, although I understand the sentiment behind amendment 11, as we said in the debate at stage 1, the Conservatives' view is that, for practical reasons, the matter is probably best addressed in the light of what happens and in a voluntary way with industry.

We oppose amendment 11.

Nicola Sturgeon: As we heard, amendment 11 attempts to deal with additional money from which the alcohol industry might benefit due to the introduction of minimum pricing. Like Jackson Carlaw, I have a degree of sympathy with the sentiment behind the amendment. I certainly agree with what he said about the need to work

with the industry to achieve a change in the culture around alcohol, with all that that entails. However, I cannot support amendment 11, because it is technically flawed, unworkable and, as Bob Doris and Gil Paterson said, unnecessary.

The Sheffield modelling estimated that the alcohol industry as a whole would benefit from additional revenue. Additional revenue does not necessarily result in increased profit—that is my first point. A point that Jackson Carlaw made is important in that context. Minimum pricing is designed to reduce consumption of alcohol over time, so we cannot assume that additional revenue will forever be an inevitable consequence of the policy.

Secondly, we do not know exactly where additional revenue that might accrue will end up. It could end up anywhere along the supply chain. People who characterise the additional revenue as a windfall profit for supermarkets are oversimplifying the issue to a great extent. Additional revenue might accrue to the small corner shop. It might accrue to the producer of alcohol as well as to the retailer.

Thirdly, I make a practical point, which Gil Paterson made well. It is not clear to me—even after some study of amendment 11—how owners of licensed premises would be able to isolate additional revenue from minimum pricing, given that there will always be a raft of measures in place to generate revenue for any particular business, and given that there will always be a range of factors that determine the eventual profit of any particular business. It is not clear how people would isolate additional profit that accrued from minimum pricing.

Even if we could get over such hurdles, some of the data that would be required to calculate the additional profit are likely to be considered commercially confidential and might not be disclosed or accessible to Government.

On a technical point, amendment 11 would require sums to be recovered from "owners of licensed premises". Often, the owner of licensed premises and the person who holds the licence to sell alcohol are not the same person. A tenant of a shop, for example, will be the licence holder and therefore any additional benefit will accrue to the tenant, not the owner of the premises. On that practical point, amendment 11 is technically flawed.

Amendment 11 is also unnecessary. As Bob Doris said, we have implemented the public health supplement, which will raise around £25 million this year to help to address health and social problems. We also have powers in the Alcohol etc (Scotland) Act 2010 to introduce a social responsibility levy on retailers of alcohol. Amendment 11 is therefore not just technically flawed and unworkable but unnecessary, because adequate measures are in place to enable us to work together to address the issue in the way that we see fit.

Amendment 11 is something of a fig-leaf for members who have found themselves on the wrong side of the argument for political rather than health reasons. For all those reasons, I urge the committee to reject amendment 11.

10:00

Dr Simpson: I accept that there may be a problem with the word "owners", which may need to be amended at stage 3 if amendment 11 is agreed to. Apart from that technical point, two major points have been made in respect of the amendment. The first is that there are measures in place that could be used. The purpose of amendment 11 is to ensure that those measures are used. It does not say how that should be done; it says that it should be done. The problem is that the Sheffield modelling estimates the additional revenue to be substantial and there is major public disquiet about the fact that that is not being recouped. The amendment requires it to be recouped.

The second issue is how we calculate the sum involved. I accept Gil Paterson's point that calculating it is not that easy, but that is why subsection (3) of my amendment says that the estimates

"are to be based on such research and modelling as the Scottish ministers consider appropriate."

The Scottish ministers have accepted the Sheffield modelling, which, as I have been careful to say, talks about profits of £140 million not to supermarkets but to the industry as a whole. It would be up to the Government, in discussions with the industry, to reach a conclusion on what the additional revenue is likely to be.

On the expectation that the additional revenue would reduce over time, that would be the case if the volume of alcohol that is consumed reduces, which is the purpose of the minimum unit price. However, we know that the industry as a whole is already committed to reducing alcohol content by 1 billion units by 2015, so the profitability of that alcohol will increase rather than decrease. To suggest that the revenue will go down is a false element of the rebuttal.

My other concern is about the fact that the public health levy, which is the only measure that is being fully implemented at present, applies to alcohol and tobacco. I shall provide an illustration. Our big problem with tobacco at the moment is the huge variation in its consumption, which ranges from 43 per cent among the most deprived

members of our community to 10 per cent among the least deprived.

In a supermarket in an area in which there is almost no deprivation—which does occur—the sales of tobacco are likely to be small. The effect of the public health levy, along with the display ban and policies that may be introduced on packaging, may be that supermarkets stop selling tobacco in areas of lower deprivation, which would mean that the public health levy would apply only in areas of greater deprivation. As an alcohol measure, the levy is substantially flawed.

However, I reiterate that we have not stated in amendment 11 precisely which measures should be used—whether it should be some form of the public health levy, the social responsibility levy or other measures. That would be up to the Government. The amount involved would be a matter for negotiation between the Government and the industry. Failure to take action to recoup the windfall more substantially than has been proposed until now is a failure that the public will not fully understand.

The Convener: The question is, that amendment 11 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

McNeil, Duncan (Greenock and Inverclyde) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)

Against

Carlaw, Jackson (West Scotland) (Con)
Doris, Bob (Glasgow) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Lyle, Richard (Central Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

The Convener: The result of the division is: For 3, Against 6, Abstentions 0.

Amendment 11 disagreed to.

The Convener: Amendment 1, in the name of Jackson Carlaw, is grouped with amendments 2 and 12.

Jackson Carlaw: To aficionados of the minimum pricing of alcohol, amendment 1 will look startlingly familiar, as it bears a close resemblance to an amendment that was moved by the cabinet secretary in respect of previous legislation. It is important that I clarify why I am moving the amendment and the way in which it underpins a change, in heart and policy terms, in the approach of the Conservatives to the legislation.

When the minimum pricing of alcohol was first promoted by the Cabinet Secretary for Justice at the beginning of the previous session of Parliament—when responsibility for alcohol measures rested with him—I was careful to say in my speech in that debate that I did not think that the measure should be ruled out but that it should be left to be considered at an appropriate time. My view and that of the Conservatives was that a considerable amount of legislation had already been passed and was still to come into effect. There was considerable concentration on the age at which young people should be allowed to acquire alcohol. At that stage, on balance, as we moved towards the culmination of that legislation, we were still unpersuaded by the evidence that underpinned the proposal.

A degree of scepticism has remained as the current bill has progressed. However, I do not think that the policy now is an act of faith—as it was then—because it is now underpinned by some empirical evidence from Canada, which has moved the debate forward even though that evidence does not involve exactly the measure that is being proposed.

I am also conscious that there has been a national election, during which the proposal, which was a cornerstone of the Scottish National Party manifesto, was widely supported by the public. Indeed, having explored the matter, it is clear to me that there is widespread support for the measure among clinicians, those working in accident and emergency departments and people in a variety of fields. Everybody who has an interest in tackling the problems of alcohol in Scotland will wish the measure to succeed.

Various claims are made for the measure. Some are beyond the likelihood of being translated into reality; others are more modest. As we have heard this morning there are people who are deeply sceptical, and there are people in the wider community who are concerned about the potential effects of the legislation. I am therefore moving an amendment that I hope will not ultimately change the direction of the policy but which will require the Parliament to examine again the measure that we are passing in the light of the experience of its effect, in order that we can be assured of the benefits that have accrued from it and can thereafter renew it on the basis of a proven track record of success. As was stated during stage 1, the legislation should be based on evidence, and in the absence of such evidence of success, evidence to the contrary would be the basis on which policy would be formed, and there would be no place for the measure.

I believe that my proposal will reassure those people who retain a degree of scepticism, as well as those who will be looking to Scotland's implementation of what is a bold measure in order to determine their practice in the future, that, in embarking on the implementation of the

legislation, we are confident that it will make a contribution to the reduction of the consumption of alcohol and are determined to ensure that Parliament will reaffirm its commitment to it in the light of the experience.

I move amendment 1.

The Convener: I invite the cabinet secretary to speak to amendment 2 and the other amendments in the group.

Nicola Sturgeon: Convener, is it appropriate for me to speak to amendments 1 and 2 now and to respond to Richard Simpson on amendment 12 later in the debate, or do you want me to do that now?

The Convener: It appears that you can, if you wish.

Nicola Sturgeon: I said at stage 1 that I had given the matter of a sunset clause further consideration, and I confirm that I think that it is right for the Parliament to have the opportunity to review the policy after five years, so I support amendment 1.

As Jackson Carlaw said, the proposed insertion in the bill of a sunset clause is a response to the concerns of some members that minimum pricing has not been tried elsewhere, which is a perfectly reasonable and legitimate position to take. Amendment 1 will mean that minimum pricing will cease to have effect six years after it comes into force, unless the Scottish ministers and the Parliament agree that it should continue.

Given the robust nature of the modelling and the evidence of the link between price and consumption and harm, as well as the evidence in support of a minimum pricing measure itself, I am confident that the evidence will be that minimum pricing in Scotland is effective and efficient.

Pricing interventions are supported by evidence. Our proposal is supported by robust modelling and a wide range of evidence. I think that it is likely that we will start to see benefits in the first year of the policy, but they will become more evident over time. We therefore support the inclusion of a sunset clause to reassure those who remain unconvinced. Quite simply, if we are wrong, minimum pricing will end. If we are right, as I believe we will be, it can continue.

Amendment 2, which is in my name, is complementary to the sunset clause amendment, as it will require the Scottish ministers to evaluate the effect of minimum pricing five years after it comes into force and to report on that to Parliament. That ought to provide sufficient time for the impact of the policy to be demonstrated.

The committee will know that the Sheffield modelling estimated the likely impact of minimum pricing after one year and after 10 years, but my judgment is that 10 years is too long a timeframe for us to wait before reporting to Parliament, which is why we think that five years is the appropriate period.

The report must include information about the effect of minimum pricing on the licensing objectives of protecting and improving public health and reducing crime and disorder; the effect on premises licence holders such as those in the pub trade, the retail sector and the wider licensed trade; and the impact on alcohol producers.

In preparing the report, ministers will be required to consult persons who have functions that relate to health, crime prevention, children and young people, education and social work, and those who represent premises licence holders and alcohol producers.

I think that what is proposed represents a fair and reasonable way to introduce a new policy and I hope that it will overcome what appears to be a stumbling block for some members, which is that such a measure has not been tried elsewhere, so we cannot be certain of its effects. My suggestion is quite simple. We should let the policy run for six years and, after five years, ministers should come back with evidence of the impact that it has had. At that point, the Parliament can take a decision on whether it should continue.

In the interests of time, I will go on to deal with amendment 12, although I am conscious that Richard Simpson has not yet spoken to it. Amendment 12 seeks to set out an evaluation package on the operation and effect of minimum pricing. As I hope will be clear from my comments on amendment 2, I absolutely agree that such evaluation is necessary.

However, I do not support amendment 12, because I do not believe that it is necessary. A comprehensive evaluation of the operation and effect of minimum pricing is already provided for in our monitoring and evaluating Scotland's alcohol strategy—MESAS—programme. That work, which is led by NHS Health Scotland, will ensure that the impact of minimum pricing on consumption and harm is closely monitored over time and that any differential impacts on or between different groups of the population or, indeed, any unintended consequences are identified and explored. That will include determining whether there have been any changes in drinking patterns or consumption and whether such changes differ according to age, deprivation, gender or any other relevant factors.

10:15

The MESAS portfolio includes studies to assess the impact of our minimum pricing proposals on individuals, communities and the country as a

whole. We are currently working with Health Scotland and academic partners to consider what further research is required, and I will be happy to keep members updated as those discussions progress.

A study that is primarily funded by the Government and led by Queen Margaret University is already in place to determine the impact of minimum pricing on heavy drinkers. It will also look at whether there are any possible displacement or substitution effects. It will use a longitudinal design to determine whether minimum pricing results in changes in consumption, type of beverage or price paid, or in the substitution of industrial or illicitly produced alcohol or drugs by those drinkers, and whether any changes are differentially patterned—for example, by deprivation. A Newcastle study arm will enable the researchers to determine whether any observed change in behaviours in Scotland is particularly attributable to minimum pricing.

The report that amendment 2 proposes must include information about the effect of minimum pricing on the various issues that I have covered. For all those reasons, I urge the committee to accept amendments 1 and 2, and I ask Dr Simpson, in light of my comments, not to move amendment 12.

Dr Simpson: I welcome Jackson Carlaw's reiteration of the sunset clause, which I will support.

The cabinet secretary's amendment 2 and my amendment 12 are trying to achieve, in slightly different ways, a similar end. It has been accepted that the policy is untested and untried. The only practical application of a minimum rather than a general pricing policy has taken place in Canada. The differences that exist there, including the national monopoly and the huge variety of different minimum unit prices—which vary not only between but within states and between different types of alcohol—make comparisons with a single universally applicable minimum unit price doubtful, to say the least.

It is therefore imperative, as I think we all agree, that there is a robust examination of the possible effects—or lack of effects—of minimum unit pricing. The detail in my amendment reflects the need for a substantial body of high-quality data and research to be produced. There must be a serious attempt to tease out the possible effects of minimum unit pricing from those of other variables.

Despite attempts by some to obscure the facts, the trend in alcohol-related deaths in Scotland has been downwards over the past five years, with an average drop in deaths per annum that exceeds the drop that was predicted by Sheffield in year 1.

We must take into account the flatlining of—or even reduction in—consumption, which may be accelerating if the effect of discounting that the Sheffield researchers reported to the committee as occurring in the first two months after introduction is borne out over time. It is a matter of regret that an amendment in my name to tighten the discount ban further has been ruled out of consideration by the narrowness of the bill. The discount ban appears to be quite effective, and the bill could have been further strengthened in that regard.

The statistics on alcohol-related admissions show a massive increase over the past few years, but that statistical analysis has been savaged in the *British Medical Journal* as yet another example of game playing. We need to be clear about the validity of the data that is to be collected.

The research must cover all areas of concern. I accept the cabinet secretary's point that the Queen Margaret University proposal, which has been accepted, now includes a control group; that is very welcome. However, it deals with very seriously harmed drinkers, who consume 197 units per week. Those are not typical Scottish drinkers who are at risk, but drinkers who are already suffering very serious harm. To prove that the policy is effective, it will not be sufficient simply to demonstrate that it has an effect on that group of seriously harmed drinkers.

I have said repeatedly on the record that I expect that minimum unit pricing will have some effect on some of that group. However, it does not address—and I am not convinced the MESAS programme yet addresses—the cohort of harmful drinkers with an average consumption of 57 units per week that the Sheffield model reflects.

The Sheffield study predicts that, with a minimum unit price of 40p, there will be a reduction in drinking among that group of only five units per week. We need to understand whether that is significant or not. It will be statistically significant, but will it be clinically significant? Will it shift the culture of drinking in Scotland?

Even more important than the position of those harmful drinkers who are already teetering on the brink of alcohol dependency is that of the hazardous drinkers—males in that category consume regularly in excess of 35 units a week—and, in particular, hazardous binge drinkers. Those are mainly younger drinkers aged 18 to 24, about whom the public have the greatest concerns: the most visible on our streets, they present the quite unacceptable face of the night economy. Some of them will undoubtedly progress to states of alcohol dependency.

Then there is the policy's unintended effect on low-income drinkers. I have repeatedly said that the evidence is that the consumption of cheap

alcohol, after discounting is removed, is substantially greater in the lowest 30 per cent of the community by income. After we take out the seriously harmful drinkers and the non-drinkers, low-income moderate drinkers in that group could be significantly affected as an unintended consequence of the policy. There must therefore be very clear research in that area.

All those elements must be researched in control groups, if possible, using areas in the United Kingdom Government's jurisdiction where minimum unit pricing is not happening. They need to be studied carefully so that a rational conclusion as to the effectiveness or otherwise of what is a novel policy can be rigorously tested.

However, if the cabinet secretary is willing not to move her amendment 2, I am willing not to move my amendment 12, so that we can sit down and work out a rational and agreed approach to ensure that the public will be satisfied that minimum unit pricing is an effective policy that we can be proud of selling to other countries. Without that clarity, I am really concerned that we are supporting a policy that does not do what it says on the tin. As the cabinet secretary knows, despite her painting of me and my party as adopting a purely party-political position, from the outset I have had—and, after examining all the evidence, continue to have—very serious concerns about that.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): The bill is clearly evidence-based legislation, as shown by the Sheffield work and Tim Stockwell's work in Canada. However, I will be happy to support amendments 1 and 2 because, as Jackson Carlaw said, the measure is bold and deserves our support. We had a similar bold measure in evidence-based legislation in 2006 with the smoking ban and, as we have seen since, that was absolutely the right thing to do.

I have a couple of points on each of the amendments. On amendment 1, the proposed five-year and six-year timetables are right for evaluating what happens after the bill is passed. On the cabinet secretary's amendment 2, which relates to the Licensing (Scotland) Act 2005, I particularly like the provision in subsection (3) of the proposed new section on the various bodies that will have to be consulted when reports are produced on how the legislation is working. Subsection (3)(b)(v) of the proposed new section refers to

"such persons as"

ministers

"consider appropriate having functions in relation to ... children and young people".

It is important that that is included in the bill.

As I said, the bill is evidence-based legislation, but the prescription that Dr Simpson proposes in amendment 12 about what evaluation should happen would, I think, hamstring the research commissioning project that will look at how the bill works in practice. The timetables in subsection (1) of the proposed new section that amendment 12 would insert are far too short to allow us to see real, practicable effects. I also understand that all the information that Dr Simpson seeks under subsection (7) is already available and is usually published by the Government annually.

There has been talk of wanting to reach rational conclusions, but I think that the bill is clearly a rational conclusion from the evidence that we saw in the Sheffield study and in Canada. For the *Official Report,* at this point I want to knock on the head a suggestion by Dr Simpson. He continually refers to the evidence from Canada as if it would not apply in Scotland because there is a national monopoly in Canada, but it is important that we all remember that Dr Stockwell made it absolutely clear to us that although there used to be a national monopoly in Canada, there no longer is. I understand that less than 50 per cent of alcohol retail outlets there are controlled by the national monopoly.

Again, I refer the committee back to the 2006 smoking ban, which was introduced on the back of evidence-based legislation that has proven its worth. I believe that this evidence-based bill will do the same again.

Drew Smith (Glasgow) (Lab): My concern about the bill relates to the windfall, on which we have not yet reached agreement. That said, I think that we are close to agreement on the issue of evaluation. As a result of the committee's scrutiny of the bill, there has been major movement on the matter; indeed, we have heard very good evidence on the need for robust and comprehensive evaluation of the proposals in the bill. Therefore, I think that at this stage it would be reasonable to ask whether amendments 2 and 12 might be reconsidered at stage 3 to allow us to reach an agreement on evaluation. I make that suggestion simply because the provisions in Dr Simpson's amendment 12, which I support, and the response of the industry should form a key part of the evaluation.

I do not wish to take up any more time, convener, except to say that, given that we are so close to agreement, it would be a shame if we were unable to reach it today.

Nicola Sturgeon: Having listened carefully to the debate, I think that there is an opportunity to try to bridge the gap between us on evaluation; indeed, I do not think that there is any gap between us in what we are trying to achieve. After all, it is not in the interests of those of us who

propose minimum pricing not to get over time a full understanding of the policy's impact and ensure that it is meeting our objectives.

I am minded to move amendment 2. Given that, as I expect, the proposed sunset clause will be agreed to, I think it important to include in the bill arrangements for reporting. However, I am happy to have further discussions ahead of stage 3 on whether there are amendments on which Dr Simpson and I can agree and which incorporate into the bill some of what he is trying to achieve in amendment 12. That is a genuine and sincere offer to him. If we can reach agreement in that respect, we will be able to lodge stage 3 amendments that build on the provisions that amendment 2 seeks to place in the bill.

The Convener: Do you wish to sum up, Mr Carlaw?

Jackson Carlaw: I have nothing further to add, convener.

Amendment 1 agreed to.

Amendment 2 moved—[Nicola Sturgeon].

The Convener: The question is, that amendment 2 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Carlaw, Jackson (West Scotland) (Con)
Doris, Bob (Glasgow) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Lyle, Richard (Central Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

Abstentions

McNeil, Duncan (Greenock and Inverclyde) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)

The Convener: The result of the division is: For 6, Against 0, Abstentions 3.

Amendment 2 agreed to.

Amendment 12 moved—[Dr Simpson].

The Convener: The question is, that amendment 12 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

McNeil, Duncan (Greenock and Inverclyde) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Lyle, Richard (Central Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

Abstentions

Carlaw, Jackson (West Scotland) (Con)

The Convener: The result of the division is: For 3, Against 5, Abstentions 1.

Amendment 12 disagreed to.

Sections 2 to 4 agreed to.

Long title agreed to.

The Convener: That ends stage 2 consideration of the bill. I thank the cabinet secretary and her colleagues for attending.

10:30

Meeting suspended.

10:35

On resuming—

NHS Boards Budget Scrutiny

The Convener: Item 2 is oral evidence on national health service boards' budgets. For this item we are joined by our budget adviser, Dr Andrew Walker—welcome, Andrew. I also welcome Laura Ace, who is director of finance, NHS Lanarkshire; Marion Fordham, who is director of finance, NHS Western Isles; and Craig Marriott, who is director of finance, NHS Dumfries and Galloway. I also welcome Paul James, who is executive director and director of finance, NHS Greater Glasgow and Clyde. Thank you for your attendance.

Jim Eadie: I want to understand a bit more about the distinction between earmarked and non-recurring funding and then move on to ask about planned savings. Of course, those issues were covered in the questionnaire that was issued to boards and you have provided comprehensive information on them to the committee.

First, I noticed that the supplementary written evidence from NHS Lanarkshire said that

"The vast majority of non recurring funding is for earmarked or ringfenced purposes."

Can the witnesses quickly clarify whether that is the case for all health boards?

Paul James (NHS Greater Glasgow and Clyde): Yes.

Craig Marriott (NHS Dumfries and Galloway): It is probably worth emphasising that in Dumfries and Galloway's non-recurring funding—that funding sits slightly to the side in terms of earmarked funding—we have a large element that relates specifically to an impairment revaluation. We are in the process of looking to build a new hospital. As part of the move to the new hospital, a revaluation of the old facility has to take place, and as part of that we have an impairment review. Against that, we are funded at a central level through annually managed expenditure and some of that is specifically within the non-recurring funding of £20 million.

Jim Eadie: The level of earmarked funding was around 12 per cent of the allocation that is provided by the Scottish Government. Do you consider that to be a constraint on local decision making?

Laura Ace (NHS Lanarkshire): We recognise that policy makers want the money to be directed to the area where the objective is in order to achieve it, so we are used to working with earmarked funding.

We welcome a recent move to bundle related allocations in a category, so that money can be moved between the specific headings, but the headings are all broadly in the same area.

As finance directors, what we welcome most is advance certainty. Rather than earmarked funding being a restriction, knowing well in advance what funding we will receive helps for the best planning.

Jim Eadie: So certainty is as important as flexibility?

Laura Ace: Yes. We are used to working with this level of earmarked funding and flexibilities have been introduced under related headings, which we welcome.

Paul James: Earmarked funding for Glasgow is broadly in line with other boards, but I agree with Laura Ace that earmarked funding is to achieve certain objectives that are set for us. That is absolutely fine.

The points about flexibility and certainty are valid. It is helpful to us in achieving our targets to have some ability to move funding within larger bundles, which is what has been happening, and also to make sure that we know a bit more about the future funding envelopes that we will face. We are in the business of providing health infrastructure, which is not always easy to change over just one year. Longer-term funding figures are helpful to us.

Jim Eadie: Will you say a little about what appears from the written evidence that the committee has received to be a higher level of non-recurring funds for some boards? We are told that NHS Lanarkshire, NHS Dumfries and Galloway and NHS Fife all have a higher level of non-recurring funds.

Laura Ace: I submitted a clarification about how a particular recurring allocation had been classified in NHS Lanarkshire. Once that is taken out, Lanarkshire does not have a high level of non-recurring funds. Such funding is mostly for project-specific initiatives. The committee's concern was that boards were using non-recurring funding for recurring purposes, but that is not the case in our financial plan. We will make good use of any non-recurring money, but we demonstrate recurring financial balance through our plans.

Craig Marriott: I emphasise the impairment issue in Dumfries and Galloway that I mentioned at the start and I support Laura Ace's position. When we do our financial plans, we are clear that we use non-recurring resources for non-recurring purposes and recurring investment for recurring purposes. We all set that out clearly in our financial plans.

Jim Eadie: It is clear that this subject is setting the heather on fire, so I will move on to planned

savings. When we asked boards to list their top three areas for savings, we received evidence that about 40 per cent of savings would be from prescribing budgets, 40 per cent would be from support services and 20 per cent would be from improved efficiency through the redesign of front-line services. Will you help the committee by telling us by what process health boards choose what spending will be reduced to make necessary savings?

Marion Fordham (NHS Western Isles): I can say what happens in NHS Western Isles. We identify the total gap, then allocate that pro rata to expenditure budgets and ask senior budget holders to identify how they will make the savings. We prefer not to impose the nature of savings on the front line; we expect people to come forward with proposals.

We work on an iterative process. When simple arithmetic is done with the numbers, it does not always work out exactly but, when areas can identify additional savings, that will mitigate the situation in struggling areas. That is how we operate.

Craig Marriott: We have been looking for a number of years at how we deliver efficiencies. We in Dumfries and Galloway have looked at the operational aspect of how we divvy savings among budget headings. We now try to look across care pathways and different services. We might start by looking at some of our corporate areas and our non-front-line areas in trying to deliver savings. We would then work back down through directorates.

We are getting slightly better at the process, but we have probably targeted the operational aspect much more until now. We are moving into the strategic and tactical stuff, which will involve much bigger service changes over a longer timeframe.

Paul James: The two answers that have been given are right. When our directorates make proposals, we always try to ensure prioritisation of the quality of healthcare first and of support costs last. Such a process always applies and our managers around the organisation understand that when they make proposals for inclusion in the financial plan. We are clear that, when we make choices, they are geared towards health priorities. That qualifies what has just been said.

Jim Eadie: I will respond to that after hearing from NHS Lanarkshire.

Laura Ace: We expect to develop an efficiency plan for certain elements every year. Procurement efficiencies and prescribing efficiencies have a process for generating savings. We will have worked out the size of the gap, so we will know what else we are looking for.

We tend to work more from the bottom up. The directorates and divisions come up with the efficiency proposals that they think could be managed. We work through and risk assess those proposals and look at any potential impact on quality or quantity. We refine the proposals into a list that is feasible to deliver, which we put in the financial plan.

10:45

Jim Eadie: How do we make sure that within the areas that have been identified—prescribing, support services, and efficiency through the redesign of front-line services—there is not an impact on patient care? Mr James made the point about ensuring that the quality of care is protected and that support services are earmarked before cuts take place in quality.

Paul James: We get feedback from the managers who make the proposals on whether there are impacts on services and we assess that feedback at the time. Different people have different views as to what service design is—whether it is efficiency, service design, or productivity. We should discuss briefly the suggested categorisation of some of the savings, although I am not sure that that is a helpful line of inquiry. In principle, we make sure that we focus people's savings and proposals on areas that will not adversely impact service, and if possible on enhancing service.

Jim Eadie: I will ask the question in a slightly different way. Through the Scottish Medicines Consortium, we have in Scotland a robust, well established and internationally respected process for subjecting new medicines to clinical and cost effectiveness appraisal. Is that robust and evidence-based process deployed by boards when they consider areas other than prescribing?

Laura Ace: I will start on the Scottish Medicines Consortium.

Jim Eadie: I do not want to talk about the SMC—that is understood. I want to talk about your process.

Laura Ace: The SMC's process is the most robust I have seen in routine use, but it is very well supported. When boards come to look at smaller issues, they do not have the same level of resource and advice from the various parties. Quite often, boards attempt to work to the same principles, but not to anything like the same extent. We ask basic questions about the impact on quantity and quality of service and on our ability to achieve national targets, as well as what the public perception might be. If, as we screen those questions, they fling up answers, we do further work. However, the Scottish Medicines

Consortium's process is beyond the capacity of most boards for every service proposal.

Jim Eadie: I am reassured by your answer, in terms of the process at the local board level. Is that process similarly robust in the other health boards?

Craig Marriott: It again comes down to the quantum and the materiality. Projects that will deliver savings of £10,000 to £15,000 might not have the same degree of rigour, although there is still the same expectation to work with general managers to make sure that there is no impact on quality. Proposals that will deliver savings of £1 million have rigid financial and service plans put in place to monitor the process and deliver the expected service outcome.

Some of the projects are highly technical and dynamic and have both a front door and a back door relationship, for example in an acute hospital there is a link between acute and primary care. Projects become very complex.

Paul James: I support what Craig Marriott said. The level at which you evaluate a proposal for a financial plan depends on its materiality and how importantly it affects service, so there is no single answer.

Jim Eadie: I am looking for more detail, similar to what Laura Ace provided us with, on what your process is at a health board level.

The Convener: We understand that you are dealing with a big efficiency saving, a cut, whatever—how we describe an efficiency measure or efficiency cut is an issue on its own, with which you may want to help us later, given that you have been making efficiencies for a long time and still need to make more, because we are into the cuts agenda.

The other issue that we would like to understand, perhaps with a practical example, is how priorities are decided. Are priorities decided purely on the health outcome, on least resistance, or on easier targets? Can you give us some day-to-day examples, or an experience, of how a priority is chosen and how that efficiency is achieved in that area, as against areas A, B and C? What are the factors that come into play?

Paul James: There is no simple formula. The proposals in our financial plan are put forward by our managers. There is an understanding that we have to meet quality targets as well as health improvement, efficiency, access and treatment targets, and we would not be particularly content with any proposal that people said would adversely impact on quality.

We submit a portfolio of savings proposals to our board, and it is the board that evaluates, assesses, and, at the end of the day, approves our financial plan. Conversations about the priorities relating to the quality of healthcare and any service impact take place at that level. There is no way that a savings proposal would be approved that had not passed through the board.

The Convener: You have described corporate governance and not necessarily the practicalities that would enlighten us as to the type of debate on and rigour around such decisions and the plans that go to the board. We understand that the board sign off the plans.

Craig Marriott: In NHS Dumfries and Galloway, our approach—to build on what Laura Ace said—is that there are fundamental elements within the efficiency programme every year. There are always drug switches that we will expect to pick up as part of prescribing, and there are always procurement savings issues that we are trying to tackle.

We carry out innovation work throughout the year. We run a number of workshops with our service team, where we attempt blue-sky thinking across the various horizons in relation to what happens elsewhere and how we can learn from others. On the back of that, we try to distil down to what we think our efficiency programme will be for the next year. The challenge is to look beyond that one year horizon to three and five years, which is sometimes where the more difficult projects are.

One of the projects that we are trying to progress this year is about out-patients. We are working with general practitioners to ensure that we have appropriate out-patient referrals from GP practices. In no way does that work cut across emergency referrals, which go straight into the system. The project is about how to build in an element of review to ensure that referrals are appropriate and that the acute clinicians are working in a clear manner with the GP practices so that GPs understand the processes and some of the other areas that could perhaps be treated differently. When you look at the evidence and across the various research that has been done, a 20 per cent reduction in out-patient referrals could be made, and for NHS Dumfries and Galloway that could equate to as much as £1 million. You will understand that there are many steps in the process that relate to releasing that, and, in some ways, the issue might be about just a capacity release.

The approach that we take in relation to efficiencies is to look at innovation and creativity, and some of the productivity issues, and to try to build up that approach throughout the year. I am sure that other colleagues do something similar that builds on some of the baseline efficiencies that we know that we will be trying to take out as part of our annual cycle.

The Convener: What tasks are your managers set to come up with proposals and plans? Are the managers just working in silos? Have they been set a target of efficiencies to meet within the health board, or are you saying to each area that it needs to reduce the money it spends by 5 per cent in each of a number of categories? How does that work with your broader approach to working with others if people are being asked to cut within their silos?

Craig Marriott: We try to take that broad approach. Yes, there may be a gap at the end of the process and that may turn into a need for a 1 per cent efficiency target across different directorates. We are trying to build up cross-cutting themes so that efficiencies are made in a broader context rather than getting just the slice effect that you would have in individual directorates. You asked about general managers. NHS Dumfries and Galloway is a relatively small board, so we can bring everyone together. It is not a case of people working in silos and passing problems among one another—that does not help the financial position.

The Convener: You described a process whereby plans come up from the directorates and go to the board. What remit have you, as directors of finance, given to the directors of the services that your boards provide? What efficiency savings have you asked them to make?

Paul James: You will appreciate that NHS Greater Glasgow and Clyde has the largest budget of all the health boards in Scotland. It is important that we try to put together a plan at the time when the other boards are doing so. We introduced quite a lengthy process this year. Shortly after the budget statement that John Swinney made, we had our first crack at what we thought the financial challenge would be. We called the senior managers into a room and discussed with them how the financial challenge might be disaggregated to different divisions within our board—along the lines that Marion Fordham described. The managers, having taken on those indicative challenges—

The Convener: Did you present the same challenge to each directorate? Did you ask each one to find 5 per cent, or did you talk about an overall cut?

Paul James: At the time, I put before the board an indicative challenge of £50 million—

The Convener: What did the cut turn out to be?

Paul James: The figure that we put in our response to the committee is £58 million—

The Convener: Slightly less, then.

Paul James: Slightly more. It went from £50 million to £58 million.

The Convener: Sorry, yes.

Paul James: Indicative targets were given to managers within the board, who went away to work on them—I do not like the word “silo”, but managers went to work in their management units on producing savings for which they would be responsible. They came back, and we had fairly good consolidation of the early figures in November, which we assessed as a management team.

Any concept of silo working is incorrect, because at that point we were discussing and assessing the various proposals that had come forward. We rejected some and asked for further savings in certain areas. An iterative process went on throughout the year; that is what has brought us to where we are.

The Convener: There were different targets in each area, rather than an overall target.

Paul James: That is correct.

The Convener: Do other boards follow a similar process? What targets did you impose?

Laura Ace: There is a similar process, but I did not impose any targets on the operating division; directors came up with the ideas, in a room in which all directors were speaking to one another. One director might offer to lead on an issue right across Lanarkshire, if it had a common theme across the area. I am thinking about areas such as administrative support or skill mix in allied health professionals.

The Convener: Directors were unaware of what was expected of them and were simply volunteering and saying, “I’ll give 10”, “I’ll give 20” and so on. It was a bit of an auction.

Laura Ace: Directors knew what the board had to achieve. We had had the discussions about procurement and prescribing. Some schemes take longer to put in place, so I was able to say, “Here are all the things that we started this year or last year, savings for which we will start seeing next year.” Directors knew what the residual gap was and they all put forward ideas, each of which was subject to the questions that I mentioned. Ideas were filtered; some were rejected because the approach would have had too much of an impact. If we still had a gap, we got back round the table.

I have not had to allocate targets to the directors; they have all behaved corporately. We handed out a specific target only to the corporate areas. During the three years since 2009 we have taken 27 per cent out of our corporate functions, by giving them a percentage each year. They take that away and come back to us with plans.

The Convener: Is it a similar story in other boards?

Marion Fordham: I tried to describe the process earlier. NHS Western Isles is a small board and therefore operates on a much smaller scale than other boards do. We try to be fair at the outset in providing people with targets that are a direct proportion of the total savings target. There is an implicit understanding that the savings that people identify will in no way affect targets or quality. The board would not entertain savings that were not put forward on that premise.

The Convener: Does anyone else want to comment?

Dr Simpson: I will come in on that point, if Jim Eadie is finished on it.

Jim Eadie: I am, although I have a further question.

11:00

Dr Simpson: I am trying to understand the issue on a practical basis. I have had the good fortune of being a general practitioner running my own unit as well as a hospital consultant and so subject to more management control. I found the experiences and the differences between them interesting. In effect, whatever the boards told the managers, we were told at the bottom line, "Take 3 per cent out of your budget this year, please." I do not know what is happening with communication down the line.

My question is on a slightly different issue. How much of the advice that boards give to managers in determining how to approach savings is based on an analysis of variation from the Scottish average or agreed areas? I will give three examples. One is on the use of day procedures in hospital rather than in-patient procedures, in which there is massive variation between boards. I will not mention the names, but one board in my region, Mid Scotland and Fife, has excellent hospital day procedures and has reached the target on almost all 19 procedures, whereas a neighbouring board has failed miserably to do that, although we know that there are substantial savings from doing that. A second example is theatre utilisation. Audit Scotland produced a report on that nine or 10 years ago, but there is still massive variation. The third example is the SPARRA—Scottish patients at risk of readmission and admission—data.

Do you get good advice from the Government through the joint improvement teams and in other ways that, if your boards are demonstrated to be inefficient compared with other boards in certain areas, you should concentrate on those areas initially to make savings?

Paul James: We are aware of the need to move to day cases and out-patients and away from in-patients where possible. That is part of our acute division's strategy, as is the improvement of theatre utilisation. You will appreciate that, as the largest board in Scotland, we dictate to an extent the Scottish average in many cases, so it is not always useful for us to compare ourselves with other boards. We try to compare ourselves with benchmarks from outwith Scotland as well as within it. We are continuing to extend that process. For example, our bed modelling is based on hospitals outside Scotland. We will continue to look at that. We are conscious of the importance of benchmarking in driving improvements in efficiency and we are absolutely aware of the points that you make about day cases and theatre utilisation.

Dr Simpson: Do you publish information on that? If I was interested in what your board is benchmarking itself against, could I find out?

Paul James: I genuinely do not know whether that information is published, but I am sure that we could provide you with information on what we have been doing so far and where we are going. That is work in progress, so I do not want to pretend that it is the finished article at this stage.

Dr Simpson: No, but it would still be helpful to the committee.

Laura Ace: We are always interested in that type of information to see whether it points us to something that we have not considered. Part of our iterative process is a stocktake against the national productivity and efficiency programme to ensure that we have covered everything that has been identified. Also, if there has been any obvious or recent benchmarking, we ensure that we pick up on the recommendations for that. Our divisions tend to pick up on those issues naturally. We do not often find that a piece of national work is completely missing from our plans—we usually find that we are working on it.

Craig Marriott: In Scotland, we work collaboratively to an extent. If there is good evidence of positive progress in one board, people often go and visit it. The issue with benchmarking is how we take the money out of the back end. That is sometimes about capacity release and sometimes about cost avoidance. When we talk about efficiencies, it is really just about trying to get to the cash, which can be a bit more difficult.

Jim Eadie: I have a couple of quick questions before we leave the issue of planned savings. First, is there a clear and established process of horizon scanning for the managed introduction of new medicines in your boards? Secondly, what proportion of the 40 per cent projected savings from prescribing is a result of medicines coming off patent in the next three years? If you need to

write to the committee on that because you do not have all the information to hand, that is fine.

Paul James: We provided the committee with a figure for prescribing savings of £17.4 million, which included an estimate of the savings from drugs coming off patent that amounted to around £8.4 million.

Your first question was whether there is an established process for horizon scanning and thinking about the implications of new drugs. I do not think that there is a more detailed process in our board than the one for drugs and prescribing. We have a number of committees that look at the advent of new drugs, assess the recommendations of the SMC, consider the expected uptake of each major new drug and try to evaluate what the impact of that will be on our financial plans. Every four to six weeks, I have a meeting with our prescribing management finance group, during which we consider exactly those issues, virtually on a drug-by-drug basis, for both primary care and acute services. The process by which we try to forecast the impact of new drugs on our financial plans is extremely complex. We are very aware of that issue because there is also a sophisticated process for ensuring that we try to optimise our drugs spend. We ensure that we have clinical advisers working with our GPs so that they can all share knowledge of what the right and most cost-effective drug is. As you will understand, that is a clinical decision and is absolutely not something in which I interfere.

Craig Marriott: The proportions that Paul James gave for savings from drugs coming off patent and savings from the switch from branded to generic drugs are probably similar in most boards. Our prescribing savings come to £2 million, £1 million of which comes from the switch from branded to generic.

Marion Fordham: NHS Western Isles has been a little bit more circumspect about anticipating the savings from drugs coming off patent, just because there is always a time lag for GPs switching to generic drugs from drugs that they have been using. From our point of view, in terms of the 2012-13 budget, we have assumed that it will account for about 10 per cent of our total prescribing savings. I can give you definite figures in writing after the committee.

Laura Ace: My answer will be similar to those of Glasgow and Dumfries. Because some of the high-cost drugs will first come in in the tertiary services, we in the west collaborate to do shared horizon scanning for the new cancer drugs, which means that we can take advantage of the views of the experts at the Beatson oncology centre.

Jim Eadie: And how much of the 40 per cent projected savings is attributable to medicines coming off patent?

Laura Ace: For us, it is probably slightly higher than 50 per cent—it is probably around 60 per cent.

The Convener: Prescribing was high among the risk factors associated with the budgets that have been set, but I do not want to concentrate on that. I want to focus on an issue that has arisen from recent disclosures and affects me locally but which did not appear on any of the risk registers: the backlog in maintenance across the estate in some health boards. The press reports and publicity suggest that the number of facilities involved is so large that there will be a £1 billion repair bill for the NHS estate. You now have an opportunity to debunk this story of the £1 billion price tag or at least give us an idea of the real though undefined risk that, as the NHS Greater Glasgow and Clyde documents suggest, is hidden in that £1 billion repair bill.

Paul James: I am afraid that I do not have any particular answer to the £1 billion price tag question. Am I right in thinking that that is the national figure?

The Convener: Yes.

Paul James: In that case, I am not quite sure what your question is.

The Convener: As you have pointed out often this morning, you are the largest health board in the country and therefore take up a large part of that £1 billion. The maintenance bill for the Inverclyde royal hospital alone is something like £26 million. In some of the information that you have provided to me, you have referred to a real but undefined risk that presumably could impact on patient care and outcomes and access to the hospital. What is the figure for covering that risk?

Paul James: Clearly, we have to ensure that we keep our estate in good condition—I do not think that anyone will say otherwise. Therefore, we must ensure that, in our capital plans, we give priority to the estates that we need to invest in.

I believe that you are referring to the property and asset management strategy papers that are published. As I do not have those documents with me, I am a bit exposed with regard to giving you answers about the specific maintenance requirements on specific sites, but I assure you that we prioritise our service redesigns in order to reduce those costs.

The Convener: I am simply registering surprise at the fact that this substantial amount of money is not on any of the risk registers and that the risk to service delivery or your budget has not been set

out. Surely if something serious happened, the money would need to be found.

Laura Ace: The reason why the risk has not been mentioned in the financial plan is that we have as far as we can built it into the plan. Lanarkshire has risk assessed its entire estate, particularly Monklands hospital, which makes up the bulk of our maintenance backlog, and we have put in place a risk-based programme to ensure that we tackle that first. We have been putting in £5 million over the past few years and, indeed, have allocated £6.6 million in this year's capital plan.

We also keep an eye on our other premises. Our programme of community health centre development has taken away some of our worst premises and the others are prioritised according to risk, with those that have health and safety issues or which might impact on business continuity receiving funding first. Going back to the issue of non-recurring funding, I point out that, if there happens to be a windfall or if some one-off move turns out better than I thought it might, we will look at the prioritised list during the year and say, "Let's get ahead with the next five". We are mindful of the issue and it is covered in our monthly financial planning.

The Convener: With regard to change funds, I was interested in Mr Marriott's earlier comments about working with GPs. Nevertheless, I am sure that you will have seen from the evidence that we have received that, although the change funds represent a significant amount, they are not that significant to the large budget holders. We have had repeated representations from the third, voluntary and independent sectors that they do not think that they will be able to access it as much or be treated as equal partners in the allocation process. I believe that Richard Simpson wishes to pursue that matter.

11:15

Dr Simpson: I do. The change fund constitutes a finite amount of money over three years and there is no guarantee that that will continue, although the same was true of the waiting times money and it was eventually merged into your budget as the targets that were designed to be achieved were achieved. I am not clear about the position with the change fund.

Is the change fund being used to do things that might produce savings a lot further down the line? For example, are you funding stuff in community care that will eventually mean that your acute side is relieved of a certain amount of pressure? If that is the case, I do not understand why the third sector, which is of critical importance in delivering social care in the community that could prevent admissions, has been given a very small amount of money in year 1. I hope that it will get more in years 2 and 3.

Will you give us a flavour of how you are using the change fund? I do not know whether other members of the committee would agree with me, but I have a suspicion that the change fund is being used, in part, to fill gaps that have arisen because of the tightness of budgets, which is not the purpose of the change fund.

Paul James: When we responded to the committee's survey, our change fund plans were not complete, but you will appreciate that a large number of initiatives are put forward for NHS Greater Glasgow and Clyde. I think that it would be a mistake to say that they are all about savings or service improvement, or that one particular objective applies to all of them. The moneys are used for a variety of objectives, and a variety of initiatives has been developed by individual community health partnerships for those purposes.

From my perspective, the change fund is very much a catalyst for change. As you rightly point out, the change fund money is not the full core funding for the areas that we are talking about. It is designed to achieve change. The question is whether the change that it is designed to achieve will be achieved in the short term or the long term. We are looking at change being achieved in the longer term so, when we talk about savings being achieved in the acute division as a result of change, it is not easy to predict when that change will result in cash-releasing savings being made. I would be quite concerned if the assumption were that the change fund was being used to fill gaps. It feels to me as though the change fund has a longer-term focus; it is a catalyst. It is about giving people the ability to invest in certain areas in which they think that it is possible to shift the balance of care.

Marion Fordham: In the Western Isles, the issue with the third sector organisations is that, locally, they are very small outfits. We need to assist them in increasing their capacity so that they can handle step changes in what they do. There is no doubt that what they do is extremely helpful but, at the moment, they could not handle significant increases in funding and make the changes that we want in the short term. It is very much a longer-term game.

Dr Simpson: To go back to what Mr James said, in none of the financial responses that we have received do boards employ the potential savings in the long term, because it is considered that they may be overtaken by other events. I think that I am right in saying that that message has come across very clearly.

That is slightly disappointing. I will give an example from my experience. A long time ago, I was involved with surgeons in developing a vasectomy service. I submitted a plan to our local board that demonstrated that, if it got rid of what was then a 10-month waiting list for a vasectomy, it would save X number of births for a start and the total savings by year 7 or 8 would be substantial, even though there would be no savings in year 1. That was pooh-poohed—it was never accepted.

Have we got the change fund working in a way that will in due course produce a major shift in resource to the primary sector?

Paul James: It is early days to say whether we have the answer to your question. That is not to say that the change fund is failing. We just do not know yet. It was introduced only last year. We must keep going and try to achieve the savings. We are redesigning services generally at the same time, as part of our financial plan. The change fund is not the core funding area. We are redesigning services within the core funding area all the time, cognisant of the change fund initiatives. It is hard to link one with the other, but I would not rule it out.

Craig Marriott: It is worth building on that point. In Dumfries and Galloway, we keep on trying to capture the change. How do we know what change is taking place? There are well-trodden techniques for measuring the baseline, understanding the change, targeting it and monitoring against that. We try to do that and to bring rigour to that.

The other issue for us is that demography might pick up some of the capacity that we release back into the system. In the longer term, we will be talking not about money going out but about building capacity, whether that is building capacity in the current way in which services are provided or building capacity by changing those services. Given the demographics that are coming, and the way in which services are run for older people, we all recognise that we will have to change the current configuration.

I would like to say that, for us, it will be about releasing efficiencies but, in reality, it might be a combination of efficiencies and capacity.

The Convener: I suppose that the intention of the change fund is to create momentum for a different way of thinking. Correct me if I am wrong, but you seem to consider the change fund an insignificant amount within your budgets as a whole. Does it catch your attention? I know that it has caught the attention of the third sector, which sees it as an opportunity to change its culture, but I am not getting any sense that the health boards are enthused by it or that it is high on their agenda. Ms Ace will confound that.

Laura Ace: It is very high on our agenda. The forecast for demographic growth is a 22 per cent increase in the number of over-65s in the next 10 years. If we simply carried on providing care in the same way, we would have to open hundreds of extra hospital beds. We know that we have to change, shift the models and promote the idea of people living independently in their own homes.

Although the change fund might be a small proportion of our total spend, it is still a significant amount. For Lanarkshire, it is more than £8 million. We see it as a catalyst—it is our one chance of getting enough money to allow us to make changes and it is very important to get those changes right. We are engaging multiple partners, and there has been a lot of capacity building in the first year.

In addition to that, because we know that money is scarce, we want to ensure that when we have an idea for a new service, that service will deliver what we want it to, so we test the service before we permanently crystallise the money for it. It is a combination of multiple partners and long-term planning. It is less than a year since the change fund money was released, but we are treating it seriously. We see it as something that we have to do to be able to cope in future.

The Convener: We have heard that there are capacity issues for the third sector and the independent sector. However, there is criticism that local government and health boards are still retaining in excess of 90 per cent of the change fund. That may be because we are only a year into the fund, and the judgment that people have made is that it could be rolled out. Anyone else on that?

Craig Marriott: Absolutely. We are working closely with our third sector colleagues. In some ways, the third sector is not geared up to thinking about large sums of money and how we create real change. It is moving away from the delivery aspects. When we get into years 2 and 3, more will start to be invested in the third sector.

Dr Simpson: I have another concern in this area. When I was a minister in another sector, we tried to build up our third sector organisations, but the trouble was that they were on year-to-year funding. They ended up saying, “How can we plan?” You have asked for some certainty about how you can plan your financial future, but a finance director of a third sector organisation is living from year to year. Many of them issue redundancy notices every Christmas because they do not know what their funding will be from April.

We introduce a change fund, with novelty and so on, and we invite the third sector to participate, which we are all keen on. However, how on earth can we do that if we are telling the third sector, “Of course, it’s only for one year, two years or, at the

most, three years. We don't know where it will go after that"? How do you develop a real partnership with the third sector that gives it the same certainty in its planning that you are asking for in yours?

Laura Ace: The premise that we are working on is that this is the future shape of services. Previously, we may have done more short-term initiatives that were funded for one year. However, we know that we must plan for the future and that is what we are working on.

Dr Simpson: If the organisations are successful and meet the outcomes that you set, you will undertake to mainstream the funding in due course, so that they do not have to live from hand to mouth.

Laura Ace: That is the premise that we are working on.

Dr Simpson: I mean mainstream on a reasonable basis, because no one is permanent these days.

The Convener: All heads are nodding.

Paul James: Laura Ace is right. At the end of the day, if we find that a particular initiative or scheme meets our health priorities and is therefore worth mainstreaming, we mainstream it.

Dr Simpson: Can you give us examples in writing of anything that you have mainstreamed with a voluntary organisation? It can be something that you plan to mainstream if an organisation meets the outcomes or something that you have succeeded in mainstreaming from previous initiatives. Such examples would be helpful for our report because they would give some certainty or hope to the third sector.

Fiona McLeod: You all nodded enthusiastically when the long-term future of the third sector was referred to, but when you write to us, can you tell us in percentage terms how you are using the change fund to support capacity building with your partners in the third sector? That information would be interesting.

The discussion about the change fund and years 1 to 3 is similar to the discussion on preventative spend. The committee is keen to understand something from you on that issue. You look for a long-term gain when you shift to preventative spending, but how do you build that into your financial planning? I quote our adviser, who has probably put it better than I can:

"Would boards like to include financial savings from preventative spending in financial plans and, if so, what is required to achieve this?"

The Convener: Who is first? Mr Marriott will start.

Craig Marriott: I will kick off and hopefully my colleagues will help.

By the very nature of preventative spend, the timeframe for recovery or generating the efficiency might be slightly outwith the timeframe for our financial plans, which are for one to five years, and we recognise that some of the preventative spend issues might impact within that timeframe.

In Dumfries and Galloway, we will build on the preventative work that we have been doing and on the availability of the change fund money. It is new money and, given the current tight financial position, we have a responsibility to ensure that we recognise where change has taken place and to be clear about the outputs that we expect—whether they are financial or service-related—and how we will monitor that. That timeframe was perhaps not part of our rigour in relation to preventative spend previously, so that will be the real challenge for us. Therefore, I would expect my board to bring forward some of the deadlines and targets in relation to change fund moneys—if we classify the change fund as being preventative spend—to within the one to five-year timeframe. Given its nature, we will have to look at much shorter timeframes than we did before.

Marion Fordham: On preventative spend being a long game and the issues that arise in trying to realise the resulting savings in a tangible form, we introduced near-patient testing and anticipatory care for heart failure more than five years ago and can point to statistics now that say that, as a result, we have reduced the associated bed days by 60 per cent. However, we still have a hospital with beds in it, so until we have a bigger service change that affects how the hospital is utilised, we will not realise the associated savings in a tangible way.

11:30

Laura Ace: I would look at each case, on a case-by-case basis. Some of the change fund proposals are necessary if money is to shift within a timeframe.

I was struck by the example in Audit Scotland's report, "Cardiology services", which noted that, in the decade from 2000, the rate of new cases of coronary heart disease has gone down by a third. That is a tremendous success story for the preventative approach. However, over roughly the same period, the national spend on cardiology services has gone up from £80 million to £143 million, because people with heart disease are living longer and new treatments are appearing all the time. The preventative approach has helped us to cope with demand and to fund advances in technology, but no money has come out of the area—indeed, we are still investing in it.

Fiona McLeod: You have given an example of money being saved and then reinvested in more advanced technology, and Ms Fordham gave an example of money being saved without the board being able to release beds. The clear intention for the long term is to move care from acute settings to the community, so the logical next step is to consider how we do that. How do we move the financial savings that preventative spend has realised from the acute sector to the community?

Laura Ace: I suppose that because we operate on a bigger scale, we have been able to make savings and release beds, but we simply have not been able to do that in cardiology. As we see in the media every week, if the SMC deems new and improved drugs to be cost effective and if new treatments become available—transcatheter aortic valve implantation is the most recent example—the public has every expectation that we will fund them.

There is a tension in that regard. We cannot just stand still, take the savings and put them into the community, because people expect us to do the things that we are spending money on. It is not that the acute sector is sucking money in; the sector is responding to policy initiatives, expectations and demand.

Dr Simpson: I very much welcome the transfer of responsibilities for prisoner healthcare from the Scottish Prison Service to the NHS, which was long overdue. Has adequate funding been transferred to boards? The Parliament has recently debated women prisoners, who might well be dispersed and no longer all concentrated in the NHS Forth Valley area—my health board area. On a more general point, addressing offenders' health issues, particularly alcohol and drug addiction and mental health problems, is pertinent to the Government's strategy of trying to reduce the load on the prison service.

Negotiations on the transfer seemed to take quite a long time. Was the result satisfactory? I understand that the money was mainstreamed this year. Was that appropriate or should some ring fencing have continued, so that any shortfall in relation to the treatment and management of prisoners' health issues could be identified?

Laura Ace: At the point of transfer, the money was certainly enough to run the services. The process by which we got the money was fair. As you rightly suggest, there could be an increase in demand if there are greater aspirations for prisoner healthcare in future, and now that the service has transferred such an increase in demand and expectations would fall on the health service. We will deal with that in our planning for the future.

Paul James: Laura Ace put it very well. We are affected by the transfer and an increase in demand will of course place pressures on us, across our system. However, the process was fairly fair and, as far as I am aware, there is no reason to believe that the funding is either inadequate or excessive.

Dr Simpson: That is helpful, thank you.

Are adequate structures in place to deal with equality issues? The written responses that we received from the boards seem to indicate that there is slight concern about whether impact assessments are consistent across boards and whether equality issues are being mainstreamed in an effective way. The agenda for change has been dealt with, but I am not clear about whether equality issues in relation to pay structures and in general have been appropriately tackled yet. Is that a concern for you?

Craig Marriott: We pick up on that matter in every decision that comes before the board. We have openly discussed our efficiency programmes today, but sitting down to do equality impact assessments of our efficiency programmes has become normal in our business. That is a common question around our board table.

Dr Simpson: I see that everyone else is nodding.

I have a final, tiny question. At the beginning of the austerity period, I followed a debate in the *British Medical Journal* about what we can disinvest in. You have talked about redesign, which is fine and that is partly about disinvestment. Four or five operative procedures were specifically listed then. An interesting report by the director of public health in the Western Isles for the public health group indicated that four or five procedures really should not be carried out except in exceptional circumstances. The savings were not massive—we are not talking about tens of millions of pounds—but it nevertheless seemed to me that, as a principle, disinvesting in inappropriate or ineffective treatments should be considered. There is the general area of surgical procedures, but there is also the whole area of homeopathy, and there is the question whether it really is evidence based. I do not want to open too big a can of worms on that, but do you have significant disinvestment programmes that are based on the low or absent effectiveness of treatments?

Paul James: We do assess the procedures, but you will appreciate that, as a finance director, I am not qualified to say which ones are or are not of clinical merit. However, conversations about them take place.

Craig Marriott: We have invested time in making difficult pathway decisions. It is about

picking up that point, and homeopathy is being considered. We are certainly tackling that issue in Dumfries and Galloway.

Laura Ace: I very much support the principle of spending our money on things that are effective and for which there is good evidence that they work. Obviously, there can be a great deal of attachment to services that have been provided for a while and the right public engagement is necessary to take those services forward—things do not work simply because of the evidence.

Dr Simpson: It would be good if you had any examples of specific disinvestment programmes that you have agreed with your clinicians and any illustrations of the barriers that there are to disinvesting, although the evidence indicates that you should be disinvesting—I refer to what Laura Ace said. It is clear that the public still like homeopathy, even if a lot of the scientific evidence on it is somewhat debatable.

Jim Eadie: That is a different debate. There is an evidence base for homeopathy.

The Convener: We will probably debate the matter over lunch; we do not need to bother our panel with it. That was just a bit of indiscipline.

We have covered many issues that were reflected in our questionnaire, but one that we have not covered—

Richard Lyle (Central Scotland) (SNP): We have not covered pay.

The Convener: Thank you, Richard. That saves me from mentioning it.

Richard Lyle: Pay is the biggest item in NHS spending. To what extent is the overall pay bill under the boards' control? What can your boards do to ensure that overall restraint is balanced against fairness to different groups of workers? We often read in our papers that managers are getting big bonuses. What percentage of bonuses in performance-related pay schemes or other schemes in your boards is paid to managers or anyone else?

Laura Ace: That is easy: at the moment, it is 0 per cent. There has been a national pay freeze, apart from—

Richard Lyle: Could you repeat that?

Laura Ace: Yes—it is 0 per cent at the moment. There has been national pay restraint in recognition of the economic conditions. The positions that we are all reporting just now would look significantly worse if pay restraint had not been operating in the background.

The lower paid, who earn under £21,000, get an element of rise but, beyond that, inflationary rises—and for senior managers, the element that is counted as PRP—have been frozen for just now.

Richard Lyle: I will be interested to hear what the others have to say. You are saying that pay is frozen—0 per cent rises—but is it not a fact that managers are still getting some form of bonus?

Laura Ace: No.

Richard Lyle: So the newspapers are wrong.

Laura Ace: Do you mean with regard to the current year? It is 0 per cent. The senior manager scales are frozen.

Richard Lyle: You are not getting my meaning. They are still—

Laura Ace: There is no rise. Senior managers—

Richard Lyle: Sorry—they are not getting a rise, but are they still getting a bonus?

Laura Ace: No. The bit that is characterised as a bonus is just part of what other staff get as a normal rise, except that for senior managers it is related to performance. Other staff progress incrementally up their pay scale, but senior managers can progress only if they demonstrate that they have met all their objectives.

Dr Simpson: I submitted a freedom of information request on that. If the information that I have from all the boards is wrong, that is interesting. It says that, last year, 487 managers got performance-related pay. That is not to say anything about it being increased or decreased—clearly some of that pay would be contractual and could not be varied, but it was nevertheless performance-related pay. There were 250 consultants who got an additional bonus last year—they were new consultants getting bonus points, rather than merit awards—and 630 consultants got additional bonus points last year.

That is the information that I was given in response to my FOI request. There were 1,800 consultants involved in getting bonus points, so only half of them did not get an increase last year, while half of them did. I have raised that in Parliament as a matter of concern.

Laura Ace: I was giving the answer for the current financial year; your FOI request would be for the previous year. The amount will be set out in pay circulars: from memory, it was 0.5 per cent from October for last year, but that information can be verified by NHS pay circulars. My answer did not refer to the consultants' discretionary awards.

I am sure that the two sources of information are absolutely reconcilable; I was replying for the current year. The information is a matter of record—it is all governed by national circulars, so it is easy to determine what the figure is.

Craig Marriott: We regularly have to respond to FOI requests on that, so it is a well-trodden path. We can all nod to Laura Ace's response.

The Convener: I see that there are no other questions, so I thank you all for your time and for the evidence that you have provided this morning. I will suspend the meeting briefly while we change witnesses.

11:43

Meeting suspended.

11:46

On resuming—

The Convener: I welcome our second panel of witnesses, both of whom are from NHS Scotland. Derek Feeley is the director-general of health and social care, and John Matheson is the director of health finance and information.

Jackson Carlaw will ask the first question.

Jackson Carlaw: Good morning. Gosh, I have to say that, in business, probably the most thrilling exchanges were when we had the accountants in, because, however fundamentally important the subject material might be, it can sometimes be a bit dry as we seek to get below its surface.

We received some fairly comprehensive responses from our colleagues just a moment ago, although I do not want to use shorthand and simply say, "Do you agree? Discuss", because I note that you joined us fairly late in the meeting.

I am interested in the area of risk, which I will couple with preventative spending and the change fund, as those issues seem to go together and were linked in the evidence that we just heard. To what extent do you think that an appreciation of risk, and the expected demographic changes, ultimately fails to find its head in the preparation of immediate financial planning? To what extent is preventative spending not appreciated in terms of financial modelling because it will not produce a dividend at an early date? Our previous witnesses told us that the change fund has not been in place long enough to judge its efficacy, but to what extent do you think that it provides a model that might assist in that happening?

Derek Feeley (NHS Scotland): Your question covered a range of issues. I am sure that you will remind me if any of them escape my mind.

We expect risk to be a fundamental part of boards' planning. We were fortunate enough to be able to listen in the ante-room to the evidence that you were given by the directors of finance, and I associate myself with those remarks.

From my perspective, the additional colour that I would offer is that a clear strategic context for doing the work that the directors of finance described is set out in our quality strategy, which also includes a consideration of risk. We would expect risk to be picked up in the development of proposals. You heard evidence from the directors of finance about how that is done through the divisional command structures and by the boards through the audit and risk committees, which identify any risks that accrue.

The dividend from preventative spending depends on your definition of preventative spending. It is important that we do not forget that we have been doing preventative spending for quite a long time. The initiatives that we have introduced on smoking and the initiatives that the committee discussed around alcohol are about preventative spending. We have seen some returns on what we have done on smoking rather more quickly than we anticipated. There is a dividend.

There is quite a strong evidence base on some of the things that we are doing on early years, for example the family-nurse partnership. There is a strong evidence base that indicates that there is a return on such investment in due course. It takes a few years, but there is a return. We would expect that to be built into longer-term planning.

The directors of finance are right to say that it is early days on the change funds and that we are finding our feet. We are gradually establishing how the funds can best add value, but their real benefit will emerge as we move towards health and social care integration, because that is the change for which the change funds are designed. People will start to see how they can prepare the ground for health and social care integration by using their change funds appropriately. The change funds will be part of a much more significant investment in due course.

Jackson Carlaw: I return to your point on smoking, because that is an instructive example. When the modelling took place on the dividend that would accrue from changes in the approach to smoking, over what sort of timescale did you imagine that the dividend from preventative spending would accrue? What has been the practical experience of the benefit that you say has come earlier? Is it typical to be able to identify the benefit that has accrued from a preventative measure? Alternatively, is some of the advantage of preventative spend in other fields subjective rather than easily proven from a budgetary perspective?

Derek Feeley: It is hard to give you a fixed timeframe within which you will get a return on the investment, because it varies depending on the intervention. Some will accrue benefits more

quickly than others, so we need to keep an open mind. We should be guided by the evidence, so we should prioritise the interventions for which there is already a strong evidence base, but at the same time we should not rule out initiatives when we think that there is a benefit. Otherwise, we will continue to lag behind others rather than set the pace.

Scotland can rightly be proud that some of the things that the Scottish Parliament has done have been genuinely groundbreaking. If we had waited for the evidence, would we have done those things? There is a balance to strike between doing what the evidence tells you is right and sometimes following your gut and persevering when you believe that something is the right thing to do. So long as we build that into our assessment of risk, we are on sound territory.

Jackson Carlaw: I am trying to understand which trumpet plays the loudest. Obviously, the NHS is a public service. However, a lot of businesspeople will no doubt have a scheme brought before them by an individual who is promoting an idea that they believe might make a material contribution to the business over a long period of time. Some people will say, "I have a profit and loss line that I have to achieve at the end of the year, so although it is nice to hear from you and that is a very interesting concept, this year the bottom line is the priority."

A public service is not a business, but you work quite closely to the same need to be within budgets. Does the trumpet that says, "We can see that this will make a material difference over time," have equal weight with the trumpet that says, "We have a figure that we have to achieve now"? As much as we might like a case that is demonstrable over time, does the system in which we operate not for whatever reason allow it to be trumpeted more loudly?

John Matheson (NHS Scotland): I will give Derek Feeley a break by responding—he might want to come in afterwards. When I talk about financial performance nowadays, I talk deliberately about quality-driven financial performance. The quality strategy that Derek Feeley mentioned is at the heart of how we deliver our financial outturn.

You are right about the temptation to have a short-term focus to financial performance, but I look at financial performance over three to five years. That is why it is useful to have the three-year spending review position clarified, so that we can give boards and other parts of the NHS certainty about the uplifts that they will get.

My colleagues who gave evidence earlier referred to another factor in risk management. I have been keen to promote the concept of bundling. Rather than micromanaging health boards and giving them allocations at a reasonably small level, allocations are bundled in themes. That gives boards the ability to use money flexibly and creatively and the assurance that money is not just a one-off—although it is earmarked in the bundle, it is not earmarked at a micro level.

Boards still have to deliver on their alcohol brief interventions, for example, so targets will not go away, but the aim is to move away from an input focus to an outcome and output focus. I am not particularly interested in whether NHS Highland appoints a part-time alcohol nurse; I am interested in whether it delivers on the target. I would trust the board to judge how to do that.

NHS Scotland is a £12 billion organisation. My final point on risk is that, in the split between recurrent and non-recurrent funding, there will always be some non-recurrent flexibility. Ideally, it should be used for non-recurrent purposes, but it can also be used as a source of investment, to allow initiatives such as those to which Jackson Carlaw referred to progress.

Derek Feeley: I will respond to the second set of issues that Jackson Carlaw raised. We have to balance the books—that is an entirely proper requirement on us. I am sure that the committee would have something to say about it if we did not do that, as would your colleagues in the Public Audit Committee.

What trumpet plays loudest? It is whatever will lead to people in Scotland living longer and healthier lives, within our financial envelope. Some of that is about investing in prevention and some of it is about investing in good-quality healthcare. Both those aspects can contribute to people living longer and healthier lives. As people who are interested in achieving that end, the challenge for us is in getting the right balance between investment in prevention and investment in good healthcare within a generous but predetermined financial envelope.

Jackson Carlaw: I think that I follow that. To many of us, it seems that the NHS's current model will be financially unsustainable in the long run and even in the medium run if the preventative spend actions on the huge issues that face us—such as obesity, early years care of young people and addictions that lead to mental health issues—do not succeed. For the NHS's long-term future to be secure, the preventative element must achieve its objectives.

I will consider what you have said, but I worry about the extent to which the appreciation of that ultimately triumphs in the debate over funding in the three to five-year model that you are talking about.

12:00

Derek Feeley: Let me give you an illustration of how we try to achieve that balance, which might help you. This is a really important point. A significant proportion of our HEAT targets—the things that we are asking boards to prioritise—concern public health measures and include alcohol brief interventions and smoking cessation. Even dementia registration is included, which I think is a preventative measure because the sooner that we can get people on the dementia register, the sooner we can get their care started. It is a secondary prevention, if you like, but it is still prevention. Even in what people characterise as our most obvious and blatant performance management of boards, we are trying to strike the right balance between prevention and care. It is an on-going challenge, and if the committee has ideas about how we can strike that balance better, we would be happy to have that debate with you.

Jackson Carlaw: I noticed in many of the written responses that we have received that a number of boards are keen to introduce abdominal aortic aneurism screening. We have set a requirement for the screening of men over a certain age, and some people think that, where there is a family incidence, there might be merit in an earlier screening. I am struck, however, by the variable commitment to that. Everybody seems to appreciate that such screening would be a valuable and worthwhile preventative action, but not every board seems to be in a position to translate that into something that it can do.

Derek Feeley: Every board will carry out AAA screening. A few have not yet identified the financial means to do it, but they will need to do it because every board needs to carry out AAA screening.

The Convener: We have been looking at preventative early intervention mainly in care, and we see a real practical difficulty in finding the finance to drive some of the initiatives. You mentioned alcohol and smoking interventions as being among the big ones. Were those interventions successful because there was not the same demand on shared budgets at that time as there is now? There is a broad consensus that that could affect outcomes. Even this morning, we are getting evidence of a lack of confidence among those who are delivering the service. We have heard of good initiatives that have reduced hospital bed usage—we still have the hospital, but the occupancy rate is down. Heart initiatives have been successful but the costs have been felt somewhere else. It seems to me that a lack of confidence is preventing us from getting on with the agenda and making the changes. As you say, we have been involved in this for 10 years, and the lack of progress frustrates everyone. I do not know whether the change funds, although providing a significant start, are sufficient to change the culture and incentivise the process.

Derek Feeley: There are two points to make. First, if you had wanted evidence from the really strong advocates of preventative spend, a set of finance directors were probably not the ideal witnesses.

The Convener: But you accept that they are key.

Derek Feeley: They are—absolutely. John Matheson talked about his personal drive to connect quality and efficiency in financial investment.

Government is sufficiently confident about the change fund to invest significant sums of money in change for older people over the three-year period. The key will come as we start to prepare the ground for health and social care integration, because the change fund can facilitate the capacity building and redesign that will be needed if integration is to be a big success, which can happen in advance of legislation to integrate health and social care. There is huge potential.

We are still finding our way. An issue that emerged in the committee's questioning of the previous panel was how we share the learning. We still have quite a lot to do to ensure that the good practice that we are starting to see locally around anticipatory care, hospital at home and so on happens reliably across the country. We can use the change fund to do that. The initiative for 2012-13 whereby 20 per cent of the change fund resources will go to carers will help us to learn how to do that better. I acknowledge that it is a work in progress, but I think that we are heading in the right direction.

Fiona McLeod: Mr Matheson talked about quality and about outcomes, as opposed to inputs, and Mr Feeley talked about the HEAT targets. You are impelling health boards and empowering them to spend preventively. Can you ask boards to provide their financial information in a way that makes much clearer to the general public what is happening on preventative spend and the long-term transfer from acute to community? We hear from you and from boards that preventative spend and the transfer from acute to community are the way to go, but boards do not seem to be able to make clear in their financial statements that that is what they are doing. Can the information be better presented?

Derek Feeley: I defer to the expert on financial presentation.

John Matheson: Let me make two comments. First, we are not starting from point zero on preventative spend. Derek Feeley mentioned the

family-nurse partnerships; there are also initiatives such as healthy start, on infant nutrition, and childsmile. We are investing in excess of £100 million in those very narrow areas of focus.

It is a pity that Dr Walker has left the meeting, because I am about to move into health economics—with a degree of trepidation. In one modelling area, we are looking at the resource that we spend in particular programmes—coronary heart disease is a good example. We look at the totality of the spend and the added value of spend at various points, and—to pick up on Ms McLeod's point—we consider the impact on healthy life expectancy of moving some of that resource from the illness side to the preventative side. In the CHD example, that might involve looking at further investment in statins or in more proactive early screening for AAA. We are looking at cancer, as well as at CHD, in that modelling work.

Derek Feeley: We have also used the integrated resource framework, which is a tool that boards have been using with local authority partners to enable them better to understand the impact of spend on health and social care. The IRF is starting to generate useful information, so people can ask, "If I invest in X, what will the benefits be?"

The short answer to Fiona McLeod's question is that we will see whether we can pull together for the committee some of the evidence on what has been done, which would at least give you a starting point for considering where you might want us to take things in due course.

John Matheson: The problem relates not just to health expenditure but to social care, housing, employment and a multitude of factors. We will perhaps start with health, with a view to broadening the approach beyond that.

Fiona McLeod: I appreciate that and thank you for doing it, but I am thinking about the sort of example that was given to us from the Western Isles, where there has been a great initiative that has reduced heart disease rates. However, the beds are still there. Can you imagine the outcry if the board said that it was going to get rid of the beds? The issue is how information is presented to members and to the public so that everybody understands that investment in preventative spend in the long term leads to longer life and healthier lifestyles for people, but different health service delivery.

John Matheson: Part of the challenge is to engage with the public in a way that focuses more on outcomes and outputs than on physical locations and the number of hospitals, beds and staff. We need to focus on what we are delivering for the £12 billion, rather than on the resource manifestations and how we are structured.

Fiona McLeod: I have come across an example of what I think might be your preventative spend. I notice that NHS Education for Scotland has to make lower savings than the other special boards. Is that an example of preventative spend, because educating the workforce is a good place to invest?

John Matheson: The efficiency savings that the territorial boards deliver—in their financial plans, they anticipate that those will be about 3 per cent in 2012-13—are totally retained within the territorial board areas. We have taken a differential approach to the special boards that are not directly patient facing. That therefore excludes the Golden Jubilee hospital and Carstairs state hospital and focuses on NHS National Services Scotland and the non-training element in NES. We have taken away the savings from the special boards and reinvested them in some of the developments that are detailed in the spending review. The special boards have opportunities for savings in the way in which they support the delivery of quality clinical care. For example, national procurement in NSS has delivered savings of £74 million in the past four years, which has been reinvested.

The question touches on the benefits of NHS Scotland having a shared service approach to training issues, staff and legal services. Rather than have a legal department in each health board, we have a single legal department for the whole service in NSS. We are considering simple things such as how to share backroom services between the special boards. For example, some of the special boards are co-located in an office building to the west of Edinburgh, which has provided benefits as a result of more integrated facility provision, communications and information technology and the sharing of finance staff. The reduction in backroom services is enabling further investment to be released through efficiencies. That investment stays in the health budget and is reinvested in front-line care.

Jim Eadie: Earlier, Mr Feeley talked about preparing the ground for health and social care integration through using the change fund effectively. He talked about the role that the fund can play in incentivising the shift that needs to take place from the current provision in hospitals to community-based services. We have talked about capacity rebuilding and redesign of services, but the truth is that that is a huge challenge because so much expenditure is caught up in the acute sector. There is significant investment in unplanned emergency admissions to hospital among the over-65s. We all understand the commitment and determination in the Government and the health service at last to tackle the issue, but how do we actually make it happen and measure success over time? What milestones should we expect to see on the road to success?

12:15

Derek Feeley: In talking to health boards and local government about health and social care integration, we have been discussing a set of national outcomes to apply consistently across every health and social care partnership. We are nearly through the process of agreeing the outcomes. I can share a draft of them with the committee, if you would find that useful.

The Convener: Yes—that would be useful.

Jim Eadie: Are you finding agreement across the NHS about what the objectives should be and what we are trying to achieve?

Derek Feeley: We seek agreement between health boards and local authorities about what health and social care integration will deliver for them. This is the first time that we have been in a position to agree a common set of outcomes that will apply across Scotland, and we are very close to doing it. We are happy to receive comments from the committee on that.

We are starting to make progress on emergency admissions. After a period in which they were on an upward trajectory, they have over the past year or two come down—certainly in the case of emergency admissions of over-75s, which is our HEAT target. That is happening because boards and their local partners have been putting in place arrangements to prevent admissions. Through case management, it is to an extent possible to say who is at risk of hospital admission and to ensure that there are support services for such people at home or close to home that will prevent admission. We have worked with the Long Term Conditions Alliance Scotland on a supported self-management initiative that ensures that people are better able to manage their conditions at home, which means that they are less likely to have a bad reaction to their long-term condition and require admission to hospital.

Jim Eadie: Marion Fordham said that although we can create the services in the community—she used the example of cardiac services—we are still paying for the hospital bed. How can we release funding from acute care into the community?

Derek Feeley: For the past 10 years, there has been a slow and gradual decline in bed numbers. My sense is that local communities are perfectly comfortable with that, as long as we have open engagement with them about the fact that it is happening in order to enable people to live longer at home. Understandably, they are less keen on hospitals simply being shut. Those are two different things, of course, and the former approach involves a gradual and managed running down of the number of beds because we have been able to turn off the tap on emergency admissions, reduce the length of stays and do more day-case procedures, all of which are—to go back to John Matheson's earlier point—about good-quality and more efficient healthcare and enabling a gradual transition to community services. We need to keep moving forward in a gradual, managed and clinically appropriate way.

The Convener: That is the difficult thing. We are all guilty of doing what you talk about. However, I am sure that Mr Matheson, who talked about good outcomes and the financial principle of good delivery and good value, would accept that it is possible to realise substantial savings and improved outcomes by closing hospitals.

John Matheson: I totally agree with that. The challenge for us is to have a robust business case that will engender significant sign-up to it and public engagement with it, in terms of the additional investment in community facilities. The end result will be a repositioning of some hospital services, which is part of the overarching thrust of shifting the balance of care.

There might, flowing from that, be a parallel business case that is concerned with additional day-case activity, which might enable beds to be used differently. We need to look at the issue innovatively and ask whether there might, rather than closing beds, be another use for the beds that is consistent with the overall clinical strategy of the NHS body.

The Convener: Has your department done any work with NHS boards to identify how, by closing hospitals, you can get better outcomes and greater financial benefit?

Derek Feeley: There are no significant proposals to close hospitals at the moment. Boards are much more inclined to take the route that I described to Mr Eadie, which involves thinking about how they use their whole provision in their hospitals—how to use hospitals differently, even if that means fewer acute beds. If boards propose hospital closures, there are well-established processes that they must follow, including engagement with their communities and clinicians. They would need to think about how any such proposal would improve the quality of healthcare for their population.

The Convener: So, our hospitals are safe. I can go back to Greenock and tell people that.

Derek Feeley: You can—unless you have news for me.

The Convener: I am happy with that, Mr Feeley.

Derek Feeley: If there were any proposal to close your local hospital, it would have to accord with the process that I have just set out.

Richard Lyle: When the director of health and social care and the director of health, finance and information for NHS Scotland are in the room, it would be remiss of me to pass up the chance to ask a question that, I am sure, everyone would want to ask you. Our health service is second to none and we spend more than £12 billion a year on it. It does a massive number of things in a wide range of areas, and we are not suggesting that any hospitals should be shut.

What involvement do you have with boards to direct their spending better when you read in your newspaper that their hospitals do not have blankets or that some people did not get their operations in time? I agree that we must constantly review what we are doing and that there is a shift towards people staying in their homes longer and not needing to be admitted to hospital. However, does it anger you, as it angers me, that we continually read in our papers that one of the best health services in the world is continually letting ordinary people down?

Derek Feeley: It does, and I will come back to that, if you will bear with me.

It is important to make it clear how well the NHS is performing. In the year just gone by, we met our 18-week referral-to-treatment target and waiting times are as short as they have ever been. Now, 97 per cent of patients wait less than 12 weeks for their first out-patient consultation, which is a huge improvement on where the organisation used to be. We have also met our cancer targets.

In the census in January 2012, delayed discharges were at their lowest-ever level. There has also been a huge reduction in the incidence of hospital-acquired infections and we have a patient safety programme that is the envy of the world; we have people coming from all over the world to look at how we are keeping patients safe in hospitals. There is a very positive message, which I am proud to be able to tell, about what the people who work in the NHS go out to do every day.

Does the other stuff annoy me? Yes, it does. Through our patient safety programme and other initiatives, we are desperately trying to make care more reliable. I am the first to acknowledge that our saying that we get those things right 99.9 per cent of the time is of little consolation to the people who are in the 0.1 per cent. We are constantly striving to improve and we are improving. An emerging body of international evidence puts Scotland right at the forefront of healthcare improvement, but there will always be more to do.

Dr Simpson: I agree, and I associate myself with the remarks that you have made. Successive Governments have progressed with a programme—particularly on patient safety—for the general development of collaborative and co-operative services. The programme does not have competition at its heart: that approach is fundamental to the ethos of the health service here. The two major political parties are in complete agreement on that.

I will ask you about two areas. First, is information on variation that is being provided to individual boards adequate? Variation is where many improvements could occur. When a new service, such as the one that Jackson Carlaw mentioned, is being introduced, there will obviously be variation, but much more fundamental variations are occurring. With the previous panel of witnesses, I mentioned theatre utilisation.

One board—I am carefully not mentioning which one—is so far behind the neighbouring board on day cases that the situation is ridiculous. Consequently, that board has far more orthopaedic surgeons, for example, than the neighbouring one. There are clear savings to be made there. How are you tackling that variation, first in terms of the information provision and secondly in terms of asking how long is "long enough", before the 70 per cent target that was set for the 19 day-case procedures is reached? That target was set, perhaps, 10 years ago.

Derek Feeley: There is a strong evidence base on that day-case basket.

To support the work on efficiency and productivity, we have set up an overarching steering group and we have divided the work on efficiency and productivity into a handful of strands including prevention—we have talked a bit about that—acute flow, out-patients, prescribing, procurement and shared services. They are things that the committee would expect us to consider.

We pull together the people who lead those work strands—they are all led at chief executive level and jointly with a director in the Scottish Government—in an efficiency and productivity steering group, which is where we do horizon scanning and information sharing about who is doing what well and how we can more reliably make it happen.

In the Government, we have also established a quality and efficiency support team, whose job is to assist boards with information sharing. We have also done a number of pieces of benchmarking, including on theatres, in which we examined variation.

We are getting more adept at providing information services to boards, although we could do more and do better. I will go a step further and suggest that we need to go beyond the boards to the clinicians with the information about variation. I am sure that, as a general practitioner by trade, Dr Simpson would recognise that.

When I talk about these matters, I always show as an example a slide that shows the variation in referral to acute care by general practice in one particular community health partnership. I could have taken any CHP, to be honest. There is something like a threefold variation. I am not saying that either end of the spectrum is right or wrong, but we need to be able to explain why there is such variation, so that is the kind of material on which we should work. I agree that we should be benchmarking and sharing information with boards, but we should also get the clinical information to the people who make the decisions—that is, the clinicians.

John Matheson: I will add a couple of points to what Derek Feeley just said.

Staff engagement is critical; there is a staff representative on each of the efficiency and productivity groups that Derek mentioned. Staff engagement through the local staff partnership forum is also absolutely critical because efficiency programmes and initiatives are developed at local NHS board level. The staff engagement structure across NHS Scotland was recently independently reviewed by the University of Nottingham and was recognised as being excellent.

The biggest area of spend in NHS Scotland after staffing is prescribing, on which we spend just over £1 billion. Between 70 per cent and 80 per cent of that £1 billion is spent on repeat prescriptions. Effective management of repeat prescriptions—how they are dealt with and monitored—is increasing efficiency and, in some cases, reducing harm. Compliance with the formulary and the interface between primary and secondary care are other areas in which we are doing extremely positive work.

On variations in the lengths of stays, to bring NHS Scotland's performance up to the upper quartile of performance in Scotland would realise between £45 million and £50 million of savings at marginal rates. It is about sharing best practice. A number of pilot initiatives are taking place in NHS Scotland. The challenge, which we are delivering against, is to embed those pilots in routine practice.

12:30

Dr Simpson: That is helpful. I certainly appreciate what Mr Feeley said about variations. In 1992, I did a study on referrals to orthopaedics in Forth Valley NHS Board's area and found an 18-times variation, which was narrowed down to around a six-times variation if some of the part-time practitioners who mainly dealt with women's issues were excluded. The top people who referred often had great expertise in orthopaedics, so that was not necessarily bad. It is about understanding that and providing meaningful data. I hope that the integrated resource framework will do that for managers and help with that.

We have heard about a lot of the successes and initiatives, which are all very welcome, but there has been one huge failure in the United Kingdom, and Scotland is no different from the rest of the country in that respect. We have not really made any significant advance in health inequalities, despite the efforts of successive Administrations to tackle them. The work of the NHS Scotland resource allocation committee and, previously, the Arbuthnott formula were supposed to be partly related to deprivation and health inequalities, but whatever that committee has done does not seem to have flowed through to tackling health inequalities. What work are you doing on that? How does it fit into the budgeting and financial process?

I am thinking particularly about the work of the GPs at the deep end steering group. In Scotland, we are fortunate that everybody has a general practitioner; that is not the case in England. There is equity of provision across Scotland, but not equality of provision, because provision does not match the variation and complexity of needs in deprived communities. The message that I get from the deep end group is that we have failed to provide to our most deprived communities the resources that would give them time to deal with the complex problems that exist, and we have failed to make the investment in social capital assets to which the chief medical officer refers. What is your strategy on health inequalities and how are you holding boards to account in the financial process?

Derek Feeley: I will let John Matheson talk about the detail of the NRAC formula and how it reflects inequalities.

The strategy works at a number of levels. Our policies are equalities proofed. As we develop policies and strategies, we ensure that a sense of their impact on both equalities and inequalities is taken into account. A range of policy initiatives, including the equally well initiative, are designed to have an impact on that. I am sure that Dr Simpson is well aware of those initiatives, so I will not rehearse them. Many of our big public health initiatives and some of the stuff that we are trying to do around early years are designed to have an impact.

Health inequalities is one of the complex problems for which I wish I had a silver bullet that I could offer to the committee, but I do not. The answer to the question is to do everything. We should continually strive to do what we can, whenever we can, to close the gap. I sense that what will be required to make a difference is an accumulation of individual interventions that will

build the asset base that Harry Burns talks about, give people confidence and enable cross-fertilisation of ideas from other sectors, including the third sector, into the health sector, and from the health sector into other sectors. There is no one solution, but a multiplicity of solutions, and the brave thing to do is to persist.

By and large, we are doing most of the right things. I do not see how a new policy direction would resolve the issue. We must keep on doing the things that we have been doing for a number of years in a better and more sustained way. We must also address the point that Jackson Carlaw and others raised about balance, and we must ensure that we value prevention as much as the downstream care input.

John Matheson: I have a couple of general comments on the NRAC. The policy direction is to move towards NRAC parity in a managed way. As part of the spending review outcome, I have tried to increase the pace of that movement.

A couple of years ago, the amount of money that was set aside for the movement towards NRAC parity was £13 million. In the current year, that amount has increased to £32 million, and there are plans to set aside £42 million in each of the next two years of the spending review. That should expedite the move towards parity.

The NRAC formula is dynamic. There is an overarching group called the technical accounting group for resource allocations, which is currently considering how the formula deals with remote and rural areas issues and how it reflects mental health and learning disabilities. I would be happy to bring the output from those deliberations to the committee, if that would be of interest.

Dr Simpson: That would be of great interest.

In the original Arbuthnott formula and in the first iteration of the NRAC formula, the primary care data were thought to be not adequate to allow us to comment on primary care. Despite the redistribution, it remains the case—as far as I can judge—that there is no redistribution within primary care towards areas of deprivation. I understand that there are special programmes within the equally well set-up, but within the fundamental core of general medical services there has, in my view, been an abject failure to shift resources towards deprived communities—such as the 100 general practices in the deep end group—in order to achieve greater equality rather than merely equity.

Derek Feeley: We have not been able to do that at formula base level, so we have relied on special programmes, enhanced schemes and deep-end type initiatives; I accept that. Now that we have better data, we could and should return to the formula—not least because the nature of general practice in Scotland is becoming increasingly different from the nature of general practice elsewhere in the UK.

Dr Simpson: I could not agree more.

The Convener: There are no more questions. I express the committee's appreciation for your attendance this morning and for the evidence that you have provided. Thank you very much.

12:39

Meeting continued in private until 12:44.

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