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Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 25 June 2013

Session 4

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HEALTH AND SPORT COMMITTEE
22nd Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)
*David Torrance (Kirkcaldy) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jayne Baxter (Mid Scotland and Fife) (Lab) (Committee Substitute)
Aileen Campbell (Minister for Children and Young People)
John Connaghan (Scottish Government)
John Matheson (Scottish Government)
Linda Semple (Scottish Government)
Diane White (Scottish Government)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 3

Scottish Parliament

Health and Sport Committee

Tuesday 25 June 2013

[The Convener *opened the meeting at 09:45*]

Subordinate Legislation

Registration of Social Workers and Social Service Workers in Care Services (Scotland) Regulations 2013 [Draft]

The Convener (Duncan McNeil): Good morning and welcome to the Health and Sport Committee's 22nd meeting in 2013. As usual, I remind all those present to switch off mobile phones and BlackBerrys, as they can often interfere with the sound system. Some members and officials are using iPads instead of having hard copies of committee papers.

Agenda item 1 is evidence on the draft Registration of Social Workers and Social Service Workers in Care Services (Scotland) Regulations 2013. I welcome for the first time to the committee the Minister for Children and Young People, Aileen Campbell, who is accompanied by Diane White, senior policy officer, and Roddy Flinn, senior principal legal officer. I invite the minister to make an opening statement.

The Minister for Children and Young People (Aileen Campbell): Thank you for the opportunity to introduce the draft regulations, which will be made under the Public Services Reform (Scotland) Act 2010. The draft regulations largely replicate processes that have been in place since March 2009 and are a consolidation of three sets of regulations that are in force, which require social service workers to register with the Scottish Social Services Council in order to work in the sector. The three existing sets of regulations set dates by which all existing workers who are working in services that are within the scope of registration must achieve registration; introduce the requirement that workers who are employed for the first time in specific groups must achieve registration within six months of commencing employment; and create an offence if service providers fail to comply with the requirements of the regulations.

The consolidation of the three sets of regulations into the draft regulations that are before the committee simplifies the application of the regulations and makes them clearer and more concise. The consolidation exercise provided the opportunity to amend the provisions and introduce a new provision on the regulation of the social services workforce. The provisions will be amended to widen the requirement to achieve registration within six months of commencement of employment to all workers within the current scope of registration and to provide the SSSC with a statutory power that relates specifically to the registration of workers who are employed in day care of children services that are provided on a seasonal basis—for example, summer play schemes.

I will deal with each of those changes separately. First, on amending the provisions to widen the requirement to register to all new workers, when the original regulations were introduced in March 2009 in response to concerns raised by the sector, the requirement for new workers to register within six months of commencing employment was applied only to a limited number of workers. Subsequent regulation placed the requirement on further groups.

However, when we agreed to progress with a limited number of groups in the first instance, it was made clear that the requirement would be placed on all the groups as soon as reasonably possible. The draft regulations provide that all new workers who commence employment in any of the groups within the scope of registration must achieve registration within six months of commencement of employment. That provision will ensure that registration with the SSSC becomes a matter of course for all new workers in the sector.

On the second change, when the registration of workers in day care of children services commenced, the SSSC received representation from providers whose service was provided on a seasonal basis—for example, the summer play schemes that I mentioned—that the standard approach to registration would be disproportionate for their workers. [*Interruption*.]

The SSSC held discussions with the sector and then consulted on a proportionate approach to the registration of workers who are employed in a seasonal service, and it received a favourable response from the sector. The consultation on the draft regulations asked for comments on the proposed proportionate approach to legislation, and the majority of responses agreed with the proposals. The provision in the draft regulations will provide the SSSC with the statutory power to register workers in day care of children services provided on a seasonal basis in a proportionate manner, which recognises the uniqueness of that service provision.

The draft regulations will maintain and fulfil the policy intention that registration with the SSSC is a prerequisite of employment and continuing employment. The consolidation will simplify the application of the regulations and make it clear that the requirement to achieve registration within

six months of commencement of employment applies to all workers within the current scope of registration. It will also provide the SSSC with the authority to take a proportionate approach to registration for workers who are employed in services provided on a seasonal basis.

Convener, I am happy to take any questions that you or the committee might have.

Nanette Milne (North East Scotland) (Con): I notice that the annual registration fee will be paid by individual workers. What will the fee be? Will it have any impact on recruitment levels?

Aileen Campbell: The registration fees have always been set in a proportionate way that recognises workers' salaries. The need to be mindful of workers' finances has always been taken into account. Diane White can say more.

Diane White (Scottish Government): For managers and social workers, the registration fee is £30; for practitioners and supervisors, it is £20; for support workers, it is £15; and for social work degree students, it is £10. It is an annual fee.

Richard Lyle (Central Scotland) (SNP): I hope that the fees will not be uprated.

Good morning, minister. How many people will the regulations affect? If someone does not achieve registration in the allotted time, what will happen?

Aileen Campbell: Thank you for your questions. We want to ensure that a sufficient timescale is provided to give people the opportunity to achieve the required registration. There will be a grace period.

Diane White might be able to say how many people will be affected.

Diane White: There are about 58,000 people on the SSSC's register. By the time that the first two phases of expanding the scope of registration have been completed, about 140,000 workers who are involved in social services will be registered with the SSSC. That will happen by 2020.

Aileen Campbell: But there is a grace period to allow folk to work towards achieving registration.

Diane White: Yes, there is. People who do not have the qualification can register, subject to the condition that they will work towards obtaining it. They must apply for registration within six months. They can achieve registration if they satisfy the conduct and character criteria, following which the SSSC can impose a time limit for achieving the qualification.

Drew Smith (Glasgow) (Lab): I have two issues to raise briefly. The first is about the length of time that it takes to register. I am thinking about people who might register over the summer. Will their ability to work be delayed while the registration process goes on? How long might it take?

My second point is about the nature of registration. Does it relate only to a single period of employment? If a student were to register for work over the summer, which is quite a brief period, would they have to go through the process again the next time that they wanted to take up such work?

Aileen Campbell: I take it that you are referring to seasonality.

Drew Smith: Yes.

Aileen Campbell: There is provision to reflect seasonality and be proportionate, so someone who works for just one summer will not have to register, but a person who engages in more regular seasonal work will be required to work towards becoming registered.

The Convener: As committee members have no further questions, we move to item 2, which is the formal debate on the affirmative instrument on which we have just taken evidence. I remind members that they cannot put further questions to the minister and I remind the officials that they cannot participate in the debate.

I invite the minister to move motion—[*Interruption*.] I am sorry—[*Interruption*.] I should have asked members whether they would like to participate in the debate. That is where I went wrong; I was trying to get through things too quickly. Does any member wish to participate in the debate? As no one does, I invite the minister to move motion S4M-07083.

Motion moved,

That the Health and Sport Committee recommends that the Registration of Social Workers and Social Service Workers in Care Services (Scotland) Regulations 2013 [draft] be approved.—[*Aileen Campbell*.]

The Convener: As no member wishes to speak in the debate, I invite the minister to sum up.

Aileen Campbell: I waive my right to sum up.

Motion agreed to.

The Convener: I thank the minister for putting up with all the disturbances—me spilling my glass of water and going off script and so on. I hope that it goes better—for me, anyway—the next time that you are here.

09:55

Meeting suspended.

09:57

On resuming—

NHS Boards Budget Scrutiny

The Convener: Item 3 is the final panel for this year's NHS boards budget scrutiny. I welcome from the Scottish Government John Matheson, who is director of health finance, e-health and pharmaceuticals; John Connaghan, who is director of health workforce and performance; and Linda Semple, who is head of the efficiency and productivity portfolio office. We will go straight to questions.

In last week's evidence session, there was a discussion about the sustainability of the appropriate efficiency savings target, which has been set at about 3 per cent. Is that target still seen as realistic and are contingency savings on that scale sufficient to meet the efficiencies, given some of the evidence that we have heard?

John Matheson (Scottish Government): I will start by giving a little bit of context on the efficiency programme and then I will move on to the efficiency programme for 2013-14. An important qualification is that we have just concluded the financial year 2012-13 and the outcome for that financial year is still subject to audit. That audit will take place over the next couple of months from a Scottish Government perspective, but the audit of the health boards has already taken place and the final sets of accounts will come in at the end of this week.

As it stands—as I said, the auditors will take their view on this—the resource position has been very much a balanced position throughout the year, so there have been no surprises. That balanced position is in the context of a £12 billion overall budget; we are looking at an underspend of £2 million or £3 million, so 99.97 per cent of the budget has been spent.

That has been achieved in partnership with staff-side colleagues and in partnership with clinical colleagues throughout the 22 organisations. Efficiency has been a key part of that—as you indicated, convener, efficiency delivery for 2012-13 was at the level of 3 per cent, which is £270 million. That was achieved across a range of areas, including service redesign, which I will come back to, and prescribing, on which colleagues who attended last week's committee presented significant detail.

10:00

Overall, the 2012-13 outturn was positive. We have signed off the 2013-14 financial plans for the individual organisations. The efficiency target remains at about 3 per cent, which is £270 million. Detailed plans on efficiency proposals are coming in from boards. Of them, 88 per cent are assessed as low or medium risk, with a low possibility of slippage, and 12 per cent are assessed as high risk, so further work is required during the year. The important message for the committee is that the vast proportion of plans are low to medium risk.

The efficiency proposals cover the broad range of services. A significant focus, supported by our quality strategies and our 2020 vision, is on service redesign and productivity. That looks at areas such as whether the level of day surgery provision can be increased and the impact of the Scottish patient safety programme on readmission rates, lengths of stay and infection rates. Over the past four years, the Clostridium difficile rate has reduced by 70 per cent and the MRSA rate has reduced by 74 per cent, so significant progress has been made. That has an impact not only on patient safety and how we look after patients but on efficiency.

The identified prescribing efficiency is just over £60 million of the £270 million figure, which is a significant proportion. The expectation is that prescribing costs, which are our biggest area of spend after staffing and which comprise just over £1 billion on primary care prescribing and £350 million on hospital prescribing, will be reduced by 5 per cent. That is set alongside the prescribing volume increase of 3 per cent.

As the committee heard last week, part of the prescribing reduction has been achieved through the movement from branded to generic drugs. For example, we are moving away from prescribing atorvastatin, which is one of the major branded statins. The reduction has also been delivered through efficiency programmes. We have an explicit efficiency programme on prescribing because we recognise its potential. If the committee wants further details, Linda Semple will be able to provide a degree of richness.

We will focus on national therapeutic indicators. For example, we are looking at some of the key cost-effective statins and at the proportion of the total statin spend that is made up of atorvastatin, simvastatin and pravastatin. We can deliver a higher percentage of savings in that regard.

We are looking at generic spend and we want to move all boards up to the upper quartile. The average for generic prescribing across Scotland is 82.8 per cent. We are trying to get boards that are slightly below that to move up to that level. There is no clinically justifiable reason why they cannot do so. We are providing direct encouragement not only through peer support from other health boards on the actions that they have taken but through support from the Scottish Government's efficiency unit.

Polypharmacy is the other main prescribing focus. Almost 50 per cent of the population aged 65 and above are on five or more medications and 10 per cent are on 10 or more medications. The clinical evidence is that, once a person is prescribed more than five medications, a lot of the additional medications are to deal with the side effects of the first medications.

Eighty per cent of the £1 billion on primary care prescriptions is spent on repeat prescriptions. There is an explicit focus on reducing waste. That waste is not deliberate; it may be through, for example, people changing medication. Waste is a cost that has no clinical benefit, because people are not taking the medication. Even a 1 per cent saving of that £800 million would be £8 million.

The kernel of your question is whether the level of efficiency savings is deliverable. I would summarise the change in NHS Scotland's approach as moving away from salami slicing, in which efficiency targets were set as a percentage of budgets, towards explicit targets in areas where we think that we can improve our efficiency. That approach is clearly driven by our quality strategy, our focus on safe, person-centred and effective care and our internationally acclaimed patient safety programme.

When I talk about financial performance now, I talk about quality-driven financial performance because, although getting the quality right does not make delivering the efficiencies and the financial numbers easy, it certainly makes things easier. If you want to have a conversation with a clinician about a 3 per cent efficiency target, they will have it, but they might well be defensive and the conversation might not be the most productive. However, talking to the same clinician about improving the quality of services will produce a different conversation and we will be able to get efficiencies on the back of that.

The Convener: Of course, it is difficult enough to get that voice heard in a board or hospital, but what interests me is how you in the Scottish Government connect to that and achieve consistency. For example, when people present efficiencies to be made in staffing levels as well as productivity, can you highlight problems or inconsistencies between one board and another?

John Matheson: I will make a couple of opening comments and then invite John Connaghan to respond. The fact that the patient safety programme is Scotland-wide helps with the consistency of approach that you are looking for, and the Scottish Government also has a central unit to share best practice across the country. Moreover, the boards have been productive in looking at regional approaches. For example, boards in the west of Scotland have got together on a regional basis to share best practice on how they are taking forward their prescribing agenda.

The Convener: Who represents the patient safety programme on boards when budgets are being set or at your level when you meet health board chairpeople? Where does the programme come into the process?

John Connaghan (Scottish Government): It might be useful if I describe the framework within which we approach efficiency and productivity, because that will allow me to answer your question about where the various interests lie.

We need to get views on efficiency and productivity not only from patients but from staff and health professionals. How do we go about that? First, we recognised that it might be useful to establish a support framework for boards on sharing best practice, which has been published as the efficiency and productivity framework and is available on the Scottish Government website. The framework, which we refresh from time to time—we are in the middle of this year's refresh—lays out three overarching themes: support for the workforce to ensure that it is appropriately skilled and trained; identification of enablers to share and sustain good practice, including benchmarking and the efficient use of technology such as telehealth; and cost reductions. On the last theme, John Matheson has referred to waste and harm reduction, but we also seek to reduce variation.

The pursuit of that support framework for boards should lie very much at local level. After all, history has shown that the imposition of top-down cost reduction targets in a salami-slicing way does not work and that it is much better to have bottom-up ownership. As a result, all the work in the framework is led by folks from the service, including clinicians, who speak for patient safety, and—most important—staff representatives.

We see the products of that work being displayed each year in our local delivery plans, which come to the Government. We see triangulation between the workforce, the service plans and the financial plans. We assess their risk—John Matheson referred to the degree of high and low risk that we see in the plans for this year—before we sign them off on behalf of Government as being a valid way forward. If the committee needs examples of the eight work streams that are in the framework this year, Linda Semple can say a bit more about that.

The Convener: Personally, I accept the general principle that more money does not equal increased quality or better outcomes. However, I am driving at how the Scottish Government monitors the principles. Who monitors and evaluates whether the support mechanisms are working, whether people are being enabled and

whether we are meeting the cost reductions? If we work back the way, we can probably quite easily monitor the cost and see the cost reductions, but we are less likely to see who takes responsibility. In other areas—we do not need to go into them—we have seen that health boards, under pressure, do not necessarily ask the right questions of themselves, whether they are about care of the elderly or waiting lists.

If this is a principle, who is ensuring that all that is working on the ground? Who is monitoring, evaluating and ensuring that that is happening and that people are involved?

John Matheson: The challenge is to ensure that the proposals are consistent with the strategic direction of NHS Scotland, as described in the quality strategy and the 2020 vision. That happens through the clarity of assessment and interrogation that takes place at board level. When boards sign off their financial plans, they are looking at their efficiency programme as a means of delivering financial balance and at whether that is consistent with the overall direction. When a plan comes up to the Scottish Government for sign-off by the chief executive of NHS Scotland, director general Derek Feeley, he looks for colleagues such as John Connaghan and me to give him a view about whether the proposals are consistent with NHS Scotland's overall strategic direction.

The Convener: So that is all self-regulating. As long as the boards tell you that they are ticking the boxes, that is fine with you.

John Matheson: I am sorry—to build on that, the staff side has a key role. The Scottish partnership forum plays a role and the employee directors in boards have a key role in the assessment.

Your earlier point was about where the Scottish patient safety programme sits. It does not sit to the side of that process; it is very much integrated in the process. As I said, the programme's impact is enabling us to deliver some of the efficiency programmes.

Nanette Milne: I will touch on service development. We heard from the boards that a lot of them are keen to invest in new services. We have not really heard about disinvestment in services that might not be efficient. What evaluation is done of services that are not efficient? What proportion of services might not be effective? Is there a move to disinvest in any such services?

John Connaghan: It might be better if we look at how the budget-setting process works locally. It is very much a bottom-up process as well as, inevitably, top down in some respects. Typically, a board has a local management structure that comprises clinical directorates, let us say to manage a large hospital. The clinical directorates have delegated budgets, which are managed by a lead clinician and a lead nurse and supported from central finance and perhaps human resources in the board.

Typically, those people put together the service plan for the directorate. They look at the historical budgets that have been available and whether there are any development moneys in the year and they come to a conclusion about the level of finance that they want to deploy in the various services.

10:15

Where do we get disinvestment? Last year, for the first time, we supplemented our framework by publishing an annual report on efficiency and productivity. We decided to use case studies in that report in 2012. I think that I am right in saying that the report included 35 or so case studies. Some of the case studies highlight instances when we changed services and when we disinvested in some things and invested in better things that give us better efficiency and productivity.

We intend to do the same again this year, so we will build up an evidence base. We expect such best practice to be transmitted across boards over time. I ask Linda Semple to give us one or two examples of case studies that illustrate the point.

Linda Semple (Scottish Government): Thank you, John. I thank the convener for the opportunity to tell the committee about some of the good work that is going on. We are more than happy to share with the committee the annual report for 2012-13, which will be published soon, and the annual report for the previous year. Between the two reports, there are about 100 case studies that show examples of good practice that boards have adopted.

Before I share the case studies with the committee, I will give members a wee bit of background about how we engage with boards. The efficiency portfolio office, which is the small team that I am involved in, engages with boards in various ways. We directly support boards either by providing them with expertise on programme management or by helping them to find the evidence base for things that they might want to do. We have more of a stand-off relationship with boards when they ask for help in coming up with ideas for work that they might do, and for support and seedcorn financing to evaluate an initiative.

We turn such work into case studies to enable us to say to other boards that because board X has saved money and improved clinical quality, they might want to consider establishing whether such work would be appropriate for them.

Having read the committee's discussion last week with the directors of finance from several NHS boards, I know that members are aware that boards are very different in terms of demographics, geography and their ability to use telehealth, so not all case studies will be appropriate for all boards. Part of our role is to have a conversation with boards about whether a case study is appropriate for them. That relates to John Connaghan's comments about taking a bottom-up approach. We do not impose the case studies on boards; we ask them to consider them and to decide whether they are appropriate for their areas.

I have a couple of good examples that relate to matters that the committee has been interested in. NHS Highland uses telehealth and teleconsultation quite widely because of the islands in its area. NHS Dumfries and Galloway also uses those approaches because it is a rural board, and NHS Ayrshire and Arran uses them on Arran. Telehealth and teleconsultation allow for a range of cost savings and improvements in quality, because patients can have a direct conversation with a clinician, whereas they might previously have had to travel for eight, nine or 10 hours, or even overnight, which represents a cost to the organisation but also a personal cost to the patient. The outcomes have been evaluated and they have done very well in terms of clinical outcomes and the patient experience. We point out that for urban boards, it might be worth thinking about using telehealth a little more smartly. Many general practitioners are very interested in that approach.

The Scottish Ambulance Service has been very good at, and has invested a fair amount of money in, innovative ideas, particularly on better ways of dealing with patient transport. One innovation has been the introduction of a smarter booking system for patient transport. There have been lots of stories about patients having to be picked up very early in the morning because an ambulance does a round in which it picks up a lot of patients, which means that when patients arrive they have to wait a few hours for their appointment and have to wait again to be taken back. That work is specific to the Scottish Ambulance Service, but use of the service by boards enables both savings and improvements in the quality of care across all boards.

I particularly like one example, which is a small example because it comes from a small board. However, it is the kind of innovation that we want and it could have a larger impact in a larger board. It seems pretty obvious and I think that the Scottish Parliament has already adopted such an approach; it is about being paper and print light. There was a time when everybody in every NHS board had a very expensive printer sitting on the end of their desk. Many boards have decided that that is no longer appropriate and so have got rid of printers and adopted smarter processes.

NHS Orkney did that, with a big-bang approach. It saved the board a small amount—tens of thousands of pounds—but other boards could make significant savings by doing that, and all the money that was saved could be reinvested in front-line patient care. We do not expect any of those savings to go back to the centre. It is important to remember that.

I will not go on about case studies; there are a lot, and I am more than happy to share them more widely with the committee, if you are interested.

John Matheson: I will follow up on that, as a generic theme. We are disinvesting in waste, which is a thrust that is linked to so much of what we do—for example, waste in repeat prescribing. Community nursing is another good example, because of the amount of time that community nurses spend on admin—writing out things, and writing them out again. The last time that was at committee, I gave the example of the use of digipens in the Western Isles, which reduced community nurses' admin time from 40 per cent to 20 per cent of their time. That is a significant impact.

We have set ourselves a challenging target for reducing management costs across the national health service in Scotland of achieving a 25 per cent reduction by March 2015, which we are very much on target to meet. By March 2012 we had reduced those costs by 16 per cent; we will get an update in a couple of months.

As regards waste, the use of staff resource and how we can procure more effectively, we have a national organisation for procurement of supplies and services, and we are seeking to extend that service to other parts of the public sector.

John Connaghan: Disinvestment in services always has an impact on clinical services—an example being the move to one-stop outpatient clinics. In many ways, we could view that as a disinvestment in lots of different clinics. From the patient's perspective, coming once to have their X-ray and their bloods done and to see both the allied health professional and the doctor is a significant benefit. Scotland has significantly increased its number of one-stop clinics over the years.

Another prime example is the move from inpatient services to day-surgery services, as clinical services have changed with new techniques and the introduction of keyhole surgery some years ago.

All such things could be viewed as disinvestment in one service, but as

enhancements in other services, with a better deal for patients.

John Matheson: Linda Semple mentioned telehealth and telecare. More effective use of information technology is another challenge for us. There is a project called the no delay project in NHS Grampian. It has been found that, when patients go to a consultant for assessment and are given bad news it can be difficult for them to take that on board. It is proposed that digital postcards be sent out, so that people in Grampian who have attended a consultation get an email summarising what was said to them. If they have been identified as having diabetes, for example, they will get a link to Diabetes UK, to eating and dietary advice and so on. They will get a holistic message about their condition and what they can do to self-manage it.

Nanette Milne: I have seen a presentation on that, and it was very impressive. Thank you for that information.

In more material terms, we know that there is a significant backlog of maintenance in a number of health boards. Is there an appropriate balance between investment in new facilities and maintaining existing facilities?

John Matheson: You are right to highlight that point. A couple of years ago, we identified the total position regarding backlog maintenance. The figure was just over £1 billion. According to the latest update, it has reduced by £60 million to £948 million. That figure is made up of all backlog maintenance—low, medium, significant and high risk. The significant-risk and high-risk component made up about £500 million of that. In the latest assessment, that figure has reduced to about £450 million. We transferred £320 million of resource money to capital, with a specific focus on backlog maintenance over the period of the spending review. Over the next five years, we think that our investment in formula capital, plus the disposal of assets, will enable us to cover the high-risk and significant-risk components of the backlog maintenance challenge.

The figure looks high—even to a finance director, £1 billion is a lot of money—so let me give an example. NHS Dumfries and Galloway's backlog maintenance gross position—for all backlog, from low risk to significant risk—was £63 million. The new build of Dumfries and Galloway royal infirmary will reduce the figure by about £40 million and the proposed plan for investment in backlog maintenance, plus disposal of assets, will deal with the balance and will leave a very low single-figure amount.

There is a challenge, but the key is to ensure that our capital investment is driven by our clinical strategy—that takes me back to my previous point. The investment areas that we are looking at, such as the new south Glasgow development, which is costing £842 million and is on time and on budget, the new sick children's hospital in Edinburgh and the emergency care centre in Aberdeen, are all driven by our clinical strategy and our quality strategy.

Nanette Milne: Some boards must be deferring expenditure on certain things. Are you seeing particular outcomes in that regard?

John Matheson: Capital is extremely tight. There is no getting away from that; there has been a 30-plus per cent reduction in the overall Scottish Government budget. We must recognise our legal commitments. I mentioned south Glasgow, and a number of other projects are in train.

Notwithstanding that, the formula capital allocation for backlog maintenance is increasing year on year as a result of the transfer of £320 million from resource to capital. At local level, there is a clear process of property and asset management, which prioritises areas on which boards need to focus if they are to meet their statutory requirements and the requirements of their clinical services. We are pretty confident that by the end of the five-year period we will have dealt with the high-risk and significant-risk backlog maintenance issues.

Nanette Milne: Is that strategy guided by Government?

John Matheson: It is guided by the clinical direction and the quality strategy of NHS Scotland. Decisions on prioritisation are quite rightly made locally and involve clinical colleagues.

The Convener: You talked about high-risk backlog maintenance. Is that the highest category, or is there a higher one?

John Matheson: Significant is at the top, followed by high, medium and low.

The Convener: As I understand it, "significant risk" means that there is a risk of impact on services and the patient experience, such as from a theatre closing down. You mentioned only high risk in your breakdown. Why did you not mention significant risk?

John Matheson: I apologise. I thought that I said "high and significant".

The Convener: You did not say "significant". Will you give the figure that includes significant-risk backlog? How much is the bill for significant-risk backlog?

John Matheson: I do not have the split between high-risk and significant-risk backlog. I can give you that. I apologise; I thought that I had said that high and significant together come to around £500 million.

The Convener: Okay. I did not hear you say "significant". Is there about a 50:50 split between high-risk and significant-risk backlog, or is it more like 40:60?

John Matheson: I do not have the split, but I can get it for the committee.

The Convener: That takes me back to the point that I was trying to make about the evaluation of decision making. How can the management and decision making that led to such a backlog of maintenance in our hospital estate be described as anything other than poor and inefficient? How did such a backlog develop without you and your team noticing?

10:30

John Matheson: That position did not come about overnight. A couple of years ago, we identified the position and quantified it for the first time. It is helpful to have that degree of quantification, whether it is a big figure or a small figure—in fact, it is a big figure and the fact that we have identified it is positive. A backlog maintenance programme is dealing with the priority areas; work is on-going. Two years ago, I asked the estate's officers to go round and identify the total position, and that is where the figure of £1 billion came from.

The Convener: I accept that. I am not making a political point about the Government, because the position arose over a period of time. I am trying to understand how we got to a situation in which the management in individual boards were left to make those decisions. Your oversight brought us to having that bill for the backlog maintenance. How can that have happened? If it can happen for backlog maintenance, why are you confident that it is not happening in other areas in which there is self-regulation? Are the boards telling you anything? Did we believe everything that was said about the backlog maintenance? Was it not an issue? Did nobody notice? Did nobody ask any questions? Why were people not asking questions about the maintenance of the estate and our hospitals?

John Matheson: That is precisely why we have the new capital programme and why we are building the new south Glasgow hospital to replace the Victoria hospital. It is also why we are creating the new emergency care centre in Aberdeen and building health centres throughout Scotland. That programme has been in train for a number of years; a number of projects are now coming to fruition while others are working their way down the pipeline. It is an on-going process. The difference is that we have now identified the scale of the position.

The Convener: You have asked the question for the first time.

John Matheson: Previously, people had part of the picture, but we have asked for the total picture.

The Convener: Mr Connaghan, do you want to add anything?

John Connaghan: I am reflecting on my experience of backlog maintenance some years ago, when I was a chief executive on several boards. When you get the figures, it will be useful to understand what proportion of the significant-risk element is impacting directly on clinical services, what proportion is calculated on redundant buildings that are still on the books but are up for disposal—they are still part of the figure—and how much is in non-essential areas that we can, with good judgment, leave because they do not pose a risk.

It is clear that local boards have a responsibility, through their local board investment plans, and have significant discretion in how they deploy their backlog maintenance fund. You will probably find that adequate risk assessment takes place that is scrutinised not just by internal audit, but by external audit. The breakdown that the committee gets will be important in putting all this in context.

The Convener: I look forward to that. I posed the question in the context of significant and high-risk backlog maintenance. I understand the difference between a lick of paint being given and a theatre being closed down for a weekend. That is not the point. I was asking about the oversight and the good management that should have been in place to prevent the backlog reaching such a scale.

Drew Smith: Last week, when we had the financial directors before us, we had a discussion about brokerage. As you would expect, boards that had been unable to manage their budgets and which had relied on loans to break even were quite positive about the brokerage experience and felt that it had been useful. Do you expect to give loans to boards again this year, or has the problem been solved? Do you accept that, as some of the boards told us, brokerage is a useful and desirable flexibility mechanism, or do you take the view that it simply should not happen?

John Matheson: Perhaps in responding to the question I should give a little bit of context. Brokerage is not given lightly to individual boards but is predicated on boards reassuring me that it is needed to meet a temporary financial challenge that they require some support to get around. One issue is the artificial nature of the financial year; if you are trying to plan on a medium to long-term basis, which is where our focus lies, the artificiality of having to hit particular financial targets every 12 months is unhelpful. It might be better to have a

rolling statutory target over, say, three years. NHS Forth Valley and NHS Fife recently received brokerage to deal with temporary financial challenges associated with the move into new hospitals, and I was assured—I checked in a very challenging way—that they had in place robust financial plans, that the situation was temporary and that they could repay the brokerage and had built that into their financial plans.

We also need to bear in mind fairness and equity issues with regard to other boards that do not get brokerage. Your initial question was whether I expect any boards to need brokerage in 2013-14. We have signed off the financial plans of all boards. We are in discussions with one board, but there are no plans at the moment to give brokerage to any of the 22. Moreover, we have built into the financial plans an expectation that repayment of brokerage will come back to us in 2013-14 and I think that for most of the boards brokerage will be completely repaid by 2015-16.

Of course, the flipside of brokerage is boards looking to return money to us; indeed, there were two examples of that last year. NHS Dumfries and Galloway looked to bank some money with us to enable it to cover the double running costs of Dumfries and Galloway royal infirmary when it opens and NHS Lanarkshire returned £4 million to us for use in backlog maintenance initiatives at Monklands hospital in the current financial year.

Drew Smith: So you would want to dissuade financial directors from viewing brokerage as a flexibility mechanism. Instead, it is for exceptional circumstances and used to deal with particular problems.

What is the balance between the money coming back to and going out of the centre?

John Matheson: We do not have any money coming back in 2013-14 because at this point in the financial year no boards have indicated that they want to return any to us. In 2012-13, we had £8 million coming in and £14 million of brokerage support going out.

Drew Smith: Thank you very much. Should not boards that are replacing a service plan for double running anyway? I presume that that will continue. Is it now the case that whenever a service is redesigned or a new service is put in place and some double running is required, you simply ask the Scottish Government to pick up the tab for you?

John Matheson: Given the significance of moving clinical services from Stirling and Falkirk royal infirmaries to the hospital at Larbert and the moving of services within the Victoria hospital in Fife, the two boards that I mentioned expected to incur double running costs. It is also expected by NHS Dumfries and Galloway, which is preparing to make a similar move. NHS Forth Valley had actually anticipated a certain element of the double-running costs through use of property receipts from the sale of Bellsdyke hospital, and it looked to the Scottish Government to support only an additional and marginal movement over and above that.

Drew Smith: I realise that you might want to run down the service but if, in planning to build a new hospital, you know that you will still have to run your existing hospital, why would you be surprised by double running costs?

NHS Greater Glasgow and Clyde is making significant investment in a new hospital; I presume that a significant amount of double running will be involved during the initial period of setting up the new south Glasgow hospitals. You would expect NHS Greater Glasgow and Clyde to manage those costs within the budget that will be provided to it.

John Matheson: The boards that I was talking about had anticipated double running costs, as did NHS Dumfries and Galloway, but it was the marginal movement on which they came back to us for support.

Drew Smith: So in Glasgow's case, for example, you would not envisage there being a problem with the south Glasgow hospitals.

John Matheson: They have not approached us and we do not expect an approach.

Drew Smith: Okay, thank you.

I will ask two questions together for brevity. How do you, as departments, deal with the scale of unidentified efficiencies within both health boards and the special boards. When bodies come back to you with unidentified savings, what checks do you make? Could you also say something about the high-risk efficiencies that boards have identified? Last week, NHS Dumfries and Galloway told us that it defined as high risk about 25 per cent of its planned savings.

John Matheson: I have a couple of comments to make in response to that. Linda Semple indicated earlier that efficiency savings within territorial boards are retained by those boards. That is also the case with certain special boards; efficiency savings for those special boards are treated in exactly the same way and are retained. Those special boards are the Scottish Ambulance Service, the NHS National Waiting Times Centre, and the State Hospitals Board for Scotland at Carstairs.

For other special boards, we set an efficiency savings target and we withdraw that target back to the centre. In 2013-14, we expect £9 million to come from the special boards and it will be used for pan-Scotland initiatives. For example, in 2013-14, we will use it to support the rare medicines

fund and the cost of new vaccines for shingles and seasonal flu. That is our approach.

On unidentified savings, when we get the efficiency savings response in we challenge the assessment of those unidentified savings as high, medium or low risk in order to ensure consistency because the assessment is to an extent subjective. Some boards might take a prudent view of how they position their savings. As I said, in NHS Scotland at the moment, 88 per cent of the savings are in the medium-risk to low-risk category. The unidentified element is about 4 per cent across Scotland. Of the remaining 12 per cent, 8 per cent is high risk and 4 per cent is unidentified; 4 per cent of £300 million or thereabouts is still £12 million, so it is still a significant sum of money. We will stay very close to those boards and ensure that they have pace and impetus for turning the high-risk savings into medium-risk to low-risk savings to give increased assurance around deliverability, and that they have moved their unidentified savings into specific schemes.

We have a mid-year review as well as an annual review for those individual boards, and we also have monthly contact with some boards. As we move through the year, we look for those boards to be developing reserve projects if we feel that there is significant risk that they will not make their anticipated progress in firming up on the high-risk savings or identifying precise projects for the unidentified ones. The process is iterative and it has already started.

Drew Smith mentioned NHS Dumfries and Galloway specifically. We would look at its pedigree and performance from last year to see what was unidentified at the start of the year and what the performance was like at the end of the year. We would ask whether it is taking a prudent position and we would have detailed discussions about how it will identify that 25 per cent saving.

The final point to make is that boards will always use non-recurring flexibility to support themselves. We take a view of the proportion of the efficiency savings that is made up of non-recurring projects to ensure that it does not get too high.

10:45

Drew Smith: That is one of the things that Audit Scotland has identified as being of concern. What is the maximum level of savings that should come from non-recurring funding?

My other question goes back to the point about unidentified savings and savings that are identified as being high risk. What is the relationship between the two? You would want to know, I suppose, about the percentage of savings that are initially suggested to be unidentified but which turn out later, perhaps at the mid-year review, to be high risk. Boards will perhaps be unwilling to say that something is high risk, or they might say that a large amount of unidentified savings will come from switching off printers and the like.

John Matheson: It is a powerful point. We have a clear and explicit focus on boards' reliance on non-recurring support, and Audit Scotland has also picked that up. From my experience as a finance director, once reliance on non-recurring support gets above 0.5 per cent, bells start to ring. In NHS Scotland, in 2011-12, reliance on non-recurring support across all the boards was £31 million. In the financial year that has just closed, it reduced to £21 million, and the indication from the financial plans that we have just signed off is that, in 2013-14, there will be no reliance on non-recurring support across NHS Scotland.

Drew Smith: Thank you. Will you say a few words about the relationship between unidentified savings and high-risk savings? How do you monitor what moves between the two?

John Matheson: We have a clear and explicit focus on that. Ideally, we would want all the savings in the financial plans that come in to sit at medium or low risk. At present, three months into the financial year, 88 per cent are at those levels, and that was the case in the original financial plans. We give boards a bit of breathing space at this time in the year to finish off the annual accounts. Although they produce monthly statements internally, we do not get the first monthly statements from the boards until the beginning of July, and they cover the three months to the end of June. In two or three weeks' time, therefore, we will have an up-to-date indication of where the boards are and how the percentage has changed—the 4 or 5 per cent for unidentified savings, for example. We will then test that, and we will look for the figure to have reduced significantly. If it has not moved, we will have some direct conversations with individual boards.

Drew Smith: Do you have a sense of what the relationship has been in previous years?

John Matheson: The figure for medium and low-risk efficiency savings is higher than in previous years. The starting point for 2012-13 was 73 per cent, which has increased to 88 per cent. The proportion of high risk and unidentified savings is much smaller than in previous years.

Richard Lyle: I have a few questions, but first I will go back to the convener's point about buildings and buildings maintenance. Some of the buildings that were built back in the 1960s and 1970s had the wrong designs, and we are seeing problems with them in 2013. Some buildings that were built way back in the 1900s have survived

better, but we are now replacing them with newer hospitals. Do you agree?

John Matheson: I agree with both those statements. We could have a detailed discussion about the pluses and minuses of single rooms, but our policy is to have single-room accommodation, and that is how hospital buildings such as the new Royal Victoria building at the Western general hospital have been designed.

We work closely with our architectural colleagues and with clinical colleagues on building design, because buildings need to be designed in such a way that they are effective and efficient from a clinical perspective. That level of clinical engagement in buildings such as those at the new south Glasgow development is absolutely essential, and there has been close and direct involvement in the design and layout of the buildings, even for simple things. For example, in some of the buildings of the 1960s, there were common corridors for patients and for the public, which is wholly inappropriate, and that has now stopped in current designs.

Richard Lyle: I come now to my main question, and it will become apparent shortly why I am asking it. Will you remind the committee how much the total overall health spend is in Scotland?

John Matheson: The total health spend is just over £12 billion. It increased by just over £1 billion in the spending review, and the overall increase for territorial boards is 3.3 per cent in 2013-14, and 3.1 per cent in 2014-15.

Richard Lyle: What is the current rate of inflation?

John Matheson: The current rate of inflation in terms of the gross domestic product deflator is 2.3 per cent so, against that 3.3 per cent, that is a 1 per cent real increase.

Richard Lyle: The reason for asking the question is that, over the past few years, the Government has reduced ring fencing—specific earmarked funding—for councils, which are freer now to spend the money that has been given to them. Why are we still ensuring that 12 per cent of health boards' budgets is ring fenced? Would we not be better to free that up? I note that the ring-fenced 12 per cent is allocated for projects such as alcohol and drug treatment programmes. Is 12 per cent too high?

John Matheson: I have a couple of comments on that. The figures and the precise budgets were identified as part of the original budget at the start of the spending review. Over the past number of years, I have promoted the idea of not giving out individual allocations and micromanaging around inputs, and I have looked to develop the principle of bundling some of those allocations and giving colleagues on boards money around generic themes, such as primary care and mental health, giving them the autonomy to spend the money as appropriate. What is essential, though, is that they still continue to deliver the outcomes and outputs. To take alcohol as an example, they need to deliver on their brief interventions, which is the key HEAT—health improvement, efficiency and governance, access and treatment—target for alcohol. There should be an element of local discretion in how they do that, rather than our giving them a pot of money and then asking if they have appointed a part-time alcohol nurse. I am not concerned about that; that is an input. What I am concerned about is the service provision that results.

Some of the major primary care practitioner contracts—general practitioner, dental and ophthalmic contracts—also account for a significant proportion of the 12 per cent, but I am totally wedded to the principle that Richard Lyle has identified. We should not micromanage the service, but should give boards the responsibility to deliver, with clear expectations of outcomes and outputs. I would look to see that model extended into the next spending review.

Richard Lyle: I am happy to hear you say that, because taking off ring fencing has helped councils, as they are allowed to manage their money and deliver the agreed outcomes. I am not suggesting that we take off the shackles and let them not do the things that we want them to do, but I know that they are doing them. Do you have a view on whether the level of earmarked funding is correct? I take it that you want to ensure that boards have more autonomy and can do more with that money.

John Matheson: I welcome the opportunity for boards to be given as much autonomy as possible. We do not hold back contingency sums at the centre; we give out as much as possible at the start of the year. Even the ear-marked allocations are given out at the earliest possible point in the year. Therefore, a significant proportion of the 12 per cent that you identified will, three months into the year, now be out with boards. I am totally with the thrust of your principle.

Richard Lyle: I take it that you are happy to consider some way of changing to enthuse boards more not only to use the money for the projects that we want them to do but to use it better.

John Matheson: I already have that process in hand and am keen for it to accelerate.

Linda Semple: It is worth reiterating that the work that we are doing to support boards to deliver their efficiency savings is freeing up resources that they can choose how they spend. The spread of

projects that we are doing with boards, which is enabling them to take a sustainable approach to how they deliver their efficiencies in the long run, means that they will be able to reinvest that money in the things that they want to do and that their citizens say that they would like them to do.

Richard Lyle: I am happy to hear that.

The Convener: This is an interesting area. It links in with some of the other issues with which the committee is dealing and in which it is interested, such as inequalities and preventative spending.

We picked some of that up at the committee meeting that we held in Stirling as part of a Parliament day. We will send you a copy of the *Official Report* of that. It was interesting that the well-meant focus on targeting particular problems in communities—I do not criticise it at all without having looked deeply into it—sometimes creates a bit of inflexibility for practitioners, who see that alcohol and drugs use is not simply an issue on its own, for example.

There were some interesting insights in that evidence-taking session, which the witnesses may want to consider, given the approach that they are rolling out. I say no more than that. Decisions made at the witnesses' level can impact on practitioners and, sometimes, unintentionally distort their work by creating inflexibility on such issues.

John Matheson: That would be appreciated, thank you.

You mentioned a preventative agenda. We have spoken about patient safety, which is aligned to that. One of the other areas that we are extremely excited about—this picks up previous comments about connectivity with the local authorities—is the early years collaborative.

Some tremendous enthusiasm is building up in the early years collaborative, with practitioners getting together at a number of national events and considering how they can improve the experience of parents and their children. They are considering how to support children to reach developmental milestones at 30 months and when they leave nursery and are trying to reduce the proportion of Scottish children who do not reach identified developmental milestones at those thresholds, which currently sits at around 30 per cent. The aim is to reduce the 30 per cent figure by 50 per cent by two and a half years and then by two thirds by the time that children leave nursery.

The approach is being taken nationwide and closely involves local authority colleagues. It is a good example of the preventative agenda that we are trying to move forward, alongside the patient safety programme.

The Convener: We have been considering that, although, as you probably know, we have not concluded our report. We all accept that health has a role in it but, across Government, a number of budgets could contribute to that benefit. That is the general point that we are making. It is interesting to hear you say so.

Bob Doris (Glasgow) (SNP): For a couple of specific reasons, I will go back to the review of the condition of the assets in the NHS estate and the maintenance backlog therein.

It sometimes feels a bit like groundhog day for me on this committee, because I also sit on the Public Audit Committee, which has considered the maintenance backlog in some detail. This committee might want to review some of the correspondence between the cabinet secretary and the Public Audit Committee to see some of the reassurances that he has given on management of the backlog.

I would like a bit more information, if that is okay, on the situation before the significant estates review across the NHS was carried out. Remind me of the year that the review was done and of what would have happened, say, five or 10 years ago, had the national Government wanted to have a snapshot of the conditions of buildings and facilities within the NHS in Scotland.

11:00

John Matheson: The estates review was carried out in 2011. That is when the figure of £1 billion was identified. Five years before that, people would have been aware of bits of the jigsaw—some of the major areas that were causing a particular problem in a board at that point. Central money might have gone out to deal with the problem.

On the capital side, we have identified the capital spend for individual major projects such as those in south Glasgow. We have also given the balance to boards on a formula basis, to allow them to do their local prioritisation. We have said to boards that they will keep the profit from any disposal of capital assets, which can be used for local prioritisation. We would expect to engage with them on how they deal with that, and we would expect backlog maintenance—especially high or significant-risk backlog maintenance—to be a major factor in that prioritisation.

Bob Doris: I was trying to draw attention to the fact that, when a figure such as £1 billion is used, it can set off alarm bells. We are identifying the real figure for the first time. The positive aspect of that is that, in order to reach a solution, we need to quantify the scale of what has perhaps been underinvestment over a generation in some parts of the NHS.

When you mention significant and high-risk repair needs in the backlog, does that include repairs for services that will be replaced anyway by the new Southern general hospital? In north Glasgow, a new health centre will open in Possilpark in a few months. Will some of the liabilities disappear from the balance sheet once that opens? In Maryhill and Woodside in north Glasgow, new health centres are about to be commenced. To what extent will the £1 billion figure reduce because of works that are already in the pipeline? It would be helpful for the committee to know that.

John Matheson: I will go over the figures again. The gross figure was £1 billion at the time of the initial survey. One year on, we recognise that investment has taken place in that period and it has reduced to £950 million. That is the total position, including the low, medium, high and significant categories. The high and significant ones—to focus on those—make up just under £500 million of that figure. Once the disposals planned are allowed for, that brings the figure down to just under £400 million. There are plans in place: formula capital is identified, partly through resource-to-capital transfer, to deal with that residual element over the next five years.

I have given the example of NHS Dumfries and Galloway. Just over £60 million of that total £1 billion figure is, say, the gross position within Dumfries and Galloway. However, we recognise that we are going to move out of the existing Dumfries and Galloway royal infirmary, with its high or significant component, which move alone will reduce the board's figure for backlog maintenance from just over £60 million to just over £20 million—a reduction of £40 million. That example was intended to show the scale of the current investment plans, the impact that those will have on backlog maintenance and the fact that we have identified formula capital within the capital programme to deal with the residual element.

One piece of outstanding information—and I apologise that I cannot give it to the committee just now—is the split between high and significant. I will come back to the committee on that.

Bob Doris: I did not ask the question to give you an easy ride and because there is a downward trend in the figures—I have another reason for asking. The situation sounds positive, although I have written down that you said that the figure for the high and significant categories of backlog will be £400 million, once all the other factors have been taken into account. You then said that there is a five-year plan to tackle that £400 million backlog. The committee carries out annual scrutiny of NHS budgets. Is there a target for what the figure will be next year? Will it be £350 million or £320 million, or is the issue not as straightforward as that? I want to ensure that, when you come back to the committee this time next year—whether or not Mr McNeil and I are still members—we have a benchmark against which to scrutinise the progress that the NHS is making.

John Matheson: I am happy to provide that. I did not think that I was getting an easy ride on the subject, by the way.

Bob Doris: Can you provide it now?

John Matheson: I cannot provide it now, but I will provide it to the committee.

Bob Doris: So the figures exist.

John Matheson: Yes. We have identified the formula capital allocation, which is increasing over the period of the spending review and is in excess of £130 million per annum. That formula capital allocation is prioritised on backlog maintenance, which is why I have confidence that, in the next five years, the residual figure will be dealt with.

Bob Doris: That is fine. When the committee asks the same question again next year, you will be able to assert that the figure of £400 million has come down to whatever, and that that is because X, Y and Z have happened. If the figure has not come down, obviously, we will need to ask questions, but you are confident that things are on track.

John Matheson: I am very confident.

Bob Doris: We have discussed efficiency savings already, but I have a very brief question, just for clarity, on the 3 per cent efficiency savings that NHS boards get to keep. We heard in evidence last week that NHS Education for Scotland is in a different position, as it is judged on the basis of efficiency savings of 3 per cent across the NHS, whereas much of its work involves direct training interventions that it must do to meet its statutory obligations as an NHS board. NHS Education suggested that there might be a more appropriate way to report how it meets efficiency savings, which takes into account the parts of its business for which a service redesign cannot be done to get more efficiency, and the bits where that can be done. NHS Education is in a fairly unique position. Has any consideration been given to that?

John Matheson: NHS Education's overall efficiency percentage comes out at 0.8 per cent, which seems very low. The reason for that is that a significant proportion of its budget is protected, as it pays for junior doctors and other clinical staff. So its efficiency target, which is 5 per cent, is focused on only a small proportion of its budget. We can look at that, presentationally, but NHS Education has the same efficiency target as the other special boards, such as NHS Health

Scotland, NHS 24 and Healthcare Improvement Scotland.

Bob Doris: You used the expression "presentationally", but on the hard facts of the matter rather than the presentation, is it not a bit unfair on that special board for its figures to be presented as a 0.8 per cent efficiency saving when, actually, if we looked at the areas that are subject to efficiency savings, the figure would be different and would probably be greater than 0.8 per cent? Might officials and the Scottish Government consider changing the rules on that?

John Matheson: NHS Education is clear about its target and the components of its budget to which that applies. Basically, its efficiency savings are focused on areas such as its use of property and administrative infrastructure, which is why NHS Education is considering reducing its utilisation of buildings and driving efficiencies through that. I will have a discussion with it on the presentational side, as it obviously raised that last week.

Bob Doris: It might be worth taking a look at the *Official Report* of last week's meeting to see its evidence. It is up for efficiency savings in any area of its business and service where it can drive efficiencies, do better and get a bigger bang for the buck. It wants that figure to be as high as possible, but a part of its business seems—in an accounting sense—to not quite reflect the efficiency savings that it is making. I welcome your commitment to have a look at the issue and to discuss it with NHS Education for Scotland.

John Matheson: I think that all four of the special boards—including the National Services Scotland Board, which has had savings withdrawn due to the differential approach that was taken to efficiency savings for its non-patient services—have responded very positively to the challenge.

Bob Doris: Thank you.

The Convener: To come back to the maintenance backlog issue, my question was not about what we are doing now; it was about why it took so long to do it. It links back to the management and oversight issues. At a certain point in time in the last decade, the NHS was awash with money. Why did management let us get into a situation in which we have to face that maintenance issue now, when the budgets are tighter—when the budgets are being reduced? My focus is on the managerial process. People around the committee table who run businesses know that the maintenance of their assets and their property has to be planned. Over a period that spanned different Governments, there seems to have been a lack of oversight and poor managerial decisions locally, which allowed that maintenance backlog to build up, so that now, when there is less money, £400 million has to be found. That is why I am focusing on management.

Still on management issues, Mr Matheson said earlier that it was a virtue that we had set the target of cutting management by 25 per cent and that we had made good progress there. How does that fit in? I know that such a target is popular, probably including among committee members—"Oh, sack the managers"—but is that the wisest decision to take when we have great challenges in innovation, change in the service and the preventative agenda? When all that is happening, is it the wisest decision to cut back on management levels and management capacity and thinking?

John Connaghan: Remember that this is happening over a timescale of three to four years. We need to consider all our managerial structures. We obviously need to ensure that we have good and adequate risk assessment of the management cuts. If we can combine directorates, for example, so that we have less managerial support but can still do the business in practice, that is important. In fact, the 2012 annual report on efficiency savings has a case study of a board that previously operated with five directorates but moved to two directorates, which automatically took out a layer of management.

We must also recognise that across boards—we have not mentioned this much today—there is a significant move to shared services, particularly in finance. Mr Matheson will be able to tell you a lot more about what has been achieved over the years in that area. However, we cannot rest there—shared services and restructuring also need to be part of this, but I recognise the point about good risk management and ensuring that we have enough local leadership to be able to move things forward.

The Convener: So the plan to cut management by 25 per cent is not simply a cost-reducing exercise.

John Connaghan: It is certainly a cost-reducing exercise in the sense that we want to see a financial return from it, but we need to balance that against what we need to achieve on such things as quality and the leadership of our workforce. It is about careful risk assessment of what boards can do locally. If there is an opportunity to do things in a much smarter way—by sharing services or by having fewer managerial levels in an organisation—we should be pursuing that.

The Convener: I can see some of that, but how do you achieve the best results? Are the managers and leaders who provided those 100 good examples the people who are leaving? Have some of those people left because they are valued elsewhere?

11:15

John Connaghan: The NHS has a no compulsory redundancies policy, so naturally some of the folks who have been involved in those schemes over the years will cycle through. They will leave the organisation, and there will be a careful assessment—which takes place at a local level—to decide whether they should be replaced.

John Matheson: The risk assessment is very important, as not all proposals for management change are accepted because of the impact on the organisation.

John Connaghan mentioned shared financial services. NHS Scotland was spending £50 million on backroom support for financial services and, to date, we have reduced that through our shared services approach by £11 million, which is a reduction of 22 per cent or thereabouts. We have achieved that by working closely with partnership colleagues.

The Convener: But the people who were delivering the services are still employed by the national health service.

John Matheson: Yes, but there is—

The Convener: So somebody else is providing the services now, but the people who used to do it are still in the health service. What are they doing?

John Matheson: To use the example of shared financial services, the saving of £11 million—22 per cent—was achieved through more efficient use of technology, such as moving to a single NHS Scotland financial system rather than having individual systems, using technology to process invoices more efficiently and so on.

The Convener: Are you on target for the savings that you expected—[*Interruption*.] I think that we are next door to the crèche; the children are probably listening to this committee meeting.

Are we on target for the expected return from the 25 per cent cut in management?

John Matheson: Yes, there was a 16.1 per cent reduction at March 2012—

The Convener: Are you achieving the appropriate management clean-out? How does that 16 per cent cut relate to the 25 per cent figure? Are those people leaving the organisation?

If the reduction was 16 per cent of the total, what was the total in figures rather than percentages? How many managerial positions did you expect to flush out?

John Connaghan: In this category we have about 1,000 managers—

The Convener: A thousand people.

John Connaghan: Yes, and 25 per cent is roughly 250, give or take.

The Convener: That puts the reduction in perspective, but the wider issue—

John Connaghan: We have 153,000-plus employees in the NHS and approximately 1,000 senior managers, and 250 of those managers will depart.

The Convener: You mentioned earlier another issue concerning local authorities, which the committee will be considering. Do you see anything in the figures for resource transfer in some health boards that gives you cause for concern with regard to good practice? It appears that resource transfer from some health boards to local authorities is quite significant, whereas in other areas it is not significant at all. Does that give you any concerns, or is it simply a matter of practice or interpretation? We are encouraging good practice. Do any of those headline figures give you any concerns? Have you had any discussions with those boards that are lagging behind in their resource transfer?

John Matheson: There are a couple of points to note about resource transfer. First, there is always a detailed annual discussion on the uplift to be given through resource transfer. We work closely with boards and local authority colleagues to ensure that there is clarity on what resource transfer is delivering.

The second point, which is more powerful, is that the discussion on resource transfer will now be incorporated in the health and social care integration debate. The Public Bodies (Joint Working) (Scotland) Bill was introduced to Parliament at the end of May, and we are having detailed discussions with the Convention of Scottish Local Authorities and local authority colleagues. We have a meeting this evening with local authority colleagues on that very subject, to ensure that we progress health and social care integration by integrating services. The bill affords us the opportunity to consider the ways in which our shared services organisation, NSS, could provide legal and other services to local authorities and other areas of the public sector. In that respect, the agenda goes beyond health and social care integration. The resource transfer discussion will now become incorporated within a much broader discussion about the integration of some of the acute health service budgets with social care budgets.

John Connaghan: I will make a broader point. Convener, you have raised a number of issues about how we engage with the service and our partners on changes—including changes to management in other areas. Each year, we issue local delivery plan guidance. In business terms,

that would be called business planning guidance. Each year, we attach to the back of that our 10 performance management principles for how boards should engage in such things.

Let us consider management cost reductions. Principle 1 is that anything that is done on performance management must support delivery of the Scottish Government's outcomes. Principle 2 is about delivering the strategy for improving the quality of patient care. Principle 8 is that staff must be engaged in target setting and target delivery locally. We expect boards to adhere to all those principles in planning their business for the year ahead. That includes, for example, management cost reductions.

The Convener: That certainly gives you cover. If boards fail on any of those counts, you can say that they had agreed to those principles. However, how do we monitor and evaluate? That is the continuing question. How do we ensure that boards are doing as you ask?

John Connaghan: We have at least two tiers of scrutiny. There is scrutiny locally, by boards. Remember that boards have both executive and non-executive members. They represent staff interests and clinical interests. There is a significant degree of local scrutiny of how boards conduct their business.

As John Matheson has outlined, we supplement that local scrutiny with two more national programmes. In one, there is a formal mid-year review of progress, in which Scottish Government officials, together with board officials, scrutinise how boards are doing on a plan-versus-actual basis.

Committee members will be aware of what we do in annual reviews. We hold boards to account, in public, for the delivery of their plans, not just in respect of their achievements but with regard to how they have achieved them.

There are significant levels of scrutiny as we go through the year—regularly and monthly by board members and on occasion by the Scottish Government.

The Convener: Is the Scottish Government confident that boards and board members are carrying out those corporate functions? There have been questions in the past, at times of crisis, about whether board members were informed enough or were not doing their jobs. There might have been changes of board members.

I understand that, at one end, there is what is expected of the boards, and there is a tick box at the other end. However, it seems that it is only in crisis that we examine the role and membership of boards and their ability to provide corporate governance at a local level. Scrutiny of plans versus action might be carried out only at a time of crisis, when something has been discovered. How do we know what is going on week to week or day to day? What governance takes place at that level?

John Connaghan: The day-to-day or week-to-week timescale requires local scrutiny.

The Convener: So it is left up to people locally.

John Connaghan: It is left up to them. Local—

The Convener: And only when things go wrong do you get involved.

John Connaghan: Local scrutiny, on a day-to-day, week-by-week basis, must be the province of boards. We have a system whereby monthly board meetings are held in public. The public can come along and observe proceedings. We are as assured as we can be that there is a good system of governance operating throughout the NHS in Scotland.

We only need compare that with what is happening in other parts of the United Kingdom. The Scottish system has very good integration systems. It has been stable. Year on year, there have been good Audit Scotland reports on the financial performance of the NHS. The last one—John Matheson will be able to give you the quote—applauded the NHS for its financial stewardship.

The Convener: Was that the report that put us on an amber warning?

John Matheson: I do not think so.

The Convener: Are we talking about the last Audit Scotland report to the Public Audit Committee? Was there not some comment about an amber warning?

John Connaghan: I am referring to the fact that Audit Scotland as external auditor for many boards has signed off those accounts. Generally, the financial stewardship of the NHS in Scotland is satisfactory.

Drew Smith: I am sure that you will have had the chance to review the evidence that we received last week from NHS Education for Scotland. I should point out that there is a certain amount of frustration in the committee; it understands not only that the NHS is facing cost pressures and budgetary challenges but that one of the roles of directors of finance is to maximise efficiencies at all times, regardless of whether we are under such pressures, and there is a bit of disconnect between some of the things that we would simply regard as good practice and the impact where the challenges are more significant. Last week, NHS Education for Scotland told us that, in 2014-15, it will find it difficult to identify more of the savings that it is currently identifying

without having an impact on its other provision, which primarily relates to the training of doctors. What is your reaction to those comments?

John Matheson: My reaction is that we have an agreement with the four special boards I detailed earlier to deliver a differential efficiency target up to the end of the current spending review period in 2014-15, and they have signed up to that and have identified it in their financial plans. Some of their efficiency proposals are quite well advanced and others are being developed, but we will have another conversation with the boards about any further potential to make such efficiencies beyond 2014. At the moment, we have only an expectation and they have given only a commitment to deliver that differential efficiency position up to 2014-15. That is our clear understanding with them, and there will be further conversations as part of the next spending review.

That said, there are other opportunities to pursue within the special boards. For example, four of the special boards are co-located at Gyle Square in the west of Edinburgh—or will be by December when NHS Health Scotland moves in—with significant potential to generate benefits from sharing services in facilities, IT, human resources and so on. We are certainly encouraging them to look at how they provide and deliver such backroom services.

Drew Smith: But is there not a tension in all of that? Should you not be doing all those things anyway? A lot of those costs are waste and we should be eliminating them as much as possible. Of course, we will be learning as we go along, so it is not necessarily a matter of blaming people for any waste that has arisen. However, NHS Education for Scotland seems to be suggesting that, at a certain point, switching off the lights will just not cut it any more in bringing down the bills that some of these boards have to pay. How long can you go on asking for these kinds of efficiency savings from these organisations without having an impact on the services that they deliver?

John Matheson: My precise point was that we are confident that they can deliver those savings for the next couple of years. After that we will have a conversation about the potential for other savings, and that conversation will include a recognition that, in a very significant proportion of the NES budget, there are areas where no efficiencies can be delivered. However, you made a telling point when you described some costs as "waste". If a further opportunity emerges, we have a responsibility with regard to taxpayers' money to take advantage of it.

The Convener: I have a final question on access to medicines, which we have been dealing with and to which we will be returning very shortly. If prices of new medicines were negotiated between NHS Scotland and the pharma companies in the light of an initial assessment by the Scottish Medicines Consortium, would such a move help boards in that it might lead to lower prices or hinder them because the size of the negotiated change in price would be unpredictable?

11:30

John Matheson: It is impossible to answer that question until we get into the detail of those discussions. It has the potential to be supportive but, as I have said, we would have to see the outcome of those discussions.

Not only are we are trying to work very closely with the pharmaceutical industry on drug pricing, we are looking at how we work in partnership with it on research and innovation and are trying to recognise that, although they are business organisations with business requirements, they can potentially work with and support us—and indeed we can support them—on those issues. We look forward to having those detailed discussions with the pharmaceutical industry. The outcome will be what it will be, and we will then take a view on where those negotiations have ended up.

The Convener: So, as far as your negotiating position is concerned, you have discussed the pros and cons and the good bits and bad bits of this approach. If you have not yet reached a final decision, can you tell us what those pros and cons might be? What are the benefits and the downsides?

John Matheson: It is not just about price but about the cost effectiveness of the product that we are looking to purchase. Price is one of a number of factors, and there is also a keenness to ensure that the market is as competitive as possible. Indeed, one of the reasons for the recent significant reduction in the price of atorvastatin is the move from a monopoly to having a number of potential suppliers in the market, and the ability to keep an open market position is equally important.

The Convener: But the SMC would be involved in that process instead of someone else.

John Matheson: The SMC would be involved in the process. It would be supported by clinical, financial and indeed procurement colleagues in carrying out these negotiations. We welcome the opportunity to have the negotiations, but we cannot prejudge their outcome.

The Convener: What discussions have you had on whether the financial impact of this approach will be good or bad? I presume that the people going into the negotiations will have some view on

that. Is it indeed the opportunity that it has been described as?

John Matheson: The negotiations provide a welcome opportunity and we expect a positive outcome from them for our ability to manage prescribing expenditure within a tight financial envelope.

The Convener: But it would be beneficial if we could get the drugs cheaper.

John Matheson: If we could get them more cost effectively. As I have said, this is not just about price but about the broader reliability of supply and so on. Price is one of a number of factors. Our expectation is that we will get them more cost effectively.

Bob Doris: Convener, I want to put this comment into the *Official Report* to ensure that we have some clarity on this matter. You talk about SMC negotiations, but the fact is that the SMC as an institution stands one step away from that. That is not how things happen in the Scottish system and, in any case, any negotiations that take place will focus on reimbursement rates not prices, which are reserved to the UK. Given the complexity of these issues, I think that, when we discuss them, we should compare apples with apples and get the factual situation right.

I also note—and we will discuss this point in private—that the SMC has said that it does not want to be directly involved in negotiations about the pricing of or reimbursement rates for medicines and that it is up to others to discuss such matters. It wants to focus solely on cost effectiveness based on the current system, irrespective of how politicians—in other words, us—and the Government decide to change it. It is important to give an accurate account of the process.

John Matheson: That clarification was helpful. The convener mentioned the SMC, but I referred to our procurement colleagues. They will be involved in the detailed discussions about price reimbursement.

The Convener: I simply note that the emerging evidence has thrown up some confusion on this matter, with people describing the negotiations as an opportunity. Basically, your response suggests that the Government has no view on whether it would be good or bad for us to negotiate those prices with pharma.

John Matheson: That is a fair summary. We are keen to enter into those negotiations.

The Convener: As members have no more questions, I thank the witnesses very much for their time and their evidence to the committee.

As previously agreed, we will now move into private session.

11:35

Meeting continued in private until 13:11.

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