The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 18 June 2013

Session 4

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HEALTH AND SPORT COMMITTEE
20th 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)
Julie Carter (NHS National Waiting Times Centre)
Rodger Evans (Clerk)
Paul James (NHS Greater Glasgow and Clyde)
Caroline Lamb (NHS Education for Scotland)
Craig Marriott (NHS Dumfries and Galloway)
Michael Matheson (Minister for Public Health)
Gerry O'Brien (NHS Orkney)
Fiona Ramsay (NHS Forth Valley)
Robert Stewart (NHS 24)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Tuesday 18 June 2013

[The Convener *opened the meeting at 09:48*]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the 20th meeting in 2013 of the Health and Sport Committee. As usual, I remind everyone present to turn off their mobile phones and BlackBerrys as they can often interfere with the sound system. People in the public gallery might notice that some members and officials have iPads; they are using them in place of hard copies of their committee papers.

The first item on the agenda is to decide whether to take item 7, which is consideration of our work programme, in private. Is that agreed?

Members *indicated agreement.*

Subordinate Legislation

Public Services Reform (Functions of the Common Services Agency for the Scottish Health Service) (Scotland) Order 2013 [Draft]

09:49

The Convener: Item 2 is an evidence-taking session on a draft affirmative Scottish statutory instrument: the draft Public Services Reform (Functions of the Common Services Agency for the Scottish Health Service) (Scotland) Order 2013. I hope that I will not need to say that again.

I welcome to the meeting Michael Matheson, Minister for Public Health, who is accompanied by Stuart Aitken, policy officer, directorate for finance, e-health and pharmaceuticals, and John Paterson, deputy director, legal directorate, Scottish Government. I invite the minister to make some opening remarks.

The Minister for Public Health (Michael Matheson): Good morning, convener, and thank you for the opportunity to talk about and speak in support of this draft order.

For the avoidance of doubt, although the draft order refers to the functions of the Common Services Agency, I will refer to the organisation by its more common title: NHS National Services Scotland or NSS. NSS is Scotland's largest shared service body and supports Scotland's health by delivering shared services and expertise that help other organisations to work more efficiently and save money. It provides national strategic support services and expert advice to all of NHS Scotland and plays an active and crucial role in the delivery of effective healthcare to patients and the public.

Current legislation dictates that, although NSS may provide goods and services to national health service bodies in Scotland in general, it has the power but not the function to provide a limited range of goods and services to a limited range of other public bodies. As that is considered to be a barrier to the ability of NSS and indeed other Scottish public bodies to be as efficient and productive as they might be, it therefore follows that the public sector in Scotland is being prevented from working as efficiently and productively as it might.

The order's purpose is to enable NSS to move from being a provider of shared services to NHS bodies to being a provider of shared services to Scottish public bodies in general. The agency, which has a strong reputation for delivering shared services and is held in high regard by the public

sector, has systems to ensure that standards are maintained across its full range of services and those systems have operated efficiently and effectively for a number of years for the wide range of public bodies to which the agency already provides services.

Clearly, there are opportunities for NSS to offer, for example, legal, procurement, counterfraud and information technology support services to the wider public sector, but I must point out that this is an enabling provision and does not impose any obligation on relevant bodies to take NSS services. Nevertheless, it is hoped that such a move will facilitate the greater use of shared services across Scotland's public sector. Indeed, the order's overarching purpose is to remove obstacles to the efficiency and productivity of NSS and other public bodies.

I am happy to answer committee members' questions.

The Convener: Thank you, minister. Do members have any questions?

Richard Lyle (Central Scotland) (SNP): Good morning. Can you give me a flavour of the other bodies that might receive goods and services from NSS?

Michael Matheson: We are principally talking about local authorities and supporting and assisting them in service delivery.

Richard Lyle: So this will apply just to the 32 councils in Scotland, then.

Michael Matheson: Not exclusively. Other non-departmental public bodies could be supplied with these services. It will principally be a combination of NDPBs and local authorities.

Nanette Milne (North East Scotland) (Con): Will this be a reciprocal arrangement? Will the reverse apply? Will local authorities be able to procure services from the health service in the same way?

Michael Matheson: NSS already provides services to NHS Scotland but does not have the function to provide them to, say, local authorities or NDPBs. The order provides that function but, as the concept of shared services is based on co-operation and mutuality, there must be a shared interest. NSS is a national body that delivers services at the request of those who need them.

The Convener: As there are no other questions, we move to the formal debate on the order. I remind members that, as this is a debate, members cannot ask the minister questions and officials are no longer able to speak.

Motion moved,

That the Health and Sport Committee recommends that the Public Services Reform (Functions of the Common Services Agency for the Scottish Health Service) (Scotland) Order 2013 [draft] be approved.—[*Michael Matheson.*]

The Convener: I now invite members who wish to participate in the debate to indicate as much. Does anyone wish to participate? No?

I do not know how you can possibly sum up, minister, but you now have the opportunity to do so.

Michael Matheson: I will take members' silence as a note of content, convener.

Motion agreed to.

The Convener: I thank the minister and his officials for their attendance. I suspend the meeting to allow them to vacate their seats.

09:56

Meeting suspended.

09:58

On resuming—

Glasgow Commonwealth Games (Compensation for Enforcement Action) (Scotland) Regulations 2013 (SSI 2013/160)

National Health Service (Superannuation Scheme and Pension Scheme) (Scotland) Amendment (No 2) Regulations 2013 (SSI 2013/168)

National Health Service Superannuation Scheme (2008 Section) (Scotland) Regulations 2013 (SSI 2013/174)

National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2013 (SSI 2013/191)

The Convener: Item 4 is consideration of four negative SSIs. No motion to annul any of these instruments has been lodged and the Delegated Powers and Law Reform Committee—what is that?

Rodger Evans (Clerk): It is the new name for the Subordinate Legislation Committee.

The Convener: So the Subordinate Legislation Committee has changed its name. That took me by surprise.

The Delegated Powers and Law Reform Committee has not drawn the Parliament's attention to any of the instruments. If no member objects to me taking the four instruments en bloc, I

ask the committee to agree that it has no recommendations to make on the instruments. Is that agreed?

Members *indicated agreement.*

NHS Boards Budget Scrutiny

09:59

The Convener: Item 5 is our annual scrutiny of the budgets of national health service boards. I welcome to the committee Craig Marriott, director of finance, NHS Dumfries and Galloway; Paul James, executive director and director of finance, NHS Greater Glasgow and Clyde; Fiona Ramsay, director of finance and planning, NHS Forth Valley; and Gerry O'Brien, director of finance, NHS Orkney. Welcome and thank you for attending.

In the interests of time, we will move directly to questions. The first question will be asked by Nanette Milne.

Nanette Milne: Thank you, convener. Good morning.

I am quite interested in service development, which boards were asked to feed back on. By and large, the responses that we received varied quite a lot. Although we were given examples of new services being introduced and of services that boards would like to introduce, we received few examples of services being withdrawn. Are services routinely evaluated to establish whether they are effective and continue to be effective? Are there any examples of services being found to be ineffective? Why are services that are found to be ineffective not withdrawn? I would be interested to hear your comments.

Craig Marriott (NHS Dumfries and Galloway): We have a process that is called making difficult decisions, which is a clear process for reviewing services and how they are provided. We look at the ethical background, at the return from the investment in a service and at the research background. Over the past few years, we have used that process to review services on a number of occasions. In the past year, we used it to review homoeopathy. On the back of that review, which took into account the views of stakeholders, professionals across the organisation and users, we decided to restrict the ability of new patients to access the service. We are not talking about a particularly large reduction—it is a reduction of only £10,000 across Dumfries and Galloway. That makes it clear that we continue to review the efficacy of services and how they are provided.

In previous years, we have used that framework to review other services. We reviewed acupuncture in the previous year and decided to restrict the use of that treatment.

Paul James (NHS Greater Glasgow and Clyde): If members look at our financial plan, they will see that the large majority of our cash-

releasing savings in 2013-14 have come from prescribing. That means that there has been very little impact on our front-line services in acute care and partnerships. We are looking to make £9 million of cash-releasing savings from those, which is a relatively small amount in comparison with the previous year.

Although we have not had any major service reductions, we have, as we pointed out in our submission, redirected some of the expenditure in certain areas. For example, we said that we were redirecting some preventative spending in relation to tobacco towards different areas. I cannot give the committee the details of where in the tobacco initiative we have reduced spend in order to increase it in other areas, but there has been a rebalancing of priorities.

Gerry O'Brien (NHS Orkney): In Orkney, we are probably at the most advanced stage with our local alcohol and drugs partnership. Over the past few years, we have been led by our director of public health in developing a commissioning model. We now have a formal process whereby the health, local authority and third sector organisations that receive the alcohol and drugs funding are asked to submit six-monthly reports on the outcomes that each of those services has achieved. A report is submitted at the end of September and at the year end. Those reports are used by the strategy group, of which health, local authority, police and third sector colleagues are all members. We evaluate those services on that basis, and that informs future years' commissioning decisions. That is probably the area in which NHS Orkney is most advanced in that regard.

We have definitely moved funding around in the way that Paul James mentioned. With some services that used to be funded through the ADP, we have said that we could see more effective use being made of the ADP money.

Fiona Ramsay (NHS Forth Valley): In Forth Valley, we have very similar processes. A strategic planning group reviews service change. Our focus has been more on service redesign. It is about making best use of the resource within particular areas and moving it around to ensure that we have maximum impact. Any proposals that follow that route have to go through an evaluation process: a year after a change has been made, feedback has to be provided to establish whether the proposal met its anticipated outcomes.

Nanette Milne: Thanks very much—that is helpful. As you know, we have been doing an inquiry into access, and it occurred to me—and I think to other people—that we know that there is intense scrutiny of drugs budgeting but we are unaware of how much scrutiny there is of other services in the NHS. It is therefore important to get on the record what is happening so that we can look at what might happen in the future.

A number of boards have said that they would like to invest in infrastructure. What sort of infrastructure investments would you consider? I know that each of you can speak only for your own board, but do you think that there is commonality across the boards on that issue?

Paul James: You will appreciate that in Glasgow we have a new hospital rapidly coming up. That is a major infrastructure investment for us, as it will have 1,109 new beds. The major spend that we will incur over the next couple of years will be for completing that facility. However, we highlighted in our written submission that, for example, we are refurbishing two wards at Stobhill hospital to provide better-quality accommodation for some mental health patients.

Those are investments in bricks and mortar, but we have also made quite an investment in IT systems recently. For example, we have invested in TrakCare, which will give us much greater auditability. The committee will be aware of the discussions that there have been about waiting times across Scotland. We have invested significant money in new systems. We were criticised not because we had manipulated waiting times but because our systems had not been designed to be auditable. We will now have a system that will be much more auditable, so that we can demonstrate that we have been squeaky clean on waiting times. However, that is not the purpose of the new system; the purpose is to get better patient management, which links to a system of electronic patient records that we are putting in. We have had a number of disparate systems in the past, so the ability to suck information together to provide a better-quality electronic patient record will mean that we can ultimately provide better-quality care for patients.

We have also invested in a system called ScriptSwitch. I do not know whether I can publicise the names of systems, so forgive me for doing so. However, that system will go into general practitioners' surgeries, and it will enable GPs to prescribe more efficiently and be more clinically effective. The system has a database that is maintained by our pharmacy specialists. I think that the system sits in all our GP practices across Glasgow; it has been fully rolled out or is on the verge of being so. The system enables better prescribing not only of the right choice of drug but of the right formulation so that it is cost effective. It therefore has a double benefit for us.

Nanette Milne: I take it from witnesses' nods that that is happening in other board areas as well. Is it the plan to roll the system out across Scotland?

Paul James: I do not know. It is a board by board initiative, so I cannot answer for the whole of Scotland. However, I know that a number of boards are looking at similar systems.

Nanette Milne: Are you also looking at areas such as maintenance? I know of one board that has a big backlog of maintenance expenditure. Is investment in new infrastructure having an impact on maintaining other infrastructure?

Paul James: Most certainly. We have had to make quite a few adjustments in our property and asset management strategy to try to reflect the impact of our new investments and the new health centres that we are putting up as well, which are part of the hub schemes. The reality is that the bald figure for backlog maintenance for Glasgow needs to be adjusted downwards to take account of the new infrastructure that we will have in place over the next few years. However, I would not want to mislead the committee, because we still have backlog maintenance and some of our estate is too old. We are in the process of reducing the problem, though.

Nanette Milne: Would anyone else like to comment on the same issues?

Craig Marriott: I just want to echo some of the points that Paul James made. We are in the process of building a new £200 million hospital. Thankfully, we got approval for our outline business case the other day, so that is a critical development for the people of Dumfries and Galloway.

We are also fortunate to be moving forward with two GP practices in Dunscore and Dalbeattie, which are going through the hub development, and there are other opportunities for us across health, whether we use NPD, normal Government capital or opportunities through the hub. Those projects give us different opportunities to deliver on some of our capital aspirations, which are detailed in our property and asset management strategy.

We still need to prioritise maintenance and backlog maintenance, and we also do that in our PAMS. In the past year, we have managed to free up some revenue to support some of the backlog maintenance. It is a question of taking a twin-pronged approach. We want to do the development to ensure that we hit our 2020 vision and deliver against the equality strategy, and at the same time we want to ensure that we recognise that some elements of our estate are ageing and they need to be modernised to provide healthcare facilities that are modern and fit for purpose.

Fiona Ramsay: Our estate was greatly enhanced with the opening of Forth Valley royal hospital in 2011. At present, working through our capital programme, we are investing in four community hospitals. The next tranche of our healthcare strategy will look at our primary care infrastructure, but we will do that jointly with the local authorities so that we can make best use of our resources and assets in communities and make the most effective use of those facilities.

Gerry O'Brien: I am probably at risk of repeating what my three colleagues have said, but we are at a slightly different stage. We are preparing a business case for a new hospital in Kirkwall and we hope to submit it to our Scottish Government health directorate colleagues in the autumn.

We have a slightly different dynamic in that we have a pressing need for backlog maintenance and new equipment, but we need to try to tie that investment in with the remaining lifespan of facilities, assuming that our business case for the new hospital is approved. Our laboratories manager comes to me and says, "We need to replace the analysers," and I have similar conversations with our central decontamination unit. We need to replace those expensive pieces of equipment, but we need to be mindful of the fact that—we hope—we will be moving to a new facility in five years' time. We need to determine how we can ensure that we do not invest money that we will have to write off over the next four years rather than get the full benefit of. In Orkney, although our instruments run at capacity, they tend to have a longer lifespan because we do not have the volume going through them, so we are also looking at that.

We all share the same challenges regarding buildings, but in the past few years we have also had investment to make in our IT. We are doing the same thing that Glasgow is doing. We recently approved a local business case through our finance and performance committee for the implementation of TrakCare in Orkney and we hope to go live with that early in the new calendar year for exactly the same reasons that Paul James set out. The systems that are in place do the job, but they do not do the job that is now required.

Backlog maintenance also remains a big issue for us. It is a question of how we handle that while keeping an eye on the new hospital, because we have to keep our statutory compliance up to date. We have worked hard over the past three or four years to get to a level of statutory compliance that we are comfortable with, and we cannot afford to let that slip. With much of the money that we are investing, we are saying, "These newly refurbished buildings could last us 10 years but, hopefully, we'll be out of them in five years when we get the new hospital." That is a slightly different dynamic. It is one that my colleagues have been through

because they are a bit further ahead in the new hospital process.

Nanette Milne: Will your investment in IT impact on the number of times patients have to travel to and from Aberdeen for treatment?

Gerry O'Brien: We are developing our telehealth capacity, although not that exclusively. In the past, we tended to concentrate on putting capacity into the Balfour hospital in Kirkwall so that we could minimise travel from Kirkwall to Aberdeen. We are concentrating this year—we did a bit of it last year, but it will primarily be done this year—on all our outlying GP practices on the northern isles so that we can save people having to come into Kirkwall for appointments with the local clinicians, let alone their having to travel to Aberdeen.

In gathering supporting information for that, we did a bit of analysis of travelling times. Somebody who lives in the more northern isles such as Westray and North Ronaldsay and who is travelling to Aberdeen for a 20-minute out-patient appointment could, depending on the timing of the appointment, be away from home for the best part of three days, just because of flight times. They might have to come to Kirkwall on a Sunday, stay overnight there, travel to Aberdeen on the Monday, come back on the same day and then eventually travel home on the Tuesday, all for a 20 minute or half-hour out-patient appointment.

We are doing a lot of work on that. Through our GP community, we have identified lead clinicians to examine why patients travel to Aberdeen. We are trying to use that information to target our investment.

10:15

Nanette Milne: That should save money in cash terms.

Gerry O'Brien: It should save cash but, more important, the patient journey will become so much better.

Bob Doris (Glasgow) (SNP): I was interested to hear Mr James talk about new infrastructure in the Greater Glasgow and Clyde NHS area. I represent Glasgow region and stay in the north of the city. A new health centre will open soon in Possilpark and new health centres are planned for Woodside and Maryhill. I know first hand that the new centres will dramatically improve the quality of the patient experience in the area. I visited the old Maryhill health centre to speak to staff and to find out how they think the process of moving to the new centre is going, and I was delighted to find significant buy-in among them. I met several GPs in the four practices and I met people from the community pharmacy. That is good news, and it is important that we put it on the record.

However, this is a budget-scrutiny exercise. Obviously, GPs and community pharmacists have a role in relation to the medicines and drugs budget. Mr James alluded to some of the cost savings that have come from NHS Greater Glasgow and Clyde's initiatives in the past few years. I have also considered the issue in the Public Audit Committee, after Audit Scotland reported on it. A figure of £9 million was mentioned, but can we get some more information in relation to the general increase in the medicines bill in NHS Greater Glasgow and Clyde? Prices tend to go up anyway, but could we also have figures on the savings relating to the reduction in inappropriate prescribing of drugs, polypharmacy and drugs coming off patent and becoming generic? That would give us an idea of how planning is going.

NHS Greater Glasgow and Clyde has been singled out as an exemplar of good practice in the area—we do not always say that, Mr James, but on this occasion we are saying it—so it would be good to know what initiatives the other health boards that are represented here are taking. We also want to hear about your budgetary targets. Obviously, hearing about various initiatives is all very positive, but the committee also wants to know what financial targets you have set so that we can, as part of our budget scrutiny of NHS boards, track the issue. More information on that would be most welcome.

Paul James: I will see what I can do. In our financial plan for next year, the latest figures show that we expect to make about £24 million of savings from prescribing. It is fair to say that the vast majority of that will come from off-patent savings. At one point last year, the price of atorvastatin came down by, I think, 93 per cent, which was a much larger drop than anybody had anticipated. As a result, because atorvastatin is a fairly commonly used drug, we expected to make savings of £4 million straight away. Obviously, we did not get the full-year effect of that, because it happened during the year in 2012-13, I think. The reality is that we have an on-going effect of the atorvastatin price reduction alone within the £24 million of savings. There are also some other off-patent savings. Quite a significant amount of the saving has come from that.

We expect to save in the region of £5 million as a result of our various prescribing initiatives. We have a significant pharmacy team whose members spend time with GPs to try to ensure that they prescribe the most clinically effective drugs. That team is not a finance team; it is a pharmacy team that is made up of clinical experts. They spend time with GPs and measure what we

call the weighted average cost per patient in each GP practice. We have found that GPs in similar areas that are adjacent to each other and, one would assume, with similar patient communities, have different levels of prescribing in terms of weighted cost per patient. As a result of that, one of our current focuses is to try to drive out some of that variation because there does not appear to be a clinical justification for it.

However, we leave that to the pharmacists. Although I am aware of the financial numbers that underpin prescribing, I do not influence it. It is important to say that, at the end of the day, prescribing decisions are clinically made—rightly so—for the benefit of the patient. We have fairly sophisticated reporting mechanisms for variation; the variation that exists in Glasgow is still too high, for me. However, the pharmacists visit the GPs and discuss individual cases. It is one of the things on which we keep an eye.

I am also aware that accountants have year ends and that there are things that hit one year end as opposed to another. At national level, if it is believed that community pharmacists have made a bit too much profit or more profit than was expected, there is a clawback scheme that brings some of that money back to the boards. That, too, is part of the £24 million.

There are a number of components. I hope that I have given you some of the flavour of what goes on.

Bob Doris: That is helpful. I would be interested to know how that is repeated in other boards. If the other boards are doing better than NHS Greater Glasgow and Clyde, they should tell us. It would be good to share best practice.

Craig Marriott: It would be remiss of me not to say that we already share best practice; good ideas are commonly shared among boards. None of us has the monopoly on the best prescribing practices.

We have found that the more pharmacists or technician support we have, the more we manage to drive down the costs; it tends to be the case that such investment brings us a return.

In NHS Dumfries and Galloway, we look to save about £2 million against our £7.5 million for prescribing in hospitals and general practices. That is a large number. We are trying to push it up every year as part of our 3 per cent. In percentage terms, we look to take out just over 5 per cent in efficiencies in prescribing every year against the 3 per cent total target. Within the £2 million, we are looking at about £1 million from drugs going off patent, and at another £200,000 to £300,000 in terms of volume. We also run an incentive scheme with some of our general practices, and some patient administration schemes are starting to come through and we are reaping benefits from them.

It feels like an open door that we need to keep open; as financial professionals, we have a responsibility to ensure that we go after all the non-pay elements before we go anywhere near the staffing services, and that is what we have continued to do.

Paul James alluded to work that has been done with ScriptSwitch, which we are rolling out in Dumfries and Galloway NHS Board. We are giving all our general practices the opportunity to take that forward. We will see what comes of it.

We tend to zero base our prescribing budget every year and build it back up based on the volume and activity that we know will come along. We have a finger in the air for any new drugs. We have found that the amount of new money that we put in tends to be balanced by the money that we take out in efficiencies. That takes into account volume. This year, for the first time, we have a net reduction in our total drugs budget, which is an important step for the organisation. We will continue to pursue that as we look for further efficiencies in future years.

Fiona Ramsay: In the Audit Scotland report that was referred to, NHS Forth Valley would have been one of the high-cost boards. However, over the past three years, we have made significant improvements and our unit cost per head of population has dramatically reduced; we are now close to the Scottish average. We have achieved that pretty much on the basis that NHS Greater Glasgow and Clyde outlined, with prescribing teams visiting practices—targeting for changes in particular the higher-cost practice areas that have similar populations—and through the standard statins switches.

We have also had a successful incentive scheme, based on their performance, for practices to scan medical records so that they can move towards holding electronic patient records and thereby reduce use of space for records and free up some of it. That has been successful and has delivered results for us.

Gerry O'Brien: NHS Orkney probably comes from a slightly different place. Two or three years ago we were well above the Scottish average in all measures of prescribing efficiencies; we have worked really hard. I say "we", but it is probably principally the director of pharmacy and his team working with GPs that has brought us back to the position that we are currently in, which is probably better than the Scottish average on most of the measures. Our biggest drive over the past two or three years was to increase our use of generic drugs. Three years ago we were sitting at 65 per cent use of generics; we are now up to about 84

per cent. We have reduced our defined daily dose cost per patient down to well below the Scottish average.

Our level of achievement is now at a similar level to that which was described by Paul James. It is similar to what we are doing with Highlands and Islands travel: we are utilising the services of one of our better GP prescribing practices in use of the interpractice comparator figures. We have reached the stage at which we need to have a clinician-to-clinician dialogue about why prescribing is apparently more expensive in one practice than it is in another. We are rolling out ScriptSwitch to all our practices and are about 70 per cent of the way through that process.

Quite a few GPs on our isles have local dispensing arrangements—we are engaging with GP practices at clinician level in order to understand prescribing practices—so we are looking at those, principally in respect of safety aspects in ensuring that the proper drugs are dispensed in appropriate quantities and are kept in date. Two national chains of pharmacies are represented on the islands and we have done a lot of work with them.

Craig Marriott: It is worth restating two key developments. One concerned the chief executive letter that was issued this year about polypharmacy, which has been very helpful in terms of taking that issue through our area drug and therapeutics committee. There is also the hospital medicines utilisation database, which is a new development in the hospital sector that gives us more sophisticated information on benchmarking drugs usage across a number of boards. Until now we have had very good data in terms of PRISMS—the prescribing information system for Scotland—which allows us to look at GP practices nationally. The HMUD is a development tool that will give us the same ability; it will allow us to develop more cost-effective prescribing within the hospital environment.

Bob Doris: That is very helpful, in particular for our annual budget review. I hope that we will see greater progress and use it in our evidence base next year.

Mr James made an important point: it may be worth stressing that prescribing of medicines is completely up to clinicians, based on their clinical judgment. Attention needs to be drawn to more appropriate use of medicines and efficiencies that can result. We cannot stress that too much. I say that because individual patients may have a patient-GP relationship in which they talk about changing their medication. A knee-jerk reaction from some patients might be, "Why are you doing that? Am I getting an inferior drug? Is this a cost-cutting exercise?" We need to get the message right. The process is not only about getting maximum efficiency; switching of drugs is sometimes to reduce polypharmacy—or multiple drug-taking—to the patient's benefit. It is also true that if a drug goes off patent there is automatically a cost saving in respect of its cost compared with identical products.

I have a question that I would like one of you to answer, although I suspect that the answer would be similar in all boards. Is there an initiative to ensure clear communication to patients when their medication is altered, so that they know that the drugs that they are prescribed are not inferior products, and that sometimes they may be prescribed medication because that drug has come off patent?

Craig Marriott: To be honest, that is not something that we would communicate. The GP and the patient would have the discussion about the patient's drug regime and any switches that were to take place.

Paul James mentioned ScriptSwitch, which is a tool that comes up on a GP's computer whenever they are about to prescribe a drug. It might suggest that the GP try an alternative more cost-effective drug. The GP has every right to go right past that screen; all that ScriptSwitch does is offer a recommendation. The decision about what to prescribe is still up to the GP and the patient.

10:30

Bob Doris: Are you content that GPs are, by and large, getting it right?

Craig Marriott: Yes.

Paul James: Absolutely—and it would be wrong if finance people in health boards tried to get involved in the communication between GPs and their patients about choices of drugs being prescribed. Craig Marriott is absolutely right to say that that is down to the individuals concerned.

Boards all have pharmacy teams that communicate with GPs. For example, when atorvastatin came off patent and became a cost-effective alternative to other statins, there would have been communication between the pharmacist and the GP, and if a GP decided to switch the patient to a different statin, a conversation would take place between the GP and the patient. That is a clinical discussion, and it is largely a local discussion.

Bob Doris: That is helpful, thank you.

The Convener: Was Mr Doris right to suggest that the significant variations in price and volume across the boards that are represented today are all down to the relationship between the patient and the GP? I presume that if other boards were represented here, the effect would be

exaggerated. There are significant variations in price, in GP and hospital prescribing and in volumes. How do you plan, in that situation?

Paul James: I noticed the differences in the summary that was prepared for the committee. I think that you might want to consider a number of things. First, we probably all prepare financial plans on slightly different bases. In NHS Greater Glasgow and Clyde we have typically used an uplift of 6 per cent for GP prescribing, but this year we used an uplift of 4 per cent. We also assume significant savings that offset the uplift, and which you can see in our plan. Other boards might not do the same thing. Members should bear it in mind that there can be an offsetting influence—

The Convener: Why should there be variations in how boards plan?

Paul James: May I come back to that?

The Convener: Yes.

Paul James: There is an important second point that I want to make. We are all at different positions in our prescribing practices. It is fair to say that some boards have had more success than others in reducing the weighted average cost per patient. For that reason, it is perfectly valid for boards to set different percentage targets. We are fortunate in Glasgow, in that we have managed to get the lowest weighted average cost per patient in Scotland, but that means that other boards will have more opportunity—I am speaking in broad, financial terms and forgetting about the clinical discussion—to secure reductions. I can see a load of reasons why boards would have different planning assumptions in relation to savings on prescribing.

The Convener: There could be any number of reasons. To whom do you justify your planning assumptions, in terms of costs? How do you explain that you have worked things out differently, if your figures stick out like a sore thumb? Does anyone ask you, as you ask GPs, why your figures stick out? When you plan, does anyone ask why you are different from the norm?

Craig Marriott: As professionals, we have a responsibility to have that discussion internally. We look at the numbers that pop up from different boards. There is a systematic approach, in that we put our financial plans to the Scottish Government, which plays the numbers back to us.

As Paul James suggested, members should realise that we might be comparing apples with oranges. I was £1 million underspent in my prescribing budget in the previous financial year. I have that on a recurring baseline, so when I look at the net increase against that, I do that on the basis that £1 million is already sitting there to put towards my volume and price increases for next year.

Other boards might be in different positions; they might have budgeted differently in the previous year. In Glasgow, Paul James might be in a break-even position; in Forth Valley, Fiona Ramsay might have a slight overspend. The amount of money that individual boards need to put in every year can be different.

We all take slightly different views in our incentives schemes, but they are similar. The national work that is done through the efficiency framework pools the shared learning, so we are all constantly trying to drive down costs. Paul James said that he is the number 1 prescriber in terms of cost. Well done: we are all trying to get there and are all trying to learn from each other.

NHS Dumfries and Galloway's costs per capita are about 10th or 11th, but our costs per weighted population are fourth. NHS board areas have different mixes of populations, our populations are different ages and there are different mixes in our drug regimes, but we all constantly work hard to try to drive down costs.

The Scottish Government looks at the situation and plays it back to us. To be fair, we know the answer before it is played back to us.

The Convener: Has the Scottish Government spoken to you about the variations and is it happy that all relevant factors have been taken into account?

Craig Marriott: We all have area drug and therapeutics committees. Our budget is built up through professionals considering it from a baseline position in terms of volume cost, what is coming off patent, and the Scottish Medicines Consortium's advice on new drugs, as part of our ADTC discussion.

The Convener: Do the ADTCs have a budgetary role in addition to all their other roles?

Craig Marriott: They have a budgetary role in terms of reviewing budgets—

The Convener: That is interesting, because over weeks of discussion we have not heard that ADTCs consider budgetary aspects in terms of access to drugs. We have heard that the process is about efficacy, safety and so on, so you are introducing something new when you say that ADTCs have a budgetary role.

I think that some of your colleagues also want to respond.

Fiona Ramsay: We challenge and share through our pharmacy networks and our financial networks. We are aware of the uplifts and of the benchmarking information that is available. For example, we could see that NHS Forth Valley was

a high-cost prescriber and that there was a challenge locally to improve the situation, so we contacted NHS Greater Glasgow and Clyde in order that we could go through the processes that it had used, because we could see what was happening from the benchmarking information. We share information through all our clinical and financial networks to ensure consistency.

The Convener: Although there might be various planning assumptions, you all say that you reach a happy point anyway. Should the Scottish Government say what planning assumptions you should take into account, and should you, if you want to depart from those assumptions, have to make the case for such local variation? That would give people, including the lay people on this committee, a small chance to subject the process to some scrutiny. That would be preferable to the current approach, which results in all the variations.

Craig Marriott: We operate the process that you have articulated. SMC advice tells us about new drugs and we take that into account locally to help us to understand how our budget has to change. Our consideration of the information locally is based on our demographic and on how our GPs prescribe. We take local factors into account in coming up with our budget.

The Convener: Do you decide whether a specific drug will be available in your area?

Craig Marriott: We have the SMC's advice, which clearly—

The Convener: You sometimes take a long time to implement that advice and there is variation. Is that part of the budgetary process?

Craig Marriott: It is all taken into account.

The Convener: The delay could be to do with the budget for a financial year, or whatever.

Craig Marriott: I am sorry. I clarify that we do not delay availability of drugs. As part of the ADTC process, every year we make a budget assessment about when new drugs will come on stream and we budget for that. The big assessment is obviously on cancer drugs in our hospital environment. As sure as eggs is eggs, we will get it wrong sometimes, so we have to be prudent in the assumptions that we make in our financial plans.

Paul James: I appreciate that it is difficult for the committee to carry out effective scrutiny of prescribing expenditure because it is a complex beast. We start off with the expenditure in the previous year—we know what we spent in that year. As Craig Marriott said, however, we get that wrong at the year end because the figures come out two months late, after we have made our prescribing accrual in our year-end accounts, and we find out what the real figure was during the audit. That is just a fact of life for us accountants. He underspent by £1 million and so did we, as it happens. That tells us our starting point for the next year.

Then, the first thing that we do is to ask what inflation and volume we will have. We also consider which of the existing drugs that we spend money on will come off patent, as that is a significant factor in the equation. We then look at the drugs that are coming in—the new drugs that we expect to see coming through the SMC, which, as you rightly say, will come on to our formulary—and when they will come in. All of that forms part of the picture of what we expect our expenditure to be in the forthcoming year. If you want to scrutinise that expenditure, you will have to get into each of those different factors.

One way of scrutinising the expenditure—it is a way in which we accountants look at it—is to think about the weighted average cost per patient, to understand how that is changing, and some of the big factors that are hitting the prescribing budget, such as off-patent savings and the pharmacy clawback that I referred to earlier. As you get into some of the bigger numbers, it might be helpful if, next year, you design some questions around that area. I am trying to help the committee.

The Convener: Yes, that is helpful. It is very difficult to plan for reductions in the expenditure other than through drugs and medicines coming off patent. How much of the £24 million is due to the clawback and other measures, and how much is due to drugs coming off patent?

Paul James: I do not have the breakdown with me, but I would think that we are talking about around three quarters of it being due to drugs coming off patent, clawback and other factors of that sort as opposed to what we would consider to be prescribing efficiency, conversations with GPs and the sort of stuff in which our pharmacy professionals get closely involved.

The Convener: The other thing that the committee is searching for—Nanette Milne alluded to it—is evidence of how much we are reviewing and monitoring within the health service and how that type of scrutiny, for little return it would seem, is being applied to other medicines that are still around. We do not see anything disappearing. We see new medicines and procedures coming on, but we do not see a lot being disinvested and we do not stop doing things. We do the things that we always did, and we do the new stuff as well.

Craig Marriott: That is a critical issue in relation to polypharmacy. Given the increasing number of people aged over 65 who are on more than five medications, polypharmacy is the key issue for us. We must start to review the number of

complementary medicines. As people get older, they take more medications, but it is only when they end up in accident and emergency units following falls and trips that we start to review their drugs regimes. That is why the polypharmacy CEL has been very helpful to us. When new drugs come out and we get the SMC advice, we also get its advice on the complementary drugs that we should stock as the new drugs regimes come forward.

The Convener: Bob Doris has a supplementary question on this, and a couple of other members want to come in. We are focusing on the subject because of the inquiry that we are carrying out. The prescribing budget is where everybody says that they can achieve cost savings and efficiencies, and certainly one of the risks that we need to focus on is the rise in that part of the budget. We will come to some of the efficiencies and cost savings later, I am sure.

10:45

Bob Doris: I will try to keep it brief, because I know that my colleagues want to come in with other questions. I want to return to the scrutiny issue. First, we should not conflate the access to new medicines review and the drugs that are on a local formulary with the financial assumptions that the boards are making. That could be dangerous, although I understand why people might do it.

The paper that we have before us covers cost pressures, including GP prescribing, hospital prescribing, prices and volume. However, what I do not have sitting beside that is information on the overall change to the drugs budget; savings from the use of off-brand drugs; savings from other measures that boards have taken; and your targets for 2012-13 and estimates for 2013-14. Quite frankly, I suspect that you have all that information and you have been scrutinised to the nth degree; you just have not been scrutinised by this committee. Audit Scotland did a tremendous job of providing scrutiny as well. Perhaps you could give the committee that information, as well as other information that you think is appropriate, in writing, which would gear us up for some effective, informed scrutiny when we return to the matter this time next year. When we are scrutinising, I do not think that we are comparing apples with apples; we are conflating different things, so it would be helpful if we were working from a baseline that was clearly understood.

The Convener: I think that there was a request in there for some additional information, which the committee would be happy to receive.

Jayne Baxter (Mid Scotland and Fife) (Lab): My question is not about pharmacy; it refers back to conversations that took place earlier in the meeting. I want to ask about what happens when services are redesigned, resources are moved around and things change in communities for service users. I seek an assurance that a bit of impact assessment goes on around that and that there is consultation with service users, community planning partners and possibly with staff. I would like a bit of information about those things, please.

Fiona Ramsay: We have been through a major healthcare strategy implementation, which had a full consultation process associated with it. That included our work around our community hospitals and the services that were provided through them. We moved from two district general hospital sites to one acute site. There are changes as you go through. Services change for different reasons. We have always worked locally, particularly with service users, on any changes that impact on them, such as changes in facilities and perhaps changes in location. We take into account any access issues and concerns that service users might have. Broadly, we came through that process quite successfully—certainly locally.

Gerry O'Brien: In Orkney, we are going through the process of redesigning our hospital-based services and some of our primary care services. We will hopefully be moving into a new hospital facility in about five years' time. We have an extensive range of groups set up to consult and we engage in dialogue with various groups, whether patients, the public or staff.

We engage very heavily with the local community councils and the local development trusts for each of our isles, and what each of them wants is different. We have examples of having told people what we would like to do, having dialogue and, following that, reflecting and changing our plans, taking on board what the communities wanted. The GP services on Hoy are a good example of the community having told us what it would like and our saying, "Okay, that's the way we will go." That works tremendously well. The importance of consultation and dialogue with all the stakeholder groups cannot be overemphasised.

Paul James: We provided quite a lot of information on inequalities in our response to the committee. We have a process called fair financial decisions. We try to ensure that all the savings challenges and processes that come through are properly evaluated for their equality impact.

The second thing to say is that our equalities team views equality not as something to be added on at the end of the normal operational management of the business but as an integral part of the business. They are forever preaching that message and making sure that we all understand it and adopt it.

The Convener: How do you deal with the question of why poorer people do not engage as effectively in public health screening as others? What have you done to reach out to and ensure a greater uptake among those people?

Paul James: One of the ways in which that is embedded in the process is that, when we are doings things like screening and healthy weights for children, we focus our efforts significantly on deprived groups.

The Convener: Has that brought any return? What sort of monitoring has been done to ensure that that strategy is working? Do you have information on that that you could send to the committee?

Paul James: I do, and I will pull something together for you.

The Convener: That is fine. Thank you.

Drew Smith (Glasgow) (Lab): I want to return briefly to the pharmacy issue and then move on from that.

I really want to understand the issue around the cost per patient for prescribing. I think that you described that as a weighted cost per patient. What does the weighting involve? There is a lot of public concern about access to medicines, particularly expensive medicines, so looking at the situation in terms of cost per patient would raise concerns if, behind that, we were failing to understand that some of the higher costs per patient are driven by boards that are providing the range of medicines to which people want access. Could you reassure me on that?

Craig Marriott: We have a cost per patient, which is just a straight cost per capita across the population. We see where we sit within that, then we get a weighted cost per case, which takes into account the age and demographic split of the population to give us a more accurate comparison cost.

Drew Smith: Are the costs of treatment and medication taken into account?

Craig Marriott: Yes.

Drew Smith: Clearly an innovative new medicine will cost more, so why would we want to drive down access to those medicines if a separate part of the health board was saying that it wanted to increase access to them when it can, because they are new and innovative and it thinks that it will get good results from them?

Craig Marriott: To be fair, two different discussions would take place. We would get information from our primary care system that would give us the weighted cost per patient, and other information would give us a cost element per patient. The discussions about new drugs regimes and how they are rolled out across the board would take place within the area drugs and therapeutics committee and would take into account how the drug would move into the formulary and the budgeting process.

Drew Smith: I understand that, but part of the issue that we are discussing is variation in the access that health boards give to medicines, because different decisions are being made. If we compare boards purely on the basis of cost per patient, how do we take into account the fact that some boards might be making different prescribing decisions that we would want to support?

Craig Marriott: That might take place as part of a review of different boards' formularies and the different drugs that are available in those different boards.

Drew Smith: Okay. Could I ask Mr James about the £24 million that he mentioned? Was that an annual figure?

Paul James: Yes.

Drew Smith: Could you give me some indication of what you spent the £24 million on once you had saved it? Where did it then go?

Paul James: Ah. I see. The £24 million forms a part of the figure of £59.9 million that is reported in your papers as being our overall savings programme. Some of that £59.9 million is made up of non-cash releasing savings. So we have £33.7 million of cash releasing savings, of which the £24 million is obviously the majority. To see where the money has been spent, you have to look at the board's overall expenditure plan. We compare that with our funding and obviously we have to take off the savings to balance the two. So I cannot tell you where I spent the £24 million, but I can tell you where the board is spending all its money. The £24 million is part of the overall equation when we are balancing our priorities.

Drew Smith: What I am asking, I suppose, is whether you can give me a rough percentage for how much of the money stays in medicine. For how much of the money do we say, "This has come off patent—"?

Paul James: Pretty much all of it goes into medicine. We have put into our pressures in 2013-14 about £29 million for prescribing, so we are not actually taking a significant net reduction in prescribing in 2013-14. In the past, we would have had a net increase in prescribing because we would not have expected to get the sort of savings that we are expecting in 2013-14.

I emphasise that this is pretty much a one-off year for us. I do not expect it to be repeated in 2014-15 or 2015-16. Returning to the convener's questions earlier, I note that that might not be true for some other boards, because they have the

opportunity to further reduce their weighted cost per patient, whereas we think that there comes a point at which we cannot continue to do that. From our point of view, 2013-14 is the last year for a period of time when we will see a benefit of that scale for prescribing in Greater Glasgow and Clyde.

Drew Smith: That is helpful.

Bob Doris mentioned the Audit Scotland report, which looked at 2011-12. One of Audit Scotland's big concerns was about recurring deficits. It criticised a number of boards for relying on one-off payments in order to break even through the year. Is that likely to be a problem next year, or this year, for the boards that you represent?

Gerry O'Brien: I will kick off on that, as NHS Orkney is one of the boards that the Audit Scotland report mentioned. Three and a half years ago, we had a recurring deficit of the order of £3.5 million to £3.75 million. We were probably touching 10 per cent of our core revenue resource limit, so we had quite a challenge. With our Scottish Government colleagues, we developed a financial plan with the objective of returning us to recurring financial balance at March 2013, which I am pleased to say we achieved.

A range of non-recurring support from the Scottish Government was instrumental in that, and it manifested itself in a couple of ways. First, we had brokerage support to get us through while savings were delivered. In addition, in the past couple of years, the Scottish Government has given us some non-recurring support for off-island activity, related to health boards with which we did not have contracts. That was a particular issue in Orkney. In 2012-13, we had non-recurring support again, but that was the end of it and we have moved to a recurring balanced position.

As we finalise the accounts, we are working with our audit colleagues to make sure that all that is clear and that there is transparency in the year-end accounts. Through our board, we have made full disclosure, and the agreed repayment of the brokerage that we had from the Scottish Government is in our local delivery plan approval letter. We will start repaying the brokerage in 2013-14, and we have a five-year payment timetable for that: we will pay £750,000 per annum over the next five years. However, for Orkney, on-going non-recurring support from the Scottish Government came to an end in the financial year 2012-13.

Craig Marriott: I come at the matter from a completely different position. More than £11 billion is managed through health. We looked for brokerage last year, but it was the other way. We have been through a strategic change and we are building a new hospital. When it is up and running, we will need money for double-running costs while we run the old facility and move to the new one, so we have been trying to bank funding with the Scottish Government. In the past couple of years, we have managed to secure some non-recurring resources and we have banked that funding with the Scottish Government. In effect, that is brokerage, whereas other boards might be taking brokerage in a different way. The flexibility certainly helps us, because the money will come back to me when we move to the new facility. Therefore, I can plan appropriately and ensure that I have enough resource in that difficult financial year to run both services.

Paul James: We are not expecting any support from the Scottish Government other than through the normal funding process. However, I support Craig Marriott's point that the ability to carry moneys forward is helpful. I think that many boards would appreciate that flexibility to help them to manage the budget in a more sustainable way.

11:00

Fiona Ramsay: In Forth valley, we have been in both situations. We banked money, as Craig Marriott described, when we were making our moves, so that we could access additional resource at a time when we were working across three sites as opposed to the one that we were moving to. We also required some support because the impact of our moves was felt in the same year as the economic challenges hit the whole country. We are well on the way to repaying that amount, and we hope to repay it a year earlier than planned.

You asked about underlying deficits. We have set a balanced recurrent budget for the coming year and for the years beyond that. It is important to stress that it is about longer-term planning, not just about next year but about the two or three years beyond that, with the pressures and demographic changes that will take place, because change takes time to work through, so we need to be clear about what we are doing on a longer-term basis, not just year to year.

Drew Smith: As you say, Ms Ramsay, you have been through that process and have seen it from both sides. What flexibility is required? My question for Mr O'Brien is about whether, if you needed a loan to break even this year, you would also need a loan to break even next year and for the five years that you are in repayment. Ms Ramsay, you said that you paid early. What factors change what you can do from what you think you can do at the start of the process?

Fiona Ramsay: What I was trying to explain was that we had banked money well before we

moved to Forth Valley royal hospital, so we had banked more than £8 million with the Scottish Government to help us, because we knew that we would have costs for double running, rates, IT infrastructure help across sites, and so on, and it is important to have the flexibility to take money when you actually need the resource. Because we got help, the arrangements for repaying are built into our healthcare strategy, and we were rationalising our footprint and the number of sites from which we were working, so our property sales tie in too. Timing the property sales, being able to market those sites and dealing with any associated conditions smoothly, to make them as attractive as possible, has helped us.

Gerry O'Brien: Fiona Ramsay has picked up a key point. One of the things that we had to do in Orkney was to develop a much longer time period for financial planning, rather than trying to survive from one year to the next. We have developed a financial model that runs over 10 or 12 years, so that we can understand exactly where we will be. That was the whole basis of agreeing the brokerage with the Scottish Government; we could clearly demonstrate that we could make the efficiencies and savings in order to repay the brokerage over the next five years.

We are now in a period of recurring surplus for the next five years, which will allow us to repay our brokerage, but the recurring surplus will be required to develop services when the new hospital comes online. The areas begin to mesh, and lots of our brokerage was about the timing of delivering savings, as Fiona Ramsay said; it bought us important time to get over a hump and make the efficiencies.

One of our big issues was off-island activity, especially with non-Grampian boards, and we now have service-level agreements with every board in Scotland and have entered into risk-sharing agreements for the more specialist services. In the past, I suspect that the board was trying to survive on the basis of hoping that something would not happen, but of course things always happen. The brokerage has been tremendously helpful in buying us the time to get into a stronger financial position, but the key element, as Fiona Ramsay said, was developing a much longer timeframe for planning and for understanding—all other things being equal, and based on a robust set of assumptions—where the board will be in five years' time, whether it can afford to make the payments and whether proper cost allowances and pay award assumptions have been made.

Going back to the earlier discussion and scrutiny of pharmacy issues, that is one of the areas in which our finance performance committee—comprising four or five of our non-executives—comes into play. We go through all our underlying assumptions in a lot of detail, not concentrating so much on the numbers in the early days of planning, but understanding where our planning assumptions sit in comparison with other boards and the rest of Scotland. We use our non-executives to get that level of scrutiny.

The big issue for me has been timing—taking time to allow us to get on to a much stronger financial footing.

Drew Smith: When the Scottish Government loans money, do you provide information to it on your assumptions about future property sales and so on? Can the Scottish Government bank on the fact that you will do that?

Gerry O'Brien: Yes, absolutely. We identified six properties for sale, of which we have now sold four—we have another two to go. That repaid a small element of our brokerage, but our plan was based on us getting back into a recurring revenue balance position. We went through quite a lot of detailed financial plan evaluation with Scottish Government colleagues. We did not just provide them with a high-level plan but dived into quite a level of detail to ensure that we were making the proper assumptions.

Drew Smith: I have one final question. I suppose that this is quite a general point, but another concern that Audit Scotland raised in its 2011-12 report is that 20 per cent of the savings that boards identified were high risk. Can you give us a flavour of what a high-risk saving means to you and your board? What sort of things would you class as high risk? For example, I presume that property sales are high risk.

Craig Marriott: There is an interesting dialogue. At the start of the year, we split up our risk analysis for each of our efficiency programmes. As we progress through the year, that risk profile will change. Some risks will remain high risk until we actually start to deliver some schemes. Some of the biggest risks will probably be around service change, such as proposals to deliver out-patient services in a slightly different way or to look at bed reconfiguration issues. Those would not change to a medium or low risk until we actually start to deliver them. In my risk profile just now, high risk accounts for 20-odd per cent—about 23 per cent—for the current financial year.

Paul James: I think that our figure is much lower than that. For 2013-14, we are looking for £59.9 million of savings, of which £33.7 million are cash releasing with £24 million being related to prescribing. I am confident about that £24 million, although I would not have put it in the financial plan, so I would not say that that is high risk. The remaining £9 million of cash-releasing savings come from our acute and partnership divisions, but to reach that figure we have already taken out all

the high-risk items. Our acute and partnership divisions originally submitted a higher figure for their savings proposals, but we consciously deleted all three schemes that were traffic light red. Therefore, all the schemes in our savings plan are either green or amber at this stage, and they are much lower risk than in previous years. I would not want to say that there is any high risk in Greater Glasgow and Clyde.

On high risk, I agree with Craig Marriott that achievability is a greater issue than acceptability, if you like, or impact on patient quality. Yes, there will always be an issue about whether some schemes will be delivered in time, but at this stage—and I am touching every bit of wood in the room—I think that we can say that we will deliver the schemes within the year.

Fiona Ramsay: For us, our risk profile changes over the year as we get more confidence as the changes come through. For example, service redesign may involve a workforce profile change because the skills mix within the workforce needs to change. If we need to move higher-cost elements in the staffing mix, we need to be able to relocate those people into alternative roles. That timing change might cause the project to be high risk, but it would move to low risk when we are able to free up the resources. Another example is that we are trying to tackle our temporary workforce spend or bank spend, which has a link to sickness absence rates. We will get confidence as some of those measures start to come through and we can start to materialise the savings. Therefore, our risk profile would change a couple of months into the year.

Gerry O'Brien: I agree with Paul James's comment that whether a saving is categorised as low, medium or high risk comes down to achievability rather than acceptability. That is a good way of putting it. We have now identified schemes for all our savings, but probably about 10 per cent of them—that is about £100,000 for us—are still sitting in the high risk category.

However, at board level we have consciously decided to link the delivery of savings with the investment plans. For some of the investments, we say to the managers, "Your prize for delivering that saving is that we will release the investment funds."

We have tried to get a careful mix, although we need to progress the investments in things such as our high-dependency unit and our computerised tomography scanner because we cannot wait until all the savings are delivered. We try to ensure that there are some investments in our plans that we can slow down if the savings do not come to fruition.

The Convener: I am interested in the discussion about some of the other things that are coming into play and what is achievable this year. To pick up on what Mr James said, I suppose that we are not expecting the prescribing bill—which is £24 million this year—to go up. My question is on the sustainability of the process. Some boards will be further on than others and will have made those efficiencies. Others will follow—they will see what was done and adopt that best practice. Alongside those challenges, there seems to be an increased demand and less money with which to meet it. How do we move on and ensure that the service is of the quality that people expect and is delivered efficiently? That will not become easier; it will become more difficult.

The other issue that interested me concerned carrying forward, flexibility and earmarked funds. There are a lot of bits and pieces which, if you had greater control over them, might put you in a better position than you are in at present to plan for the next five or 10 years. The earmarked funding is ring fenced and monitored and you are accountable for it. You have to spend it on certain things and show that you are doing so. That may mean that you are spending it not in the best way, but just to meet the target, and you could perhaps spend it in other ways.

When Mr James mentioned phrases such as "carry forward" and "flexibility", the other witnesses were nodding. How could we improve the situation for you? Do you have any suggestions that we should take into account?

Paul James: I will kick off on that. There are two points, which concern sustainability and carrying forward.

On whether the process is sustainable, we have to go through it because we have to set savings targets or make some sort of financial plan. We have to have some boundaries in which to do that, whether they cover a year, three years or whatever. From that very simplistic perspective, the process is sustainable. However, you are asking whether we can continue with it. As I explained, the level of prescribing savings in Glasgow will be greater in 2013-14 than in 2014-15. That means that we need to plan for the medium term, as I have mentioned to various colleagues at different times.

I am making great efforts to take my management team and my board through a longer-term planning process, and we are looking at all areas of the clinical service that we provide to see where we are efficient and inefficient, to do some benchmarking and to decide which services we want to expand and which we want to stop. There will be a series of fundamental debates about how we plan in the medium term.

We must bear it in mind that we spend a third of a million pounds every hour. That figure will be different for each of the boards that are represented round the table. The sort of numbers that I am discussing are different from those that some of my colleagues are talking about, and we have to get the relative materiality right.

We have a new hospital coming in 2015, and integration is starting in April that year. Those two things will have a significant impact on my cost base as we move forward. So now is the time to do some medium-term planning for Glasgow and ensure that we understand what the impact of the new hospital will be on our cost base, how much money we will put into healthcare and social care priorities and how we will prepare for all of that. I am looking at a three or four-year horizon in my financial planning. That has only just begun, so I am afraid that I cannot give you any details, but I can tell you about the process that we are embarking on, which we will stick to because we need to.

11:15

The Convener: That information is interesting to the committee, because we have looked at preventative spend. You talked about medium-term plans, but preventative spend focuses on the longer term. I understand the pressures that you have described. The building of the new Southern general hospital will give you 1,100 beds, but you do not need or want an additional 1,100 beds.

Paul James: No.

The Convener: So that gives us an idea of what is doable with all the other hospital beds, wherever they are. I am speaking from an Inverclyde perspective here and not just as the convener of the committee. Do you see the clinical review as a central part of the medium-term analysis and management of the challenges?

Paul James: Yes, very much so. I was not around then, but back in 2002 there was an acute strategy review for Glasgow that generated various changes to our service provision and culminated, to an extent, in the building of the new hospital, which is due to open in 2015. However, we must look beyond 2015 and ensure that we are prepared for the longer term. The clinical services review that we are embarking on is designed to achieve that and to look, for example, at the pathway of care for chronic conditions and what we need to do and change for that to provide better care.

The Convener: But what do you expect that clinical review to deliver for your budget?

Paul James: That is exactly why I have launched our medium-term—

The Convener: Is it standstill?

Paul James: We are not yet in a position in which I have financial forecasts from the clinical services review. I am happy to try to keep the committee updated.

The Convener: So the board has gone ahead without that information.

Paul James: The board started the clinical services review—rightly, in my view—with a clinical focus and with the aim of working out the right way of delivering care for patients over the next few years. I have backed that up with a medium-term financial strategy, which will increasingly integrate with that piece of work so that we make absolutely sure that the expectations that we are talking about on service design and delivery are genuinely affordable and deliverable. That is not just about money; it is about facilities and infrastructure, and people and skills. We must therefore ensure that, given the practical constraints, our clinical aspirations are realistic. However, that piece of work has only just started, so I cannot give you any great detail about it at this stage.

The Convener: I am sure that you certainly have not given a blank cheque.

Paul James: I am a finance director, so you would not expect me to say that I had.

The Convener: I will not press you further on that. However, I understood that the review is going out for consultation in October this year, so if we have not done the sums on that—

Paul James: No. We are doing some sums, but we have not got them yet.

The Convener: Will they be available by—no, I will not ask.

I bring in Aileen McLeod.

Aileen McLeod (South Scotland) (SNP): My question, which is related to some of the points that the convener mentioned, is on the potential savings that you anticipate from the various initiatives and projects that are part of your preventative health programmes. I am keen to know more about the extent to which boards are assessing potential long-term savings from preventative spend and about any modelling work that you have done to help with that assessment and future financial planning. There are examples of best practice, such as NHS Dumfries and Galloway's putting you first programme. It would be good to get some of that on the record, so perhaps Mr Marriott can explain a bit more about that programme. Perhaps Mr O'Brien can explain what NHS Orkney has been doing in relation to its impact analysis.

Craig Marriott: We led the discussion on the change fund, and the putting you first programme takes a similar approach. The programme involves considering our older population and how the local authority and the health service work together in dealing with the ageing population. Our numbers are pretty stark: 21 per cent of our population—the over-65s—utilise about 40 per cent of our resources and, by 2035, 46 per cent of our population will be over 65. We therefore have some pretty stark choices, and we have sustainability issues that we are having to deal with.

As part of the putting you first programme, we are working with social work colleagues to look at all the issues to do with our ageing population to see how we can deal with some of the demographic changes by changing some of our services, because the sustainability issues will impact on services.

It is interesting that Ms McLeod suggested that we are doing some good work in the putting you first programme, because I think that we are doing good work in it and we are on the cusp of understanding what some of the changes will mean for us. From a director of finance's perspective, preventative spend is always one of those things that are just outwith my financial plan in terms of any changes that are going to come forward. The reality is, though, that we need to work closely with commissioners and service providers to consider what it will mean for us further down the line if we make such changes.

We have an evaluation team that is considering three aspects of the putting you first programme: the qualitative aspect, the quantitative aspect—which is what I am interested in—and evaluation of the pilot projects. We have had some update reports from the team, which is now starting to articulate how difficult it is to do the different elements in the reviews. However, we need to stick with it.

With any project, we need to be clear about the outputs that we will get and how we are going to measure against them. It is easy for us to get the patient's story and how it has changed. Our non-executives are pushing us hard to understand that element of the patient's story. From a financial perspective, I am looking to the medium and longer terms for the ageing population and at how we provide our services and utilise our resources, because that must change. We are utilising all the money that we have in the change fund to create kernels of change and see what comes from that.

I lead one of the work streams, which is on supporting people at home. We are doing interesting work with the voluntary sector that involves good neighbours and volunteers going on to wards, working with patients and helping those who perhaps do not have strong family bonds to get back to their homes as quickly as possible. The good neighbours element works in the community as well, to help people avoid being admitted to hospital. We are looking at a wide spectrum of services. The difficulty is trying to pull all of it together to see what has changed.

We have clear metrics from the joint improvement team that we are supposed to score against. This year, we got a target for 2015 for the number of emergency beds for over-75s. Surprisingly, we hit that target in 2012. We wondered whether that was because of something that we had done in the putting you first programme or something that we had done through the change fund. However, the process is multifaceted. So many different things are happening in the organisation and the public that it is difficult to see what is going on in the short term. We must therefore base what we do on perceived trends. To continue to deliver something, we need to see how it scores against some of the key projects that we have taken forward.

We are seeing positive steps and doing really positive work with our third sector carers and social services. We are taking real steps towards integration. We are starting to think about a joint budget and how we can maximise the output that we want for patients or clients, rather than about where the resource comes from. The move to integration is starting to mean that we are having very different discussions. However, I hope that, perhaps within the next couple of years, we will have more concrete returns.

The Convener: How much of your budget, in percentage terms, are you investing in the initiatives that you described?

Craig Marriott: We are looking at it in the context of the change fund, so it is about £10 million over a three-year quantum. That is just the change fund element, but the real beauty is in considering how we change services and then move the resources that come behind them, whether that is our baseline budget of £250 million or the £70 million that comes from social services. That is the real change that we are trying to make.

The Convener: I asked the question because we are looking for a measurement. We see that shift in budget, but people have complained to the committee in previous evidence sessions that they do not see a shift in the budget. They say that they see the local authority and the national health service or board playing about with money but do not see a significant shift in commitment to preventative spend. That is why I asked for an indication of the percentage of your budget that is invested in that.

Anyway, we will carry on, with Mr O'Brien.

Gerry O'Brien: Over the past six months or year, we have been doing a lot of work in Orkney on bed modelling for our new hospital. As we said in our response to the committee's questionnaire, although we are experiencing exactly the same demographic challenges as the rest of Scotland with our older population rising year on year, our figures tell us that we can survive on the same bed numbers in five years' time as we have at the moment. That is what we are planning for.

There are two reasons for that. At the moment, we are making a shift in the way in which our medical services are provided within the hospital from a GP-led model to a consultant physician-led model. We are looking at changes in medical practice having an impact on lengths of stay. A move to the Scottish average length of stay would impact by about 1,800 to 2,000 bed days in Orkney. In the context of 47 beds, that is tremendously significant.

Orkney has the highest European age-standardised rate of alcohol-related hospital admissions in Europe, so the preventative agenda in relation to alcohol in Orkney is massive. We really must get into that. Luckily, we do not have a significant drugs issue, but we have an alcohol issue. The number of alcohol-related admissions is quite phenomenal. When you look at the charts comparing us with the rest of Scotland, you think that there must be a mistake, but there is not. As I said earlier, that is where we have really targeted our resources. We have targeted some of our initial work on a more focused commissioning piece of work in relation to our alcohol and drugs partnership. If you take that together with all the spending for the childsmile programme and the child healthy weight activities, our preventative spend probably does not touch much more than £1 million out of the £40 million that we might spend across the board.

The board constantly discusses how to move the money about. We have one of the highest resource transfer arrangements in Scotland and we are looking to the integrated partnership to try to move the money that has traditionally been tied up in beds and day services. If it can redesign those and move the money about within the partnership, we will be more than happy. The money does not necessarily need to come back to us to go back out again; we would be more than happy for it to stay in the partnership. That is £2 million in the equation that is tied up in traditional services at the moment.

That is where our preventative agenda has been going. On the change in our medical model, we have recently employed two new consultant physicians. We have taken on a local consultant obstetrician and gynaecologist, which has an impact on what we can do locally on the island. A significant point for the committee to understand in relation to Orkney is that we do only general services on the island and 90 per cent of everything else goes down to Aberdeen. We are trying to get into how much we can avoid transferring to Aberdeen. If Alan Gray from Aberdeen was sitting here, he would tell us not to assume that we would save money.

Similarly to the situation that Craig Marriott described, we have not yet factored in any financial consequences of the preventative spend. We are asking whether it allows us to live within the same bed numbers and have a footprint for a new hospital and our community services that is sustainable within what we have. We are doing a lot of work with the board on how we use the preventative and population health agendas to determine which of the services that we currently provide we should continue to provide in the future.

11:30

Fiona Ramsay: I would focus on our local alcohol and drug partnership. It is important to stress that that is about improving the quality of life and the health outcomes for the individuals, families and children concerned. It is successful locally in partnership working with local authorities, health and the voluntary sector.

There are a range of schemes that have had successful evaluations. I cannot give you breakdowns of the actual amounts, because there might be smaller schemes but with good outcomes, but I stress the improvement in the quality of life. We will not see cash savings over the timeframe that we are talking about; there will have to be a constant effort to focus on families and all the challenges, so we need to keep that level of spend going. In the future, however, some of the changes will help us to meet the demand that we know will happen because of demographic change. Therefore, although the preventative agenda might not help us to release cash, it will help us to be sustainable in the long term.

Paul James: If it would help, I can give the committee an example of one of the benefits of the preventative spend—namely, that on smoking cessation. We have seen an increase of 40 per cent in the number of quits in the sector that is most deprived according to the Scottish index of multiple deprivation. We talked earlier about equalities. I spoke yesterday to the director of public health, who reckons that there is a cost of under £1,000 per quality-adjusted life year in relation to those quits—although I do not take responsibility for that figure. There is therefore a significant payback, albeit that that is probably one of the most extreme examples, to be fair.

The Convener: It tempts us, though. We get a focus on and description of the alcohol and drugs funds, which are ring fenced and for which you are held accountable. The politicians are becoming emboldened. The action on smoking was a parliamentary initiative that was responding to failure in the area. The change funds created some action. The questions to consider are whether we should encourage more of the targeted approach to money, or whether, if money was released as a result of the preventative agenda and you had a free hand in its use, you would use it in the areas that we have talked about.

Craig Marriott: I will be brave enough to kick off on that. I was fortunate enough to be at the committee last year, when we talked about the allocation that we get in bundles. We said that there is now greater flexibility because, rather than having 18 different allocations in one bundle that all had to deliver different specialisms, we have been given greater flexibility in how we utilise the resource to deliver the outputs. From a financial perspective, we would always want that flexibility.

From where I sit, if we are to have greater flexibility in where the money goes, we need clarity on how we want the outputs to happen and what outputs need to be delivered. You can understand that to turn round and say that we have to have a left-hand specialist in a specific area might not be the right way to proceed. It would be helpful to articulate what output is wanted and to have more flexibility in how the budget can be moved to deliver that output. That is what we have through the bundling allocations.

The Convener: We are almost out of time, given that we have another panel of witnesses.

The prescribing measures and other preventative measures are pretty focused and you have to be accountable for them. At some point, you measure the outcomes, but does that apply to the bulk of what you do? Does the same scrutiny apply to the outcomes that are delivered in our hospitals every day?

All those other measures are the periphery. The main issue is whether we monitor and evaluate all the procedures that take place. Questions are now beginning to be asked about whether we should apply the same sort of scrutiny to the services that we provide in our hospitals every day as we apply to the prescription of end-of-life drugs.

Fiona Ramsay: We have a local performance management framework that is built on a balanced scorecard across the quality pillars that we use. That covers efficiency, effectiveness, a patient-centred focus and quality initiatives. We have that at strategic board level so that we can see the indicators. The framework develops all the time as things are added, and we are now cascading it through our individual management units, which cover hospital services, community primary health care and mental health. We have a balanced scorecard for each of the units so that we can pick up and evaluate the outcomes and see where we need to change and flex within the organisation.

The Convener: Is that as tough as the scrutiny that is applied to new medicines, though? If not, why not?

Fiona Ramsay: The process will evolve and be built on. We are working through a range of indicators and there is a tough challenge on some of them. Certainly, if any are in the red category, we would challenge that locally, and we are challenged on it locally.

Paul James: I am happy to comment but, with respect, convener, you should ask your question of the medical directors, as it really concerns clinical quality and I am reluctant to go into that territory. However, there has been a massive impetus through the patient safety programme to measure the negative aspects of what happens and the harm done. There is regular reporting on that. I am not qualified to comment on quality issues such as how we know one hip operation from another and whether one is better than another. However, you could correctly ask your question of the medical directors.

Nanette Milne: I have a small point. I think that it was Mr Marriott who, in answer to Drew Smith, mentioned discussion between boards to do with drugs. How much discussion takes place between health boards on formula make-up? Is there any attempt among boards to achieve alignment of formulae across the boards?

Craig Marriott: Again, that probably happens more through the relationships between directors of pharmacy. They have strong networks in which they have discussions on those issues. Some of the formulae are shared between individual boards.

Gerry O'Brien: We do not have a formula of our own, so we use the Grampian one.

The Convener: As we have no more questions, I thank you for your attendance, the evidence that you have provided and the patience that you have displayed.

11:37

Meeting suspended.

11:41

On resuming—

The Convener: I welcome to the meeting our second panel of witnesses: Robert Stewart, director of finance and technology, NHS 24; Caroline Lamb, director of finance and corporate resources and deputy chief executive, NHS Education for Scotland; and Julie Carter, director of finance, NHS National Waiting Times Centre.

I will go straight to questions and call Bob Doris.

Bob Doris: I had not realised that I would be asking the first question but, unprepared as I am, I will start with what might be considered a stock question. I see from my briefing notes that the territorial boards are seeking 3 per cent efficiency savings that will then be reinvested. Do your institutions have the same targets and go through the same process? If so, how are those savings reinvested?

Julie Carter (NHS National Waiting Times Centre): We are absolutely under the same kinds of targets and are constantly striving to improve our services. We do that through efficiency savings, which are then directly invested in our services. For example, through the Golden Jubilee national hospital, we have made savings in excess of £2 million or £3 million each year for the past couple of years.

Robert Stewart (NHS 24): I confirm that NHS 24, too, is subject to the 3 per cent per annum efficiency savings target, and it is important to remember that that funding is retained and reinvested by the board. We have continued to meet our efficiency target; indeed, this year, we plan to achieve a higher saving of around 4.5 per cent, which will be reinvested in patient care.

Caroline Lamb (NHS Education for Scotland): NHS Education for Scotland is in a slightly different position in that the savings that we make are taken off our revenue resource limits. As a result, we have suffered a budget reduction over the past three years.

When you look at the percentage levels for efficiency savings in the Audit Scotland report, you might think that our efficiency saving of 0.8 per cent looks very low, although I note that it still represents £3 million. It might help if the committee understands that 63 per cent of NHS Education for Scotland's budget supports the training of professional clinicians; in other words, we pay the basic salaries of doctors, dentists, clinical psychologists, pharmacists and healthcare scientists while they are in training. They are trainees, so they are working towards being fully qualified professionals but, at the same time, they also provide services—they treat patients while they are in training.

11:45

As a result, we cannot target that area for efficiency savings at all. We have to discount that because, if we were to make efficiency savings there, it would reduce the workforce. It would reduce the number of trainees, and that would have a direct impact on the number of doctors who come through to take up consultant posts, for example. On top of that, we spend a further £91 million on supporting NHS boards' spend to support undergraduate medics in training.

If you start to adjust some of those figures out, you find that the £3 million represents about 6 per cent coming out of our budget rather than the 0.8 per cent that it looks like on the surface.

Bob Doris: That is helpful, Ms Lamb. I was not aware of how efficiency savings work in your area. I fully appreciate why it is more difficult and challenging for you to make efficiency savings, given the model that you outlined. I suppose that there is also not much of an incentive to make efficiency savings if the money is lost to what you do, but that is perhaps a debate for another day.

Caroline Lamb: Absolutely. Our position is that that money directly supports services and territorial health boards and, if we were to make efficiency savings, it would not be us delivering the savings because it would have a direct impact on what territorial boards need to deliver to patients.

Bob Doris: That is a reasonable point and one that the committee might explore. I would be interested to get a flavour from your colleagues of what efficiency savings they have made. That would be helpful.

Julie Carter: Do you mean the actual schemes that we are considering?

Bob Doris: Yes.

Julie Carter: There are a variety of things. We are examining the scheduling of patients. We are primarily an elective facility, so we are fortunate in that we can plan things a little bit better. We maximise that to ensure that we can schedule better and improve patient outcomes.

The other aspect concerns the pricing and buying of things. Because we are a fairly small health board, we have a centralised procurement function to ensure that we standardise procurement and get the best overall prices that we can.

That is a flavour of our approach. We are also making efficiencies in energy and the other areas that other health boards are examining, but we tend to focus our work on scheduling and procurement.

Robert Stewart: We have tended to consider areas in which we can minimise any impact on

front-line services. We have considered facilities and looked to share accommodation. The Scottish Ambulance Service has worked with NHS 24 to share accommodation in our headquarters clinical area and in Norseman house. That has provided some efficiencies.

We recently reviewed our facilities management contract, which was previously provided by BT. We were able to tender that and we made some fairly significant savings in the contract. We operate only in leased premises, so we need an FM facility. This year, we plan to move out of our quite expensive private rented accommodation at Riverside house and share accommodation with the Grampian emergency care centre. That will generate full-year savings of about £320,000. We are also considering other areas such as carbon savings and unit cost savings in salaries.

There is a broad range of areas through which we can achieve our 3 per cent savings and reinvest them in developing additional services.

Caroline Lamb: I explained that we seek to ensure that we do not target areas that would directly impact on front-line services in other boards. Many of our recent savings have concerned properties. We recently consolidated from three premises in Edinburgh into one and we now occupy about a third of the floor space that we occupied previously. That has been done by moving to no owned offices, which has been a little bit controversial but is working well.

Bob Doris: That is helpful.

The Convener: What has been the impact on your organisations? You have tried to protect front-line services and, in Caroline Lamb's case, the number of doctors in training. Has that slowed down the progress of doctors? We get complaints about how long it takes to get a consultant in Scotland compared with somewhere else. Do the efficiencies impact at all on doctors' progression, rather than their training?

Caroline Lamb: No, I do not think so. The savings that we have made have been very much around facilities, which I mentioned, and some of our back-office functions. Like Julie Carter's board, we look at our procurement processes. I think that I can safely say that none of that has had any impact on the time that it takes for doctors to progress through training or on particular areas for which it is more difficult to recruit doctors. The time that it takes for them to progress through training is much more about factors such as the more flexible working arrangements that exist nowadays, feminisation and maternity leave.

The Convener: I am looking for some information on risk factors around how you decide to cut.

Caroline Lamb: One of the main risks to avoid in looking for efficiency savings is salami slicing and just chipping away at things. In our approach, we look carefully at where we spend our money, and a lot of that is around staff time and staff resource. We try to analyse that to ensure that we are being as efficient and effective as possible across all our areas of spend. We take a step back and analyse what we are doing, then look at where there are opportunities for savings.

Julie Carter: We take a proactive approach to savings. We look at quality, and I can tell you that every saving that we have made has improved patient quality. That is our focus. I tend to take a back seat and let the clinical people take things forward, then I come in and we start talking about money. We have had fantastic engagement from all our staff in making savings, and I hope that that will continue.

The Convener: I do not mean to be cheeky, but all your savings are sensible ones—for example, savings from moving into one building—so why did you not make them before the cuts came? Why was that not done as part of normal practice? What are you doing now to ensure that you will continue to be efficient? Will you wait until another budget cut creates an opportunity for you to have a debate in your organisation about savings, rather than plan how to be efficient?

Robert Stewart: The programme is not something that is just happening now. For example, our headquarters shares a building with NHS Greater Glasgow and Clyde's finance department, which occupies the top floor. That was taken forward five years ago because both organisations felt that it was a way of managing. We also worked with the Ambulance Service a number of years ago in Queensferry, so it is an on-going programme.

The Convener: It is poor understanding on my part, but I thought that you suggested in response to the question from my deputy convener that the efficiency savings that you have made were a result of the cuts and standstills in the budget.

Bob Doris: I do not think that I mentioned cuts and standstills.

The Convener: No, you did not mention cuts.

Bob Doris: They could not have answered that question if I never asked it, convener.

The Convener: I am sorry, but I misunderstood when my deputy convener mentioned efficiencies. I thought that you told us that moving in together and so on was a result of the current efficiencies rather than those five years ago. Frankly, I am not interested in hearing in the committee today about what happened five years ago. I am anxious to hear how you are dealing with the situation as it

presents itself. Does anyone else want to comment?

Caroline Lamb: I referred specifically to moving from three buildings into one. We lease all our properties, and that was always in our strategy. It was about getting to the point when we were coming out of leases and managing to align that so that we could make the move into one property without it costing us more.

Nanette Milne: My question is for Mr Stewart. Being from the north-east, I am well aware of the new Grampian emergency care centre. It is tremendous that you will be there with the Ambulance Service and the GP call-out people. Do you see that as a model that could be transferred to other parts of Scotland and result in savings for NHS 24? It strikes me that to be co-located with clinicians is important because it creates potential for savings and it benefits patients as well.

Robert Stewart: Yes. That is a valid point. We see significant benefits in linking with the clinicians in Grampian. We link with the out-of-hours services in our local centres, but I think that the model bears further scrutiny. Working with other clinicians and complementing what they do, whether through out-of-hours services or others, is a key aspect of the way in which we are taking forward the services that we provide. We are developing more services for boards and branching out from just the out-of-hours, overnight service that we have historically provided into some other areas where we are supporting territorial boards and taking forward various clinical agendas.

Nanette Milne: It strikes me that physical co-location is good because you can have more informal relationships that probably work to the patients' benefit and do not cost any more money.

Robert Stewart: Absolutely. It is all about delivering better patient services and keeping the patient at the centre of our focus.

Drew Smith: The Scottish health budget is falling in real terms. Probably naturally, although perhaps not appropriately, people look at the special boards differently from the territorial boards. You mentioned that a budget cut is applied to your organisations and it is your job to find the savings, which is a slightly different process from what happens elsewhere. My question goes back to the convener's point. What is the scale of unidentified savings in your organisations and where are the opportunities for those savings coming from?

Caroline Lamb: When we submitted our local delivery plan, about £800,000 of our savings were unidentified, but we have now managed to identify all the savings. Essentially, we are looking at areas such as procurement, ensuring that we are maximising the use of national contracts and looking at how we buy goods. We are looking at being as efficient as possible in our use of staff time for that. That translates into what we are doing in looking at staff time in other areas and ensuring that we are using our people as effectively as possible, because they are one of our most expensive resources.

I have talked about the facilities savings that we are making. We are looking at the rest of our estate and the opportunities for lease breaks to enable us to do something similar there.

Occasionally, other opportunities present themselves. About 18 months ago, we took on employment of all the GP specialty trainees—that is, doctors who are in training to become GPs while they are in their practice placements. As a result of that, we were able to move from having to buy them individual professional indemnity insurance when they were working in practices to bundling that together under one employer and under the totality of the NHS scheme, which saves about £600,000 per annum.

Such opportunities present themselves but, as Julie Carter and Robert Stewart have said, we have to be proactive. We spend a lot of time and energy looking at where there are areas where we can do things better, because we do not expect the situation to change overnight.

Drew Smith: The problem is, though, that it sounds like that is the job of directors of finance anyway.

Caroline Lamb: Yes.

Drew Smith: Could you take another £800,000 out of your organisation next year with no impact on anything that you do and no need to divest from anything?

Caroline Lamb: No. There will come a point at which this becomes more and more difficult.

Drew Smith: Quite.

Caroline Lamb: We are really struggling. We plan on a three-year basis, and at present we are struggling to identify the savings that we anticipate we will have to make for 2014-15.

Julie Carter: We do not have any savings to make that we have not earmarked for the next year. We have had really good engagement. We are starting to look at the 2014-15 and 2015-16 savings, and we spend a lot of time looking at innovation. Information management and technology services have changed dramatically over the past five years and I am sure that they will change over the next five years. We are constantly looking at ways in which we can improve our services. I do not have a feeling that

our organisation will reach a point in the near future when we cannot come up with savings. There are always better ways of doing things. That is a key message that we play out within our board, and it is a key message that we get back from staff who work at the coalface.

12:00

Robert Stewart: I said that NHS 24 is to move into the Grampian emergency care centre, which will give us savings of between £320,000 and £325,000 per annum. The biggest element of savings for us going forward is the future programme, which involves reprocurement of our current applications and our infrastructure. We have presented a business case that identifies significant savings on the current contract costs. The contracts were entered into when NHS 24 was established 10 years ago. There will be savings in the infrastructure, which will be hosted by BT. We will make capital savings on the infrastructure that we will no longer require to procure or manage. The integration of the applications, which currently come from a number of different suppliers, into one application via Capgemini will deliver significant savings.

We have a fairly clear idea of how our medium-term requirement for savings will be taken forward. We are not quite there yet for years 4 and 5 of our financial plan. We still have to do some work around that. However, for the next three years, we feel that we have an agreed way forward for our savings plan.

Caroline Lamb: We also have to be cognisant of the pressures that we face to do different and additional things. For my organisation, that is particularly about managing the doctor revalidation process, but it is also about managing some of the educational requirements that might emerge from that process. That is why it is important to keep a balance between the savings that we can deliver and the things that we know we must deliver for the service and for the regulator.

Drew Smith: You said that, by 2014-15, NHS Education for Scotland will not be able to find more of the kind of savings that it is finding at the moment, so the savings will then have to come from the training side and how we facilitate and ensure the training of doctors.

Caroline Lamb: It is not for me to make a decision on that. The number of doctors that we train is driven by workforce planning and is determined by the Scottish Government rather than by us. The budget that I have is for training a set number of doctors. We would not look to amend that without there being a decision about our requiring fewer of them. Our position is absolutely that we will not look to take money out of the training grade establishment.

Drew Smith: I am confused. You say that there is a set number of doctors, which makes sense, and we know broadly how much that costs. You also say that you would find it difficult to identify more savings from the other things that you can do, but you expect that you will continue to be asked to make savings in 2014-15 and beyond. Those two things do not add up, do they?

Caroline Lamb: We obviously need to carry on looking to see where there are more opportunities. What I am trying to highlight is that it is difficult to keep on trying to generate savings—which come off our budget—while trying to manage the pressures that we have to continue to respond to requirements from the regulator and others.

Drew Smith: Thanks very much.

The Convener: Is that a discussion that you have had with the Scottish Government?

Caroline Lamb: Yes. It is a continuing discussion.

The Convener: As well as the tight budget, can you say more about the additional responsibilities that are expected of your organisations? On a more positive note, I think that we discovered earlier that making savings is not always about focusing on money, because changes can be made that create savings. Money does not equal service development, but at this point is money dominating discussions in your organisations, instead of your focusing on service development? Are financial considerations dominating to the extent that you are unable to develop services as you would like?

Julie Carter: Finance absolutely does not drive service change; clinical staff drive service developments, innovation and change. We work closely with them; if it looks as though we will see cash savings out of change, I can pick that up quickly. I tend to sit with, but slightly behind, clinical staff as they drive that forward.

The Convener: You are in a fortunate situation, in that case, if you are able to meet all of the clinicians' demands and tell them that you can get them whatever they want.

Julie Carter: We do not have a blank cheque; the people who work with patients every day have fantastic ideas and we have an open way with them. They come and suggest to me for example, that if they were to use a certain type of valve, it might cost a little bit more but would save on intensive care unit days. I would examine that suggestion, set it up as a pilot, ensure that it will work and deliver it. It is very much the clinicians who drive that; it is not us.

The Convener: That relates to the question in the questionnaire that the committee sent out about what you would do with a bit of extra money. Are you saying that there is nothing that you would do and that you are perfectly happy?

Julie Carter: Yes.

The Convener: Good. Watch the next budget round.

Julie Carter: I know. I am going to wish that I had not said that.

Robert Stewart: It is important to recognise that we retain savings within the organisation and that we tend to use them to develop services.

In NHS 24, we have been keen to determine how we can support territorial boards by using digital technology directly in our work with some of them on the patient reminder service, in which we help them to manage their did-not-attend lists, through having a skills mix that can support boards on musculoskeletal work and through wider use of digital technology in managing a sustainable health service, in respect of which the committee has heard about some of the challenges. In the work that we have done with the Scottish Government on the European agenda, there is a real opportunity to use digital technology to help to manage demographic pressures, for instance.

We use our savings to develop that investment and to support other boards, including in the emergency dental service, smokeline and cancer helplines. That work can provide savings; it does not provide them directly to us but can help territorial boards to manage their resources differently.

The Convener: I take it that that is a key difference between an efficiency saving that you control and a top-slice—I will not use the C word in case I upset anybody.

Robert Stewart: A top-slice is a bit different from genuine efficiency savings that are reinvested.

The Convener: So, you and Ms Carter have all those savings to reinvest.

Robert Stewart: Yes.

Caroline Lamb: In my answers to the questionnaire, I flagged up a couple of areas in which we recognise that there will be real demands for additional input to training and education in the future. One of those is health and social care integration. To get it working operationally and culturally, there will be a real requirement for such increased input. We have done quite a lot of work on that, particularly on things that do not cost much extra money, such as building partnerships. We have been working closely with the Scottish Social Services Council for the past three years and have a memorandum of understanding with it and a joint action plan. That work is about bringing together the resources and expertise from two organisations to start to identify the areas in which we will need to work together in the future.

We have also been considering how the infrastructure that we have built up for education in health can be deployed more widely across the social services sector. We already have the knowledge network, which contains more than 3,500 electronic journal subscriptions and e-books. It has been spread more widely so that it is more accessible to social care staff as well as NHS staff. Those are the sort of things with which you can make a difference without having to spend a huge amount of additional resource—although if funding were available we would want to do a lot more.

The second area is around healthcare support workers, which is a huge group. I read yesterday that there are more than 60,000 healthcare support workers in the NHS workforce. That group tends not to have had a lot of access to structured education, or to transferable education. The importance of doing things nationally is that if people move jobs, they do not start from scratch because they have qualifications or accreditations that they can transfer.

We mentioned those two areas on the questionnaire as being things that we are talking about a lot, with regard to how the health service is developing, how we all want integration to develop and how we can help to make that happen.

Bob Doris: I apologise for continuing on efficiency savings. It is because what we are doing is budget scrutiny. There are lots of questions that we would like to ask about what you do generally, but that is not the purpose of today's evidence session.

Ms Lamb, I will return to efficiency savings in your organisation shortly, but first I want to check something for clarity. Before I was on the Health and Sport Committee, I was on the Local Government and Regeneration Committee with the convener of this committee, Duncan McNeil. Local authorities were not able to keep their efficiency savings; their budgets were top-sliced and the savings were lost to local government. I have no idea what the position has been in the health service. Mr Stewart and Ms Carter, when you were asked to make efficiency savings, did you always keep them?

Julie Carter: We have always kept efficiency savings.

Robert Stewart: Our efficiency savings have always been retained.

Bob Doris: That is a consistent situation.

Julie Carter: Absolutely. We have always kept efficiency savings.

Robert Stewart: There was a distinction between territorial boards that provide patient-facing services, similar to the Golden Jubilee national hospital and NHS 24, and boards that do not provide patient-facing services. That is the only distinction. We have always retained our savings.

Bob Doris: That is really helpful, for accuracy.

Ms Lamb mentioned continuing discussions with the Scottish Government over the cost pressures that NHS Education for Scotland will face in the years ahead. I assume that that dialogue has been on-going for a number of years. Is that something that normally happens, or have you had to raise cost pressures specifically? Is a weather eye always kept on it?

Caroline Lamb: A weather eye is always kept on cost pressures and we are in constant dialogue. We are not doing anything specifically different. Much of the discussion has been about getting clarity on the budget breakdown—how much is untouchable, if you like, and how much is the bit that we are focusing on.

It is very helpful to have the opportunity to talk to the committee about this. From our perspective it is a bit disappointing when people look at the stark figures and see that our savings are 0.8 per cent, because that is not how it is in real life on the ground. It is important that the Scottish Government and the committee appreciate how the position stacks up: there are big areas of the budget that, if we were to start to make savings on them, would not affect us particularly but would absolutely affect territorial boards and their patients.

Bob Doris: That leads to my next question. There are budget rounds and budgets will be set. You mentioned the workforce planning tool—which the Health and Sport Committee has heard about before—and how that will impact on the number of undergraduates that go into the system across our universities, not just to become doctors but to join a variety of clinical professions.

I will not ask what the funding formula is, but does what comes out of the workforce planning tool kick-start a formula? Which part of it feeds into your budget allocations? If you anticipate that there will be a reconfiguration and that there will be slightly more nurses and considerably more GPs in five or six years—I hope that you plan over the medium term—would that have a direct impact on your funding settlement, on a formula basis?

Caroline Lamb: The straight answer to that is probably no, because the budget is not driven on a formula basis. The other point to understand is that there is a very long time from starting to recruit extra undergraduates, to their getting through medical school, to their coming into our sphere of responsibility—let alone eventually ending up as consultants. That is why workforce planning is so complex and difficult.

Our budget would certainly be adjusted following a decision on recruitment. For example, a few years back as part of the dental action plan there was a decision to increase intake at dental schools, and the University of Aberdeen dental school was also set up. That was reflected as a change in the number of vocational training places that we were then expected to provide at the appropriate time. We respond to specific decisions, because their knock-on effect is that we will need more places, of whatever variety.

12:15

Bob Doris: Was there a specific budget settlement from the Scottish Government to your organisation for that example?

Caroline Lamb: Yes.

Bob Doris: I am trying to get at whether, when it is made clear that you must deliver X, the Scottish Government gives you Y for it, via whatever formula or ring-fenced budget. The question is how that is reported in your budget. Obviously, if it is part of the overall cash sum on which you make a percentage of efficiency savings, what I have described is a false comparison. I am not trying to put words in your mouth, but for me it is about getting better accounting for such budget sums. For example, it could be said that a specified amount of money goes directly to specific commitments for which efficiency savings are not made. That is because you want more of X, so the Government gives you Y for that, and there are no efficiency savings around it because X just has to be done. So, perhaps the efficiency savings are made around back-office stuff, better management and the overall bureaucracy.

Caroline Lamb: Absolutely. In practice, that is how efficiency savings are treated. We have had helpful dialogue with the Scottish Government about making that kind of separation of efficiency savings, which is why I am sure that the Scottish Government would not have found it acceptable for us to deliver less than 1 per cent efficiency savings, given that every board has an average of 3 per cent efficiency savings. The outcome of our discussions with the Scottish Government is that, when all our budget numbers are adjusted, our efficiency savings work out as a higher

percentage; there is an understanding of how the numbers break down. However, that does not appear when only the headline budget number is looked at.

Bob Doris: I hope that this evidence session has allowed the committee to tease some of that out so that when we look at our briefings and do next year's budget scrutiny, we will perhaps not be looking at the global sum that is spent by your organisation but at the efficiency savings that are based on part of your budget. That might be more helpful for the committee. However, what you have said is really informative. Thank you.

Caroline Lamb: Thank you.

The Convener: I do not think that I have any more questions from members for the witnesses. I will ask the question that we asked the previous panel: what evaluation have you done of your work and its outcomes? I ask in particular Mr Stewart, with regard to the smokeline and other such services on which we spend money. Are we confident that they have good outcomes, that they tick all the boxes, including the equality box, and that therefore they should continue?

Robert Stewart: Absolutely. For example, we have done work with some territorial boards on helping them manage their DNA—did not attend—waiting list issues and there has been and will continue to be evaluation of those pilots from a health economics perspective in order to understand whether the investment that we make to deliver the service equates to benefit for the wider health environment. We want to confirm that helping boards manage their waiting times frees up slots that can be used more efficiently and effectively or allows the boards to reduce the number of their waiting initiatives. So, with the boards, we will evaluate that.

There is, of course, the wider issue of the digital technology agenda and the work that we are doing with the Scottish Government on telehealthcare. There is also the European funding that we have to promote digital technology more widely for a number of areas of work. That will also be subject to rigorous review to ensure delivery towards our 2020 vision—our quality agenda—and to provide value for money for the health service.

The Convener: I can understand that in terms of the do not attends, but I was thinking more about, for example, the helpline for those who want to quit smoking. There is an argument that such services should be delivered by the local pharmacy at the end of the street or in the local supermarket. Are the outcomes good for helplines?

Robert Stewart: I cannot give a definitive clinical answer to that question. We are progressing an NHS smokeline as opposed to what we have at the moment, which is a commercial smokeline. There is an economic saving in using our technology to deliver the service. The benefit of that will be demonstrated by health boards. Intuitively, though, I think that there is a benefit to it.

The Convener: What I am asking—I do not know how the question applies to other areas—is whether that aspect of your work is evaluated and monitored, given our discussion this morning about what we cut and what we do not cut. The question is whether the smokeline service is evaluated, has good outcomes and is worth continuing. Alternatively, should people be able to phone another smokeline or go into a pharmacy for a similar service? I suppose my question is whether we can justify offering such services.

Robert Stewart: The work is evaluated. Some of that will be done by NHS 24 and some will be done by health boards when we work with them on services; they evaluate the benefits of services that we provide and—

The Convener: You hope that the boards would evaluate the work—you do not.

Robert Stewart: Yes—we hope that they would evaluate the work. However, they are under significant pressure to ensure that they manage their resources in the best possible way. I therefore think that they would welcome anything that we can do as a national board to help with that.

The Convener: The broader question is whether we are delivering services that are evaluated to assess whether they are worth while. Are we reviewing services in such a way?

Julie Carter: The answer for us is absolutely yes. We have quality dashboards in every ward in the hospital and we know the outcomes for everything that we do in the hospital, including patient satisfaction. We monitor all that. We look at the information almost daily, which flags up whether there are areas that are starting to waver. We then decide whether that is something that we need to invest money in or whether we need to consider efficiencies.

The Convener: Is that an important tool in your decision making and budget process and is all the information taken into account?

Julie Carter: It is, indeed.

The Convener: So, you use the system as a tool.

Julie Carter: We absolutely use it as a tool.

The Convener: Is there anything similar in the other witnesses' organisations?

Caroline Lamb: The largest part of our business, which is also the most expensive part, is training of doctors. Our evaluation of that is, in effect, our assessing whether we meet the General Medical Council's standards and are training people to be good doctors.

We also do a lot of other work around developing educational interventions and we evaluate all our education interventions. We take that into account in deciding, for example, whether we have gone about something in the right way, whether we have delivered the education appropriately, and whether we have hit the right targets.

As the earlier panel said, it is sometimes challenging to pin down a result to just one factor. Education is particularly challenging because there are so many things that have impacts apart from how somebody has been trained and educated.

Robert Stewart: We have performance dashboards, where appropriate, and local delivery plan targets. We also discuss with boards how a service is being provided. For example, for our musculoskeletal service for Lothian, in which we try to triage patients who require physiotherapy, we determine the impact of that on their clinics. So, there is work with boards around performance standards, which is a key part of what we do in NHS 24, as a special board.

The Convener: I have no other questions, so I thank you all very much for your attendance here today and for your evidence.

12:24

Meeting continued in private until 13:26.

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