The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

# HEALTH AND SPORT COMMITTEE

Tuesday 29 October 2013

Session 4

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## CONTENTS



## HEALTH AND SPORT COMMITTEE
**30th Meeting 2013, Session 4**

**CONVENER**

*Duncan McNeil (Greenock and Inverclyde) (Lab)

**DEPUTY CONVENER**

*Bob Doris (Glasgow) (SNP)

**COMMITTEE MEMBERS**

*Rhoda Grant (Highlands and Islands) (Lab)
*Richard Lyle (Central Scotland) (SNP)
*Mark McDonald (Aberdeen Donside) (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)

*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab) (Committee Substitute)
John Matheson (Scottish Government)
Alex Neil (Cabinet Secretary for Health and Wellbeing)
Dennis Robertson (Aberdeenshire West) (SNP) (Committee Substitute)

**CLERK TO THE COMMITTEE**

Eugene Windsor

**LOCATION**

Committee Room 2

# Scottish Parliament

## Health and Sport Committee

*Tuesday 29 October 2013*

[The Convener *opened the meeting at 10:00*]

## Decision on Taking Business in Private

**The Convener (Duncan McNeil):** Good morning and welcome to the Health and Sport Committee's 30th meeting in 2013. As usual, I remind all who are present to switch off their mobile phones, BlackBerrys and other wireless devices, as they can interfere with the sound system. Members of the public might notice that some members and officials are using iPads and other tablet devices instead of hard copies of their papers.

We have apologies from Richard Simpson and Aileen McLeod. Malcolm Chisholm is with us as the Labour Party substitute for Richard Simpson, and we welcome Dennis Robertson back to the committee as the Scottish National Party substitute.

**Dennis Robertson (Aberdeenshire West) (SNP):** Thank you.

**The Convener:** Agenda item 1 is a decision on taking in private consideration of the committee's draft stage 1 report on the Public Bodies (Joint Working) (Scotland) Bill. We normally take draft reports in private. Do members agree to take that item in private under item 3 today and at future meetings?

**Members** *indicated agreement.*

## Draft Budget Scrutiny 2014-15

10:01

**The Convener:** Item 2 is part of the annual process to scrutinise the Scottish Government's draft budget, on which we will take evidence from the Cabinet Secretary for Health and Wellbeing. On the committee's behalf, I welcome Alex Neil, the cabinet secretary, and thank him for being here. I also welcome John Matheson, director of health finance, e-health and pharmaceuticals at the Scottish Government.

I invite the cabinet secretary to make opening remarks before we proceed to questions.

**The Cabinet Secretary for Health and Wellbeing (Alex Neil):** The Scottish Government remains committed to publicly funded healthcare services for the people of Scotland that contribute directly to growth in the Scottish economy. The contrast between Scotland's approach to the national health service, which is based on its founding principles, and the competition and privatisation that are being introduced in England is growing ever more pronounced. NHS Scotland does not seek to promote competition; high-quality healthcare is provided by a variety of other means, including efficiency and productivity initiatives centrally and in individual boards.

Our record of achievement is recognised internationally as innovative and aspirational in its scope and in its potential for improving health and healthcare. Our achievements have all been made in the context of the most dramatic reduction in public spending that has ever been imposed on Scotland by the United Kingdom Government.

Within those constraints, we continue to deliver on our manifesto commitment to pass on the Barnett consequentials to the health service. Resource funding will increase by £285 million in 2014-15 and NHS territorial boards will receive allocation increases of 3.1 per cent in 2014-15 and 2.7 per cent in 2015-16—those increases are above forecast inflation in both years, which reflects the importance that we attach to protecting front-line, point-of-care services.

We remain committed to investment in capital and infrastructure. In 2014-15, capital funding of £150 million will be provided for estate maintenance and equipment replacement, and £111 million will be earmarked for the children's and adult hospitals element of the new south Glasgow hospitals project, with a further £27 million to complete that in 2015-16.

In delivering and improving high-quality and sustainable healthcare services, our record of success includes significantly reducing waiting

times for diagnosis and treatment and the introduction of the Scottish patient safety programme—Scotland is now regarded as a world leader in patient safety—as well as major reductions in levels of healthcare associated infections, improving mental health wellbeing and services, and creating a new relationship with industry and research to pursue a joint agenda of healthcare improvement and economic growth through innovation.

We have made a significant contribution to the marked reductions in mortality rates from the three big killers—cancer, heart disease and stroke. That includes the detect cancer early programme—a £30 million investment that concentrates on lung cancer, breast cancer and colorectal cancer.

Over the next few years, the demand for health and social care services, and the circumstances in which they will be delivered, will be radically different. Our vision is that, by 2020, everyone will be able to live longer, healthier lives at home or in a homely setting. For 2014-15 and 2015-16, we will prioritise spending on further improving the quality of care that we provide, improving the health of the population, and securing the value and financial sustainability of the health and care services that we provide.

Key priorities for 2014-15 will include increasing the role of primary care through a focus on keeping people healthy in the community for as long as possible; integrating health and social care as part of the Scottish Government's commitment to public sector reform; accelerating safety improvement programmes in all healthcare environments by extending the patient safety programme to maternity services, paediatrics and mental health; driving forward the early years collaborative; reducing health inequalities, particularly in the context of benefit cuts, which will have the greatest impact on those at risk of ill health; preventive health measures on alcohol, tobacco, dental health, physical activity and early detection of cancer; and establishing a vision for the health and social care workforce for 2020 and setting out a clear plan of action.

We continue to maintain a high level of investment in NHS Scotland infrastructure. Work continues on time and on budget on the £842 million new south Glasgow hospitals project, which is due to be completed in spring 2015. The official opening of the £70 million mental health project at the Murray royal hospital in Perth—the first non-profit-distributing health project to be delivered in Scotland—took place in June 2013. Procurement for a further four such projects commenced in 2013, with a combined capital investment value of £440 million.

The Scottish Government is working with key partners to ensure that the 2014 Commonwealth games are an outstanding success. That success will include ensuring that the games have an impact beyond the 11 days of sporting competition. For example, in the east end of Glasgow, housing development for the athletes village and supporting infrastructure will support sustainable economic growth.

To summarise, despite the biggest reduction in public spending imposed on Scotland by any UK Government, the Scottish Government is committed to delivering on health. Furthermore, NHS Scotland's achievements continue to be recognised internationally as innovative and aspirational in their scope and in their potential for improving health and healthcare. We continue to deliver on our manifesto commitment to pass on Barnett consequentials to health, which means that NHS territorial boards will receive those above-inflation allocations for the next two years. We will continue to focus on further improving the quality of care that we provide through the healthcare quality strategy; securing greater integrated working; prioritising anticipatory care and preventative spend; prioritising support for people to stay at home as long as is appropriate; and taking action to ensure that people are admitted to hospital only when it is not appropriate to treat them in the community.

**The Convener:** Thank you, cabinet secretary. The first question is from Richard Lyle.

**Richard Lyle (Central Scotland) (SNP):** A recent Audit Scotland report stated:

"The NHS has made good progress in improving outcomes for patients, such as reducing death rates from heart disease".

However, it also stated that

"there were signs of pressure within the system in 2012/13. Not all boards met their waiting times targets ... and boards increased their use of agency and bank staff and their spending on private sector healthcare."

In fact, I am led to believe that such spending is up by nearly a quarter, with some £80 million spent on private sector healthcare. What is your opinion of the spend on private sector healthcare and on agency and bank staff, and do you believe that too many targets have been introduced as a result of political party requirements?

**Alex Neil:** There were quite a lot of questions in all of that.

**The Convener:** There were indeed. I think that the rest of us could just go home. Well done, Richard.

**Alex Neil:** Inevitably, there are and will always be pressures on the health service, because of our ageing population and the population increase—we now have a record population in Scotland.

If members look at the figures for people who have been through the health service in the past year, they will see that there were 1.65 million presentations at accident and emergency, 6 million presentations at consultations with doctors in the acute sector and 24 million consultations with doctors in the primary care sector. In addition, more than 50 per cent of people over 65 take more than five tablets per day—it goes on and on.

Those are huge figures, by any standards. Given an ageing population, the financial constraints to which I referred and the fact that a record number of people live in Scotland, I accept that demand pressures are high. A key part of our strategy is better management of demand, for example in relation to presentations at A and E and primary care surgeries, by streaming patients and so on. I am happy to go into more detail on that.

On the private sector, let me first put the issue into perspective. South of the border, the private sector accounts for 10 per cent of the entire £105 billion budget for the health service. Therefore, well over £10 billion is spent in the private sector, and the proportion is rising—intentionally—as a result of the reforms that are taking place south of the border. In Scotland, 0.8 per cent of our total £12 billion budget is spent on private healthcare—of course, that excludes independent general practitioners and dental contractors, who I do not think are regarded as private sector providers for the purposes of the question.

There is no doubt that, particularly in the Lothians, there has been a temporary increase in the use of the private sector as a result of the difficulties that I think the committee is well aware of. To reduce the backlog that the new administration in NHS Lothian inherited, the board has had to make greater use of the private sector than it did in previous years. We are determined to bring down the use of the private sector, although it is only 0.8 per cent of the total budget, particularly where capacity already exists in the national health service in Scotland.

On nursing, let me make the important distinction between agency nursing and bank nursing. I think that spend on agency nursing is down to under £7 million a year, which represents a substantial reduction from the position 10 years ago. Bank nursing accounts for, on average, about 5 or 6 per cent of nursing hours across Scotland. In some boards the ratio is higher: for example, according to figures that I have seen, bank nursing accounts for 14 per cent of nursing hours in NHS Greater Glasgow and Clyde. I have asked the board to bring down the proportion. Bank nursing has an important role to play where there is a short-term supply requirement, but it should not be a substitute for permanently filling positions in the nursing profession. A proportion of round about 5 or 6 per cent is reasonable, given winter pressures, summer holidays and all the other reasons why we would want bank nursing, but 14 per cent is far too high. We will bring the figure down, particularly in Glasgow.

The number of consultants in the health service is far higher today than it was six years ago. In particular, if members consider the 24 accident and emergency departments in Scotland—accident and emergency is one of the main pressure points—they will find that we have doubled the number of accident and emergency consultants in Scotland in the past six years. Over the past 18 months or so, there has been a 50 per cent increase in the number of accident and emergency consultants.

I accept that there are pressures but I think that we have been managing them much more successfully for a number of years. The implementation of the unscheduled care plan, for example, will lead to further improvement, particularly in accident and emergency figures. However, I accept that we have some way to go in some areas.

**Richard Lyle:** Occasionally when I pick up a newspaper I read comments about health tourism—people getting off a plane in Scotland or the UK and immediately going to A and E. What action are we taking to reduce health tourism or to quantify how much it is costing the health service in Scotland?

10:15

**Alex Neil:** We have looked at the issue and we think that it is very marginal in Scotland. Health tourism is very much focused on London and the south-east of England.

Where appropriate, the NHS in Scotland pursues people to recover costs, but sometimes the costs of recovery can exceed the amount to be recovered. I will ask John Matheson whether he can give you a more precise figure or the latest figure, but I believe that the issue is totally marginal. A couple of weeks ago, Jeremy Hunt, the English health secretary, said that the UK figure was £500 million a year but I think that we are talking about single figures—certainly very low figures—in Scotland. We are nowhere near £50 million or 10 per cent of the UK figure; as I said, health tourism is heavily concentrated in London and the south-east of England.

That said, we should be very careful when we talk about health tourism. After all, people from the European Union who visit Scotland are entitled to access health services, per our reciprocal

arrangements as a result of being part of the European Union. I assume therefore that the term "health tourism" refers to people who come here and receive free health services that they are not entitled to receive for free and whom we are pursuing to recover appropriate charges. Where that happens, we pursue those people as best we can.

**John Matheson (Scottish Government):** The overall figure is very small—in fact, it is a single digit—but nevertheless the cabinet secretary is right. Scotland has a counterfraud service and when such matters are brought to its attention it collaborates and works in tandem with the United Kingdom Border Agency to pursue those cases.

**Richard Lyle:** Thank you.

**The Convener:** Cabinet secretary, you concede that there are pressures on the system, as highlighted by the increase in overtime, the increased use of bank nurses—which reverses the previous trend—the situation with consultant vacancies and so on, and you have also told us about the increase in demand, which is something that we have heard about in many debates. What in this budget will ensure that we meet those demands and reduce the use of bank and agency nurses and private healthcare? What in the budget tells me that the Scottish Government is addressing those issues in a planned way?

**Alex Neil:** You should consider, for example, the figure that we have allocated for the unscheduled care plan, which, having been launched in January with funding of £50 million over three years, is about to go into its second year. As we know—indeed, as the committee will know—accident and emergency is one of the major pressure points in the system, and I want to tell the committee about a number of initiatives that the budget will fund or is already funding.

First, as I said, over the past year there has been a very significant increase in the number of A and E consultants in Scotland's 24 A and E departments. Secondly, there has been a substantial increase in the number of nursing and other allied professional staff in those departments. Thirdly, to deal with the pressures that presentations to A and E put on other parts of a hospital, we are investing heavily in improving the management of patient flow—which, after all, is the key to dealing with the issue—and bed capacity in our hospitals. For example, an electronic ward management initiative that has been piloted in the NHS Borders area will be rolled out across Scotland by next April or May, and we are also investing heavily in improving co-ordination in hospitals to ensure that matters are not managed in silos. Finally, we are considering a whole range of community initiatives to reduce pressure. This is all in the budget—

**The Convener:** Where in the budget is that focus on change of delivery?

**Alex Neil:** It runs right through the budget. The above-inflation increases for the territorial board budgets will fund such initiatives, which are not highlighted as individual line items in the budget. Obviously, we budget for them below the level 3 and level 4 figures that the committee deals with, but they form part of the calculation of the budget for each territorial board and each of the eight special boards in the health service in Scotland.

**The Convener:** You recently announced that we are going to have a 24-hour, seven days a week health service. What pressure will that put on services that are already under pressure? How will that help to reduce use of the private sector and of bank nurses and agencies? How will we manage that? Where does the budget say we are going to manage that?

**Alex Neil:** First, on 24/7 working, there is in the press a lot of shorthand reporting of health service matters, so let me explain what 24/7 working is. We already have 24/7 working in the national health service and have had it since the day and hour that the NHS was brought into being. For example, emergency services are 24/7 services. We also have out-of-hours GP services that are run by NHS 24, so there is 24/7 access to GP services.

What drove us to make the announcement to which you referred, however, is that the way in which we run our hospitals in particular is very much geared to the five-day week. I will give you some practical examples. A patient might be ready for discharge on Friday evening or Saturday morning, but cannot be discharged until Monday. That is not because of lack of consultants or nurses, but because there is nobody in pharmacies to dispense the drugs that are needed for discharge, so we need to extend 24/7 working to make pharmacy services available on Saturdays and Sundays in order to allow discharges to take place. All the evidence—not just from Scotland, but from elsewhere, too—clearly tells us that the longer a person stays in hospital, the less chance they have of maximising their health outcome. In the scenario that I described, to keep people in hospital two days longer than is necessary is not the right thing to do in terms of health outcomes.

The second major thing is that we have looked in our hospitals at patterns in the flow of patients, bed capacity management and a range of other factors, in terms of what happens at the beginning and the end of each five-day working week. In essence, there is a very uneven flow, which results in some of the pressures that we have talked about being exacerbated. We believe that we can significantly improve efficiency and quality,

and patients' health outcomes, if we manage the flow of patients and bed capacity over a seven-day week, outside planned care—70 per cent of patients in hospital are there on an unscheduled basis. I am happy to arrange a more detailed presentation on the rationale and the figures behind that argument.

**The Convener:** I think that all politicians and all our constituents want a good-quality service whenever people go into hospital, so there is no difference in our views on that. However, I am trying to highlight what Audit Scotland has highlighted, which is that there are symptoms of pressure in the system. Indeed, we have had evidence on that from those who deliver services. I see that Mr Matheson would like to comment.

**John Matheson:** I want to follow up on the convener's comment about where there is evidence on the strategic direction that we are trying to achieve. One of the problems that we have, because of the way in which the budget is presented, is that people understandably tend to focus on the marginal increase and how the budget has moved compared with the previous year, which means looking at how the additional £284 million that is going into the health budget in 2014-15 is being allocated and how it will be spent. However, we try to have a broader focus not just on the additionality but on the core budget.

A good example of that is the musculoskeletal service in NHS Ayrshire and Arran, which is a redesign of an existing service that uses physiotherapists to triage orthopaedic referrals. The impact of that has been a reduction in referrals to orthopaedic consultants in Ayrshire and Arran of 288 per month, and a reduction in the waiting list figures, which have gone down from 2,000 to 1,000. That is a redesign of an existing service, not a new investment. As well as looking at the marginal increase, we need to consider how we use the 98 per cent core budget effectively.

**Alex Neil:** To add to what John Matheson rightly said, we are now rolling out that musculoskeletal service in NHS Grampian. One reason why Grampian's waiting times have not been as good as they need to be is because of the number of people who are waiting for orthopaedic procedures. Through rolling out that initiative to Grampian—it will be rolled out to other areas, too—we expect a similar significant impact on waiting times and waiting numbers for orthopaedic procedures in the NHS Grampian area.

**The Convener:** The committee is interested in the preventative strategy, the change agenda and inequalities, but the budget that is before us does not say what the Government is doing to make that shift. It does not even look at what we have got wrong in the past and what we need to fix. It is not clear on that. I am sure that that will come out in members' questions.

**Rhoda Grant (Highlands and Islands) (Lab):** The committee has been working on the Public Bodies (Joint Working) (Scotland) Bill, which emphasises the integration of health and home care and care in the community. How can we track in the budget whether the spending is moving in the right direction?

**Alex Neil:** I will pick up on a point that John Matheson made. The committee is looking at the budget at levels 3 and 4, but there is much that is at a more detailed level. For example, West Lothian has run an integrated health and social care system for the past eight years. However, in the budget at those levels for NHS Lothian, that would not stick out as being the case, because of how the budget is presented, as required by Parliament. Everybody in the committee knows that there has been successful integration in West Lothian over the past eight years.

It is important that the committee considers the budget along with the narrative on what we are trying to achieve in the health service, a key point of which is, rightly, integration. Going forward, because we are putting integration on a statutory footing, presentation of the budget will have to change to show the integrated budgets for health and social care of each of the 32 partnerships. I envisage that, once the bill that will implement integration is passed, we will in two or three years, when we present our budget to Parliament, be including information that shows the budget for each of the 32 integrated partnerships, because that will make up a substantial proportion of the total health and social care budget for the whole of Scotland.

At the moment, we do not do that because, with the exception of a few areas including West Lothian, we do not have integrated systems, and the approach is not statutory. Once it is on a statutory basis, we will in future years show the budgets of each of the partnerships, because they will be such an important part of the overall picture.

**Rhoda Grant:** Would it be possible to have that information sooner, because we would then have a starting point from which we can make comparisons as the changes roll out and further integration takes place? That would allow us to track the changes.

**Alex Neil:** The problem is that the partnerships are at different stages of development. We are happy to provide the committee with information from areas where there are integrated partnerships. For example, we could provide information on how much the West Lothian partnership spends, its budget and how that is

funded between the health board and the local authority. However, it will be difficult to do what Rhoda Grant asks us to do until the bill is passed and the integrated partnerships are up and running. Clearly, at present, integration is done voluntarily and there is wide variation among the existing voluntary partnerships on how they account for budgets, how the budgets are reached and what services are provided. That will become much more standardised once we have statutory implementation. Certainly, when that information becomes available, I will be more than happy to supply it to the committee at the earliest opportunity.

10:30

**Rhoda Grant:** That would be helpful. I understand that you currently have integrated resource framework reports that show some of that spending and how it is tracked. Would you be happy to give that information to the committee as well?

**Alex Neil:** Absolutely—we can give you a full briefing on the integrated resource funding framework.

**Rhoda Grant:** In your statement, you mentioned the ring-fenced money for health board budgets and how it is protected. How do you overcome moving funding from acute health into community care, which has historically been a local government service? Is there a block that stops that resource moving, or will community care move into health to become part of that funding?

**Alex Neil:** There are three important points to make. First, we envisage that as the partnerships are created, the primary care budget of health boards will become the responsibility of partnerships. Secondly, we envisage local authorities' budgets for social care, as defined in legislation, becoming the responsibility of partnerships. In addition, a share of health boards' acute budgets will be under the direction of the partnerships; they will not physically handle the money, but how that resource is used—particularly in respect of how we make the transition from treating certain conditions in the acute sector to treating them in the community—will be under the direction of the partnerships.

**Rhoda Grant:** The budgets will stay the same, but how will that work in practice? If you see that you could use, let us say, some acute care funding for preventative spending in the community, would not that be blocked by the ring fence?

**Alex Neil:** That is where commissioning and the plans for each partnership are important. The partnerships' plans will have to be partly about the transition, in each area, to providing in the community services that are currently provided through health boards' acute hospital budgets. The question is about how to get to where you want to be from where you are starting; each partnership will have a transition plan. We have already done this during Mr Chisholm's period as minister with responsibility for health, when we transitioned to care in the community. Obviously, the starting point was a map of mental health institutions and other bodies across Scotland; over a period, working to a plan in each area, we transferred those patients into the community, but the services have to be available in the community before the patients are transferred from the acute sector to the community sector.

We are not looking at the situation in terms of silos. The way in which much of it will work is that many consultants who, at the moment, provide services entirely in hospitals, will in the future work in the community. That is already happening in many parts of Scotland, even where there are not formal integration partnerships.

**John Matheson:** The other factor that I would like to highlight is the change fund, which is £70 million in 2014-15 and will increase through the integration fund to £100 million in 2015-16. It is specifically designed to deliver exactly what has been described. There is £50 million over three years for unscheduled care, which will be used for investment in primary care, for preventative and anticipatory care. For 2015-16, there is also a central pot of £20 million for developing hospital-at-home services, telehealth and telecare.

There are a number of specific pots of money, so in a sense I am arguing against myself in trying to describe the totality of the budget, but those funds have been set up to deliver exactly the change that has been described.

**Rhoda Grant:** My concern is that what is really happening out there at the moment is that local government budgets are being cut and home care is being cut, which leaves vulnerable people without the care that they should have. That has knock-on impacts because people become unwell through not eating properly, not being looked after properly, or not taking their medication properly. It could lead to people's conditions becoming health problems rather than social care problems, as their health deteriorates. Some people are being admitted to A and E because they reach a crisis point. My real worry is that that is social care, which is a local government responsibility. If we have only the money that is currently available in local government budgets to fund that part of the integrated system, we will not really get the preventative spend that will prevent people from moving into health services. Unless we use some of the health budget for that preventative spend, I do not think that we will make a real difference.

**Alex Neil:** I will give a practical example of how to approach the issue. I think that I have mentioned to the committee before the pilot project that is being run in Dalmellington in East Ayrshire. That project, which is run jointly between the local authority and the health board, involves 20 older people with comorbidities. Basically, it is run through the local GP service, although obviously all the agencies are involved. The project looks at the total health and social care needs of those 20 people. Through use of telehealth technology, over the first 18 months of the pilot the level of hospitalisation among those 20 people was reduced by 70 per cent. That is a small example of what we need to do in the future.

Rather than think in terms of a certain budget from the local authority and another budget from the health board, once the partnerships have their budgets, they will need to consider where their priorities are in order to achieve the national outcomes that they will be charged with achieving. Their following the approach that has been taken in Dalmellington—I could cite many other pilots—will achieve that.

That approach is much more cost effective because, in effect, it is transferring resources into the community, although it would be difficult to find that out from a budget statement. It costs £4,600 a week to keep someone in an acute hospital, but the telehealth service costs a maximum of £900 a week, so we save a lot of money by keeping people out of hospital, which frees up resources to expand the service once it is rolled out.

**Malcolm Chisholm (Edinburgh Northern and Leith) (Lab):** I will just pick up on some points that have been made before I ask the question that I was going to ask. I am trying to work out what Mr Matheson said about integration. As I understand it, the change fund will come to an end in 2014-15. I can see a small integration fund of £10 million, but is there another line somewhere in the level 4 figures on integration, or is that just the change fund in another form?

**Alex Neil:** I will explain the general point and then let John Matheson explain the detail. In John Swinney's budget statement, he announced £120 million to help with integration. Of that, £100 million is for an integration fund, so there is £20 million left. We announced last week that half of that £20 million will be used to help to roll out the Dalmellington project. On the £100 million, Michael Matheson has been charged, along with officials, with designing that fund and the criteria for it in consultation with all the key stakeholders in order to address the kind of issues that Rhoda Grant mentioned in respect of moving from care in the acute sector to care in the community. That fund will become available in 2015-16.

**Malcolm Chisholm:** We are examining the current budget. Is that somewhere in the current budget line?

**Alex Neil:** No—the £100 million is for 2015-16.

**Malcolm Chisholm:** Yes, but is that information available? Are you giving us additional information now, or is that in the level 4 figures?

**Alex Neil:** No. John Swinney announced the £100 million in his statement.

**John Matheson:** Part of the draft budget is in the draft budget book.

**Malcolm Chisholm:** Is that just the change fund in another form? I presume that the change fund will come to an end before that.

**John Matheson:** The specific focus of the money is to deliver health and social care integration. We are giving £100 million to health boards, and there is £20 million to take forward initiatives at scale nationally.

**Malcolm Chisholm:** Okay—I am sure that we will look further at that.

I mainly want to ask about the linking of indicators and outcomes with financial decisions, but before I do that I want to raise two points that Audit Scotland has raised in a recent report. First, it says that it would be helpful if boards could be given a break-even period of three years rather than one year, because it thinks that having to break even every year causes a lot of problems for boards. Secondly, it highlighted that the fact that some of the ring-fenced money that goes to health boards does not go at the appropriate time creates problems for boards.

You must have seen that Audit Scotland report, so I wonder whether you have any comments on those two points.

**Alex Neil:** I will get John Matheson to give you the details but on the first point, we are in discussions with John Swinney and his team about setting up a similar arrangement to the one for local authorities in respect of end-year flexibility, whereby they are able to not lose the money. If they have not spent all their money, they can build up a reserve. John Matheson told me this morning that a reserve of about £36 million has been built up in Orkney, for example. It is about what the Treasury calls—I think it is the exchange—

**John Matheson:** The budget exchange mechanism.

**Alex Neil:** The budget exchange mechanism. I will ask John to explain how that would work and how getting agreement for the health service to have access to the budget exchange mechanism

would help to address some of the issues that were identified in the Audit Scotland report.

**John Matheson:** On the budget exchange mechanism, we are clear about—and focused on—the need to achieve our financial targets, and our regime is set up around the annual delivery of financial targets. However, we are also extremely clear that we need to do medium and long-term planning as well. That is why the financial plans that come in from boards are normally for three to five years and we sign them off on that basis. For certain boards on which we have a particular focus, the plans are signed off annually because we are looking for reassurance on the delivery of financial balance going forward.

The delivery of a financial break-even every year is not helpful for medium to long-term financial planning, so having some flexibility across the year-end—as you were suggesting, Mr Chisholm—would be very welcome. Local authorities have that ability and the overall Scottish Government—through the budget exchange mechanism—has that flexibility, so we are looking for the health component of the Scottish budget to be given some flexibility as well. It would not be significant in terms of scale, but it would allow the management of the in-year financial targets to be achieved in a way that would not disrupt medium to long-term planning.

On the second point about the allocations to health boards, we have tried to do two things. We have tried to reduce the number of specific ring-fenced allocations, particularly those driven by inputs, and we have tried to move on to more of an outcome and output approach. We have tried to bundle allocations around themes, so rather than giving a specific allocation for alcohol brief interventions, we have given a more generic allocation for primary care initiatives. The totality of that bundle is just over £200 million and it goes out—early in the year—to health boards.

Where we can, we give the allocations out to health boards as early as possible in the financial year and the vast majority of allocations have gone out to boards in the first three or four months of the year. Sometimes we keep some moneys back to deal specifically with issues that happen in-year—for example, there may be a particular focus on the delivery of waiting times and some specific allocations in relation to that. Sometimes some technical accounting allocations are given out towards the end of the year. However, boards will get 96 or 97 per cent of their allocation in the first four or five months of the year.

**Malcolm Chisholm:** I will move on to my main question. The Finance Committee in its budget scrutiny has focused in particular—and has reported to committees—on trying to link up some of the indicators and objectives with the financial allocations.

One of the problems in health is that there seems to be a proliferation of indicators and outcomes—we also have new outcomes coming with the Public Bodies (Joint Working) (Scotland) Bill. It would be interesting to hear your views on that point and on how all the indicators and outcomes relate to each other. However, the more substantive question is, can we have more linking up of those overall outcomes, objectives and indicators with the actual financial allocations? For example, could the budget be linked to the health improvement, efficiency and governance, access and treatment—HEAT—targets? The convener asked whether it could be linked more to prevention and dealing with inequalities, which are two overarching objectives. The Finance Committee is very much asking committees to focus on that this year.

10:45

**Alex Neil:** There is already quite a linkage. The NHS Scotland resource allocation committee formula looks at the degree of remoteness and rurality as a factor in deciding which health boards get funding and what that funding is. The formula also looks at the profile of an area's population in deciding who should get more funding. That is a good example of how the funding formula for the territorial boards very much relates to the challenges that they face in their communities and to the socioeconomic profiles of their communities. The NRAC formula is designed to look at that.

You ask whether we have too many targets and how they relate to the budget. We have applied downward pressure to the number of HEAT targets in recent years and we are down to 16. There is scope to reduce the number further; I would like the targets to be directed even more towards outcomes rather than throughput.

For example, our HEAT target on alcohol concerns the number of consultations. That is a throughput target rather than an outcome target and it is one of the targets that I am keen to look at, to see whether we can get a more appropriate outcome target or whether we should have a target at all. I am totally with you on your first point—there is scope to streamline the number of targets further. It is ironic that, the more targets we have, the less management control we often have over the budget and the wider operation.

As for achieving a clearer link between targets and the budget, each board is charged with achieving its share of the HEAT targets and other national outcomes, but there are also performance targets, such as those on managing a board's estate and prompt payment to companies, which

is part of a Government target. All that relates to the budget, but it does so collectively; it is not the case that each target has a budget line, which would be impossible to manage.

**Malcolm Chisholm:** I will raise one more point in case I do not get in again. I want to ask about two budget lines, one of which has been highlighted before. We certainly want to know the reason for the big drop in the clean hospitals line. The reduction in the research line is smaller; I have been told about a downgrading of primary care research, which seems a bit inconsistent with what you said about the increasing importance of primary care.

**Alex Neil:** I will deal first with the reduction in the line for addressing hospital infections and so on from £28 million to roughly £18 million. That is not a reduction in expenditure; it is because much of the work that we previously had to pump prime is now part of the mainstream work of hospitals.

As the committee is aware, the level of healthcare-acquired infections has reduced substantially in recent years—so much so that Professor Don Berwick has said that, through the patient safety programme, the Scottish health service is probably the safest in the world. What has happened is not a reduction of £10 million; we simply no longer need the £10 million for pump priming, because it is part of the day-to-day business of every health board to deliver on such issues.

I will make a number of points on research. We are using our research budget in different ways. Not all the research that we are doing is contained in that budget. For example, as part of the Glasgow Southern general hospital project, a new learning and education centre will be established, which will do research and development. That is in the Glasgow budget as opposed to being itemised in the research and development budget.

Secondly, we have adopted a proactive strategy of using our own research and development resources to leverage in additional R and D resources from elsewhere. For example, John Matheson has been successful in negotiations with the European Union, using our R and D spend to leverage in additional spend from the European Union.

Thirdly, some of the funding also appears in the capital programme. For example, yesterday we officially launched the digital health institute, which is all about research and development, but the capital costs for that are in the capital budget, as opposed to being double-counted in the R and D budget. So, if you add up everything that we are doing in research and development, you will see that we are doing much more than that particular line suggests.

**Nanette Milne (North East Scotland) (Con):** I confess that my brain functions more medically than financially, so I find it quite difficult to reconcile the interesting things that you have been telling us this morning about forward planning with the budget lines in an annual budget. However, I am interested in forward planning and particularly in workforce planning, because I have serious concerns about that. I know that you have mentioned the increasing number of consultants in A and E, and you have also spoken about a different way of looking at orthopaedics. In Grampian, seven-day operation with pharmacy work at the weekends certainly works in one orthopaedic unit, where patients are routinely discharged on Saturday or Sunday, with help from the pharmacy, following procedures such as hip replacements. I have been there and had that experience myself, so I know that it happens routinely.

Nonetheless, Audit Scotland says that there has been a 21 per cent increase in consultant vacancies between 2012 and 2013. I presume that that is across the board. I am not sure about A and E, but I know that there have been difficulties in orthopaedics in Grampian, and that there are also difficulties in recruiting consultant staff in paediatrics, rheumatology, ophthalmology, psychiatry and psychology, so I worry about what will happen in future. What assessment has been made, not just in Grampian but across the board, of the need for medical staff over the coming decade or so? When you are looking at different ways of working and at the professional mix, how much consideration is taken of those issues, and how does that tie in with current budgets?

**Alex Neil:** First, let me say that the professional mix is as important as the raw numbers. When we are doing our workforce planning, we look at the professional mix that is required as much as the overall numbers, because both are important. There is no point in having a surplus of consultants in A and E when some of that resource should be in orthopaedics, in ophthalmology or wherever. The mix is as important as the raw numbers; that is point number 1.

Secondly, with regard to the vacancies issue reported by Audit Scotland, when you are increasing the overall number of consultants, and particularly when you are increasing it dramatically, as we have seen with the 50 per cent increase in A and E consultants over a very short space of time, there will inevitably be a period when you then have a rise in the number of vacancies. The rise in the number of vacancies is to some extent a factor of the rise in the number of jobs, so it is good news rather than bad news.

That said, there are some key areas such as paediatrics in which there is an overall shortage in the availability of consultants, not just in Scotland but throughout the UK and further afield. At St John's in Livingston, we have spent an additional £100,000 on advertising four paediatric consultant appointments, which are now being filled, two of them by people from Myanmar, which is very welcome and I am glad that we were able to recruit them to fill those vacancies. However, I would not like to give the impression that many such vacancies are easy to fill. In areas where there is a shortage—sometimes a worldwide shortage—of particular skills, we have to spend a lot of additional money, as we did in the case of St John's, to recruit consultants.

Thirdly, on workforce planning, we have already published our workforce 2020 plan. That is a very detailed plan, and it relates to both the numbers of people we need and the mix. You are aware of the increase in the overall number of staff, particularly qualified nursing staff, over the past year, which is a welcome development.

In addition—and some of this is being done with our colleagues south of the border—we are involved with Sir David Carter in his role as chair of the academic board, and we are involved with the Scottish funding council, together with my colleague Michael Russell, in considering education and lifelong learning and the future supply of medical trainees. We have halted the reduction in the number of trainees this year, and we are considering whether we need to increase further the number of trainees next year and beyond. Sir David Carter and others are actively working on those issues.

We consider the pipeline, involving people going to medical school, those who drop out from medical school, people reaching the point of qualification and, following qualification, the number who specialise in different areas—the number who want to be GPs, A and E consultants and so on. At every stage, we have a very detailed understanding and knowledge both of the current situation and of what is likely to happen in future, and we can identify where we are likely to have future shortages. Where we see that, we can take appropriate action. If the shortage is a long-term one, we can work with Sir David Carter and his team to increase the number of trainees, for example. For more short-term situations, we can increase the spend on advertising to fill the vacancies concerned. I personally get a report every month on all vacancies that have been vacant for more than three months, no matter for what position. My team follows up the matter to find out why any vacancy has been vacant for more than three months. If necessary, we then offer our support to the relevant board to try to fill any vacancy that has been vacant for more than three months.

**Nanette Milne:** I realise that that takes a long time, and that the pipeline is quite long between planning and getting the trained staff in. I have been around long enough to see it happen: too many doctors, then too few, and so on. Given the sort of planning that you say is going on, should we not, in future, be considering what has happened? I am not sure what the current situation is but, until very recently, there were trained nurses who were unable to get jobs, and there were trained allied health professionals such as physiotherapists and occupational therapists who were unable to get jobs simply because the funding was not there to provide the jobs for them. Is that being taken into account in forward planning? Can we look forward to that not being an issue?

**Alex Neil:** We obviously have to plan according to the needs of the service, rather than dealing with any particular surplus or whatever. Basically, there is no strategic shortage of nursing jobs. As you know, the number of jobs and positions in nursing has increased significantly in the past 12 months or so.

**The Convener:** I, too, am interested in this point about current needs versus future needs and the overall strategy of getting people out of hospitals. Meanwhile, we have a 2020 vision that involves stuffing the hospitals with more doctors and nurses. That seems to be a contradiction, although I am sure that there is a reason for that.

The committee saw from recent figures that there was an expected downturn. That was planned for in respect of the reduction in the number of nurses. However, we saw figures in other columns showing an anticipated rise in the number of health professionals more widely. That was perfectly logical to me.

This goes to the heart of Nanette Milne's problem. A couple of years ago, we were planning to reduce the number of nurses, beds in hospitals and so on. Now, within 18 months, there is a recruitment drive to get the number of nurses and doctors up. That is no way to run a railway, is it?

11:00

**Alex Neil:** Let me say that whether in relation to their forecast of nursing requirements or their forecast of the number of beds required—some forecasts were for one but not the other and some related to both, but in any case across the piece—some boards were overoptimistic about the number of nurses that they would need.

Let me take the example of NHS Lanarkshire. In my view, the overall reduction in the number of

nurses for which the board planned was overoptimistic if it was to meet the demands on the NHS in Lanarkshire. The board has recognised that and, for the last nine months, has been recruiting nurses to ensure that it gets up to the level of staffing that it needs.

Forecasting is very difficult. Consider the situation in Edinburgh. The main strategic issue there is that the forecast that Malcolm Chisholm and his predecessors and successors had for the population of Edinburgh when they were planning the new Edinburgh royal infirmary turned out to be wrong by 20 per cent. It was too optimistic and the population of Edinburgh is 20 per cent higher than was forecast when the ERI was being planned.

As Denis Healey, I think, famously said, we might as well talk to the Boston strangler as rely on economic forecasts to inform policy. In the health service, forecasting is not an exact science; situations change.

When we came into the Parliament, the big issue was depopulation in Scotland. The registrar general forecast then that, by 2030, the population of Scotland would reduce to less than 5 million. Today, the population of Scotland is at a record level and rising. The registrar general's forecast was nonsense. At the time, he could not tell that it was nonsense. Life changes.

Forecasting is not an exact science in the health service any more than it is anywhere else.

**The Convener:** No, but I would like to think, cabinet secretary, that you could give the committee more confidence in your overall radical strategy to shift the delivery of health services from the hospital setting into the community, as well as in the budget, the ambition and the workforce planning that will describe a new workforce. If the radical new shift out of the hospital and into the home, where everybody wants to be, is going to happen in three years, what workforce will deliver it?

**Alex Neil:** In direct response to that question, convener, I pick up on your comment that you found it difficult to reconcile our saying that we would reduce the level of hospitalisation and, at the same time, plan for an increase in the number of hospital consultants.

Even though more healthcare will be delivered in the community, a lot more of it will be delivered by hospital consultants, who currently do not work in the community to a great extent. For example, in the south-west of Glasgow, there has been a major initiative to treat far more patients with chronic obstructive pulmonary disease in the community than was the case previously. That initiative has been successful and part of that was due to consultants coming out to work part of the time in the community, which, previous to the pilot, had not happened.

Thinking in silos is mistaken. We need the consultants in relevant cases to work in the community along with the GPs. It is not a case of confining consultants to the hospital.

One of the reasons why the integration in West Lothian has been so successful, particularly in recent times, is that there is much more involvement of the hospital consultants in the provision and delivery of services in the community. That is extremely important.

That is why that apparent contradiction is not a contradiction but part and parcel of our plans.

**The Convener:** Are you talking about consultants doing house calls?

**Alex Neil:** Well, working in the community, yes. In West Lothian, they go to people's houses and do some consultancy work there.

**Dennis Robertson:** Good morning, cabinet secretary. Do you envisage flexibility in acute services across the board, so that staff, including consultants and nurses, can go into the community on what would be like a secondment? If so, are the logistics in the community facilities in place to allow that to happen? If the capacity in hospitals is returned, the staff would obviously go back to them.

**Alex Neil:** I have just come from a major telehealth conference. I have mentioned the Dalmellington project. Consultants are working more and more with patients in the community and are using, for example, new technologies such as telehealth. Let me give you an example. I visited the mental health services in Inverness a few months ago. They have started to transform how they deliver consultant mental health services in the community. While there, I saw and sat in on a consultation of a dementia patient in a nursing home 50 miles from Inverness. Before the telehealth technology was in use, in order to get a consultation with a consultant, those dementia patients were being forced to travel a 100-mile round-trip. That is absolutely the last thing that such a patient should be forced to do. Even in the face of the then scepticism of the consultant, we were able to persuade her to introduce the telehealth service. She is now the biggest proponent of the technology because, from her Inverness base, she is able to consult much more regularly with the dementia patients and their carers in a nursing home 50 miles away. That is an example of consultants working in the community in a way that was never possible before. It may be that, from time to time, they will make house calls in person—

**The Convener:** I am sure that they will be pleased to hear that.

**Alex Neil:** However, they are much more likely to carry out such a consultation using telehealth. That is a very good example of a consultancy service being provided directly in the community rather than the patient being forced to visit a hospital.

**Dennis Robertson:** You have talked about consultants but what about staff across the board? What about nurses? If you are saying that there might be overcapacity in parts of the acute sector and in hospitals, will there be secondments into the community, such as to family nurse partnerships or as health visitors? Would the reverse happen if those staff were needed back in the acute service? Will there be flexible working across the board?

**Alex Neil:** I will bring in John Matheson to respond in a minute. Before doing so, I make it clear that I am not saying that there is overcapacity in the hospitals. I am saying that, in the future, we must all work in a different way and we will have to use, for example—

**Dennis Robertson:** You are talking about early discharge and getting more people out of hospital, so perhaps there should be less bed capacity in the future because more people will be treated in the community, in which case nursing care and other care facilities will need to be provided there.

**Alex Neil:** Yes. However, the problem with the capacity issue is that, although patients are getting turned around a lot quicker in hospital, the cases that staff see are different and the complexity is much greater compared with cases 10 or 20 years ago. The Royal College of Nursing talks about pressures in certain areas. When it is asked what is causing those pressures, it refers to the complexity of patients' conditions. I do not wish to give the impression that there is a lot of spare capacity in the acute sector; rather, I am saying that, to face up to the challenges of an ageing and increasing population and reducing inequalities and finances, we need to work differently. That includes hospital consultants, too. Many of them are already working differently and doing so successfully.

I ask John Matheson to come in and make any supplementary points.

**The Convener:** When doing so, I ask Mr Matheson to tell us about the scope of the information technology and telehealth budgets and whether there has been significant investment in them, or whether they have gone down or even stayed the same.

**John Matheson:** I am delighted to start by responding on that issue. The cabinet secretary mentioned the European telemedicine conference that is taking place in Edinburgh over the next couple of days. We have 400 delegates who have come not only from Europe but from the United States, Korea, Hong Kong and around the world to learn about what we are doing in Scotland and to share their experiences. Some of our work has a high profile at European level.

At the reference site awards at the beginning of July, Scotland got two three-star awards—we were one of only three regions in Europe that did so. One of them was for the Scottish patients at risk of readmission and admission programme, which is operated through the long-term conditions collaborative. It looks at how we use technology to identify patients who might be at risk of readmission and seeks to prevent that from happening through some upstream work.

You asked specifically about investment. We have been successful in gaining a significant amount of European money to support some of our investment. It is not just a case of us putting in money through the budget; support is provided through European initiatives. We are actively involved in looking at how we can increase the healthy life expectancy of the Scottish population by two years over the next four or five years, in line with the European initiative on that.

I have a couple of further points to make. I make it absolutely clear that our 2020 vision for the workforce is driven by our overall quality strategy; it is driven by our route map. That is what drives us.

On technology, we want to use mobile technology to enable our community staff to work more effectively and more productively. I have spoken to the committee before about the use of digipens in the Western Isles, and smartphones and iPads are other specific examples of the technology that is being used.

Earlier, I spoke about the risk of focusing on the margin and not the totality of the budget. We can have a detailed and constructive conversation about vacancies and whether they are rising or falling, but we also need to look at the totality of our workforce and how we can use in a more productive way some of the untapped skill mix potential that we have. I mentioned the MSK project in Ayrshire and Arran, in which physiotherapists are playing a more proactive role. In some parts of Scotland, we have consultant podiatrists—chiropodists—who are now doing minor orthopaedic work, such as bunion removal. That is allowing orthopaedic consultants to use their expertise at the more intensive end. Orthopaedic consultants support that initiative.

How we use our existing workforce and the skill set that it has is another challenge that we are

making progress in addressing, but the telehealth and telemedicine agenda is one in which Scotland has a high profile in Europe. The digital health institute that the cabinet secretary mentioned is being developed in partnership with major worldwide players such as Samsung and Philips.

**Alex Neil:** I hope that the convener noticed that we are to extend his lifespan by another two years over the next three or four years.

**The Convener:** I am very appreciative of that.

Is the budget line for IT and telehealth up or down?

**John Matheson:** The budget line for e-health is flat, but the European investment will mean that, overall, investment in it will increase.

**The Convener:** By how much?

**John Matheson:** I do not have the precise figures, but I can get them for you.

**The Convener:** Rhoda Grant has a question on future planning.

**Rhoda Grant:** In their evidence to us, the RCN and Unison mentioned the cut to training for nursing, midwifery and allied health professionals. They made the point that if we are to make a shift and get people to work differently, we need to train them to make efficient use of e-health and to work in the community as well as in the acute sector. The RCN and Unison said that that cut in budget did not marry with the change that they will have to make and the training that they will have to undergo to make it.

**Alex Neil:** We saw that evidence. Quite frankly, we do not see how they have arrived at the suggestion that there is a cut in the training budget for nurses.

**Rhoda Grant:** I have that in front of me. It is in table 3.03, which has the heading "More Detailed Spending Plans (Level 3)". Under "Education and Training", the figure for the workforce goes from £31.1 million to £30 million to £33 million over the three years, whereas the figure for nursing, midwifery and AHPs goes from £148.9 million to £137.8 million to £135.8 million.

**Alex Neil:** That is just a small part of the overall training budget. If the amount that we spend on continuing professional development and a range of other things is taken into account, we think that we are probably spending more on the training of nurses, but I will ask John Matheson to comment on that table.

**John Matheson:** The specific reason for that reduction is that there was a non-recurring increase to cover the support that we were giving centrally for the employment of interns on a one-year job guarantee. From May, that responsibility has been picked up by the individual health boards.

**Alex Neil:** I should also emphasise that overall we are not spending less on the training of nurses and midwives. We think that the organisations that you mentioned have misread the budget.

**Rhoda Grant:** It would be helpful to get a breakdown of those costs and the reasons for them.

**Alex Neil:** No problem.

**The Convener:** In light of the previous evidence, we would appreciate some clarity on that issue.

11:15

**Bob Doris (Glasgow) (SNP):** Good morning. It has been a wee while since we discussed the Boston strangler but, unfortunately, I am going to return to him.

Although we have discussed workforce planning and although Ms Grant has mentioned workforce training, neither committee members nor you have referred to the workforce management or indeed bed management tools that are being developed. The cabinet secretary said that NHS Lanarkshire had been overly optimistic about how much it could downsize nursing numbers in an acute setting and has now had to revise its figures. Before I go on to my more substantive questions, can you give us some more information about the workforce and workload management tool and how it might be shared across health boards to ensure that, although this is not an exact science, we move as far away as possible from the Boston strangler?

**Alex Neil:** It is not just a case of sharing; from 1 April, it has been compulsory for every health board to use the workforce management tool—and we will also make compulsory the bed capacity planning tool, which is currently in development and which we hope to implement in the next 18 months or so. The tool itself is generally regarded as very robust—obviously, we piloted it before we made it compulsory for every health board—and covers the mix of skills and the overall numbers in each of the relevant professions. Already we are seeing some changes; I cited Lanarkshire as a very good example but there are many other boards where the tool is informing human resources strategies with regard to recruitment, training and skills mix.

**Bob Doris:** Were unions and workers representatives involved in the tool's development?

**Alex Neil:** Absolutely. Indeed, it is all part and parcel of the wider workforce 2020 strategy, in the

development of which we consulted 10,000 individual health service employees.

**Bob Doris:** Thank you. That was helpful.

We are scrutinising the budget this morning. In the coming financial year, NHS boards will receive a cash increase of around £270 million, which represents an increase of almost 3 per cent in their budget—and a real-terms increase at that. Of course, there are always demands on the NHS and you could always spend more money if it were available. During our budget scrutiny, we have asked witnesses not only where they would spend more money but, more important, what other areas of the health and sport budget they would take it from. After all, that is the task before us. I have to say that I cannot recall anyone volunteering where money should be taken from, but have you received any representations about how the health budget should be reprofiled?

**Alex Neil:** I get loads of representations about where more money can be spent but in my first 14 months in this job I have received no representations about what areas should be cut.

**Bob Doris:** I thought it important to put that on the record.

One theme that has come up time and time again relates to service redesign and preventative spend and where they are contained in the budget. In that respect, I want to focus on the change fund for older people, which I understand amounts to a substantial cash sum of around £300 million over three years. I am really keen to find out not only how that money promotes service redesign and restructuring or preventative spend but how it is then embedded in the mainstream budget. For example, you said that the budget line for HAIs had gone down because some of the work covered by it had been put into the mainstream budget and there was no need to have an individual budget line for it. In tracking the budget this year and next, when will we be able to identify the areas where change fund moneys have promoted service redesign? I know that you have given some examples, but where can we see that such redesign is now being funded through territorial health board core budgets? How can we track in the budget spend that transition from annual funding to promote change to core budgets for service redesign?

**Alex Neil:** The change funds are still in operation but when they end in 18 months or so we will undertake a very detailed evaluation of the funds, including where a programme has been mainstreamed in particular board areas and whether it has been rolled out across the country. All of that will be done as a one-off exercise rather than in bits and pieces; after all, loads of different projects are going on as a result of funding from the change funds, and we will want to look at all of them and then at the funds' total impact and the difference that has been made. Some projects might not be mainstreamed if they are not as successful as expected. I know that individual change fund projects have been evaluated, but we will be carrying out an evaluation of all the projects and publishing a plan for what has transitioned from change fund financing to mainstream funding either in individual boards or across the board. Moreover, the £100 million integration fund that we discussed with Malcolm Chisholm can also be used to mainstream and roll out successful change fund projects.

I should also point out that prevention runs right through the budget. We cannot just have a budget line called "Prevention", put everything that relates to prevention into it and then double-count all those things elsewhere. I can give you a very good example of that. The budget contains a substantial planned increase in the money that we are going to spend on immunisation; although the funding is primarily for childhood flu immunisation, it also covers the introduction and expansion of the shingles vaccination programme. I would argue that every penny of that programme is about prevention; after all, that is what immunisation is about. Although the programme is not labelled in the budget as "Prevention"—it is labelled as "Immunisations"—it is nevertheless about prevention. It all comes back to the general question of how we relate the budget to the overall strategy and narrative.

**Bob Doris:** I will probably return to that issue in a moment when I ask about health inequalities, because I think that there is a connection in that respect.

Sticking with the change fund, however, I cannot remember whether the change fund for older people amounted to £70 million or £80 million in the previous financial year but it was certainly a significant amount of cash. In the current budget, health boards are getting £9.4 billion. When we get the health boards in front of us, would it be reasonable to ask them, "Last year, you got your share of £80 million from the change fund. How much of that have you put into this year's mainstream core budget?"

**Alex Neil:** Absolutely. It would be reasonable to ask them what they are planning to do. Some boards might have already mainstreamed certain projects, but they might also be planning to mainstream them next year instead. It will all depend on what stage the project in question is at, whether it has been properly evaluated and whether the board has decided to mainstream it. However, the question is perfectly legitimate.

**Bob Doris:** But do you understand our frustration in trying to follow the public pound

through the health service to ensure that we are getting the best value for money and that the money is being spent appropriately?

**Alex Neil:** As that happens to me day and daily, I fully understand your frustration.

**Bob Doris:** I await with interest the health boards' comments when they come before us.

I see that the health improvement and health inequalities budget is marginally down in the coming financial year, although it is planned to increase again in 2015-16. Does that budget line accurately reflect the Scottish Government's health inequalities agenda? In that respect, I was interested in your reference to the immunisation programme. Are certain conditions, diseases and afflictions more likely to befall certain parts of our communities than others and, as a result, do certain immunisation programmes help to address such health inequalities? In other words, could the budget more clearly quantify what the Scottish Government is actually doing on health inequalities? The raw data in front of us make it look as if the Government has given less of a priority to that issue than it did in the previous financial year.

**Alex Neil:** I think that that is another example of a line item that is in essence about pump priming individual initiatives.

Earlier, I referred to the formula for allocating budgets between territorial boards—the NRAC formula—which takes into account the profile of the area, including things such as rurality and remoteness as well as the socioeconomic profile. The way in which we allocate the funds between territorial boards is probably the single biggest contributing factor in the health service to trying to reduce inequality.

Also, many of our policies are designed to reduce inequality but are not actually big budgetary items. For example, the tobacco strategy is about reducing inequality, because there is no doubt that the damage that tobacco is doing among the poorer sections of the population is disproportionately greater than the damage that it is doing among the richer sections of the population, for the simple reason that there is a clear correlation between levels of income and the amount that people smoke.

The same is true with drink, or alcohol. Our alcohol strategy is also about reducing inequality because, again, there is clear evidence that the incidence of drinking cheap drinks such as cheap wine, cider, vodka and gin, which do the most damage to health—as opposed to a deluxe whisky taken occasionally—is much greater among poorer people and communities. That is the fact of life, and the evidence is there. The alcohol and tobacco strategies are not big spending items in comparison with many of the things that we have heard about, but they are both absolutely critical.

This afternoon, I am off to Estonia at the invitation of the Estonian Government to speak about minimum unit pricing. Members probably noticed that, last week, the Irish Government announced that it is going to follow our example on minimum unit pricing. The introduction of minimum unit pricing would be the single biggest contributor to reducing inequality and damage to health among poor people living in deprived areas.

**Bob Doris:** I agree with those comments. It is worth noting that there was a glimmer of hope in the convener's eyes when you mentioned deluxe malt whisky.

My final question on health inequalities is about funding for GPs. You said that deprivation and health inequalities are taken into account in the core funding for health boards. What direction is there from the Scottish Government when health boards then decide how to prioritise the deployment of GPs—I know that they are private contractors—across their areas? As you know, in a 10-minute consultation with a GP in, say, Bearsden, there might be time to spend on health promotion measures, because fewer morbidities are presented to the GP, but, in areas such as Springburn, there is less time to do that. Across Scotland, when the money is given to the health board, how much say does the Scottish Government have in directing it towards the areas that are most in need?

**Alex Neil:** I will give a two-pronged reply to that. First, we agree and issue a local delivery plan for each health board, including the special health boards. There has to be a delivery plan in each health board. We do not just give them the budget and say, "Get on with it." We give them the budget and say, "This is what you have to deliver." So whether it is investing more in primary care, solving problems of GP shortages or whatever, the local delivery plan for each health board will reflect what we want the health board to do, particularly in the year ahead, although obviously we take a five-year horizon in our discussions with health boards. That is the main way in which, overall, we influence decisions by health boards.

11:30

Secondly, at national level, we are doing some exciting policy work on what a futuristic GP and primary care service would look like. We have undertaken a number of successful pilot projects.

Let me give the example of a GP surgery in Buckhaven, which has adopted what is called the Alaska model. As the name suggests, the model was developed in Alaska, which has a very small population but covers a huge area. It was found

that something like 70 per cent of visits to GPs in Alaska were unnecessary, in that the patient did not need to see the GP and would have been better off seeing another professional, such as a podiatrist, a psychiatrist or a nurse practitioner. Only 30 per cent of the people going into general practices in Alaska actually needed to see the GP.

The services in Alaska have been redesigned so that the 30 per cent who need to do so see the GP—patients with a suspected cancer, for instance. Instead of those patients having just a few minutes with the GP, the GP spends much longer with each patient, getting much closer to the root of the problem. GPs take much more time to ensure that a proper care pathway is in place. In the meantime, the remaining 70 per cent are also much happier with the care that they get, as they go directly to the professional they need to see, whether that is a podiatrist or whatever. The system in Alaska appears to be working very well.

I talked to the GP at the practice in Buckhaven about two weeks ago, just before the recess. He said that, although he did not think that the 70:30 ratio applied in Scotland—he thought that it was more like 60:40 here—he believed that the Alaska model offered one way dramatically to improve primary care services.

That is an example of the initiatives that we need to consider for the future in order not only to manage the demand and the pressures better but, most important, to ensure that the patient gets the service that they actually need as quickly and directly as possible, rather than the service that they think they need or the service that they say they want when they phone up for a GP appointment.

Furthermore, we need to be talking—and we are talking—to the British Medical Association about the future of the GP contract. With regard to the future design of GP services, there is now such an increasing divergence between what is happening north of the border and what is happening south of the border that the GP contract that is being negotiated for the English health service is increasingly not fit for purpose for the health service in Scotland. That is the conversation that we need to have about the future.

**The Convener:** On GP contracts, what timelines are we working to?

**Alex Neil:** The terms are changed by negotiation every year. At the moment, it is a UK negotiation. Last year, however, we made a number of significant changes in Scotland. In particular, we reduced the bureaucracy that is imposed on GPs to free them up to do the other things that they need to do. I would like to go much further in reducing the bureaucracy that we impose on GPs, and to free them up to do the job that they are there to do.

**The Convener:** That has been discussed in evidence. GPs are essential to the transformation of the delivery of care in communities. How much is in the budget to incentivise that? Usually, to put it politely, change comes only after GP incentivisation.

**Alex Neil:** Obviously, the budget covers primary care services, but incentives, or removing disincentives, are dealt with through what is called the QOF—the quality and outcomes framework—which is essentially the core of the GP contract.

**The Convener:** Will you be able to do that? Surely it will cost you more to develop that new way of working.

**Alex Neil:** We have to agree the way forward, and there is a strategic discussion to be had.

**The Convener:** Yes, but you are going into the negotiation without having thought about what you want, what you are going to have to pay for or how much it is going to cost.

**Alex Neil:** The transformation cannot be done in 12 months. It is a longer-term discussion about the strategy going forward.

**The Convener:** So you do not see any progress on that for 12 months. We would have to pay up after that.

**Alex Neil:** No, no—I am sure that we will make progress. As I said, we have been running a range of pilot projects with GP practices across the country. We are also doing innovative work, particularly with the 100 deep-end GP practices, which is useful.

**The Convener:** I was just trying to get a feel for the negotiation. I suppose that we will read about it.

On the change agenda, which has attracted significant moneys, did I pick you up as saying that there will be no evaluation of the approach for a couple of years?

**Alex Neil:** There has been evaluation of individual projects, but we need to conduct a proper evaluation of the change funds as a whole, to consider their total impact. We need to look at what is and is not mainstream, what has and has not worked and what lessons we can learn from the whole change fund programme.

**The Convener:** Given that a substantial amount of money has been transferred, that finance is tight and precious and that there are performance indicators, are we taking a chance that we might spend money for another couple of years—as well as the money that we have already spent—only to

find out in a subsequent review that we did not spend it wisely?

**Alex Neil:** No. We monitor projects as they go forward, and the health boards monitor projects, too. I am talking about an overall evaluation of all programmes in the health service. When something that has a definitive lifespan comes to an end, there is always a comprehensive evaluation of the entire programme. There are individual projects, whose budgets range from the very small to the quite significant. Such projects will be individually evaluated, and that work will feed into the programme-wide evaluation.

**The Convener:** Have you or boards stopped projects as a result of evaluations?

**Alex Neil:** Some individual projects have been evaluated. I think that we can probably send you details of them.

**The Convener:** My final question is a constituency one. You mentioned the NRAC funding model. I represent an area with a declining population, but there is deprivation in the community and there are significant numbers of elderly people—above the Scottish average. I would not agree that the distribution is fair and based on need, given that population is the dominant factor in the allocation of funding. Do you intend to go further to acknowledge such issues and improve the system to take account of inequalities?

**Alex Neil:** The system is designed to do that. The NRAC formula that we apply allocates funds between health boards. The health boards must then consider how much they spend in different areas—in Glasgow, Paisley, Inverclyde and so on in your case. I refer you back to your health board.

**The Convener:** I am sure that it is not claiming credit for coming up with a needs-based funding model.

**Mark McDonald (Aberdeen Donside) (SNP):** I want to raise a couple of issues that have come up in evidence, and I will also mention a couple of personal hobby-horses. First, on early intervention and diagnosis, I know that there have been great improvements in relation to cancer, but early diagnosis is still patchy for some conditions, including dementia and autism—that is a personal issue for me—which might not be life threatening but which generate additional support needs and have impacts on other budget areas as well as on individuals' lives. What efforts are being made to drive earlier diagnosis and greater awareness of such conditions among GPs?

**Alex Neil:** Dementia and autism are good examples of areas in which we have made significant improvements in recent years. I think that I am right in saying that we are identifying dementia more speedily than it is being identified anywhere else in the United Kingdom; we identify a far higher proportion of older people as having dementia earlier than happens anywhere else in the UK. That is the result of a number of initiatives that we have taken. For example, when people of a certain age are admitted to hospital, they can be examined for dementia—if there is a prima facie case for doing so, of course. We are identifying far more dementia patients among people who come into hospital than we did previously.

Similarly, detection of autism is at a record level. The main challenge in autism is still to catch up on the backlog of previous years and to identify people who are now in adulthood who suffer from autism but who were not diagnosed while they were at school. That is the biggest challenge to further improvement in the level of diagnosis of autism.

However, I totally agree with the general point that Mark McDonald made: early diagnosis is absolutely crucial, and throughout everything that we are doing we are trying to improve rates of early diagnosis, because a child with autism clearly needs a level of support that a child without autism does not need.

**Mark McDonald:** When we took evidence from organisations and professional bodies recently, I raised a point about spend to save. We often receive evidence—as individual members—from organisations or representative bodies to the effect that £1 spent on something will save £X in the future. I have asked about modelling work that is being done, where it can be evidenced, and where health boards are aligning their budgets to take cognisance of that. The feedback has been that evidence is patchy, at best, at health board level. Is work being done at national level, or is encouragement being given to health boards to look at the added value of the pounds that they are spending, to ensure that money is being spent in a way that will reduce budget pressures in the future?

**Alex Neil:** We do that where we can. I mentioned the immunisation programme; you can see from the budget that we are substantially increasing investment in immunisation, particularly in relation to children's flu vaccinations and the shingles vaccination. That is a good example of spending to save, because it is far cheaper—as well as being the right thing to do from a health policy point of view—to immunise the population against flu than it is for them to take flu and, in some cases, to have to be hospitalised. Flu, as we know, can also be fatal. Similarly, with shingles—which is a debilitating illness—it is far better for the individual and for health outcomes that we spend to save by immunising people against it, as we are now doing, than it is to have them take shingles,

because once you have taken shingles it is difficult to shake it off, and it can cost the individual and the health service a lot of money to treat it.

Those are two good examples, but the overall approach, and part of the effort to make efficiency savings, must involve looking at where we should spend money to save money. John Matheson may wish to say more about how that approach is also built into the local delivery plans and how we encourage the boards to do that. He can give other examples, besides the ones that I have mentioned, to show how we have been spending to save, and doing so successfully.

**John Matheson:** I can give a couple of specific examples. The alcohol brief interventions money is an example of investment to reduce the incidence and recurrence of alcohol problems and thereby to save money in the long term. The HAI investment programme is another example of spend to save; we have invested in some basic infrastructure and procedures in hospitals to reduce levels of infection. Clostridium difficile has come down by more than 80 per cent across Scotland in the immediate past.

We have also made a small investment in mobile technology; we put out £1 million across NHS Scotland to take forward initiatives and pilots in a range of technologies. We deliberately were not prescriptive about solutions having to be adopted across Scotland—digipens, for example—but have instead allowed a bit of initiative to be shown in decisions about what suits staff at local level. We are trying to do that with staff rather than take a central dictatorial approach. I could give numerous other examples; those are just some that spring to mind.

**Mark McDonald:** I made the point, as the RCN did at the previous evidence session, that it is not always the person who spends the money who gets the benefit in terms of savings. It may be that money that is spent in other budgets could have a positive impact on the health service, because it would reduce admissions and the occurrence of ill health. What discussions are taking place on that?

I suppose that that ties into the health inequalities agenda, because we know that often, from the health service perspective, that means dealing with people for whom health inequalities have already manifested themselves, but other budget areas need to be looked at. What work are you doing with your colleagues on how they can tailor budgets to impact on, for example, the health inequalities agenda and derive benefit to the health service through reduced admissions, for example?

11:45

**Alex Neil:** Those discussions take place at Cabinet and ministerial level in the overall budget considerations. Also—as you know—we are being led by John Swinney on behalf of the Government in reforming the community planning partnerships. John Swinney made some announcements on that in his budget statement. If, through the community planning partnerships, we can get local authorities, health boards, housing associations and the whole gamut of organisations to talk to each other before they decide their budgets annually, consider where they can maximise the impact of their budgets and allow each to comment on the others' proposals, we believe that that would be a much more joined-up approach to tackling inequality and a range of other issues.

One area that we think is important, and not just in terms of the budget, is data sharing. An initiative on that is being led and developed from the health service point of view by Sir Harry Burns, the chief medical officer. Already, effective arrangements are in place in the Forth valley, Fife, Edinburgh and many other parts of Scotland where there is a multi-agency approach to sharing data. Very often, it is identified that families are involved with the police and a range of other services, including education and health. That is another way in which we are trying, at operational level, to get far more co-operation and sharing of data among agencies so that, together, they can intervene much more effectively.

Within the health service, we are doing that with social care. For example, in parts of Edinburgh, teams meet every week to go through the individuals and families who require multi-agency support within the health service and from the health service and other agencies. That is an effective way of maximising the impact of interventions by all the agencies and leads to a much wiser and more effective use of the money.

**Mark McDonald:** The point has been made that we have to have oversight of the health budget, but we must also take cognisance of the fact that budget decisions that are taken elsewhere in the Government will impact on the health budget in the future.

Another issue that comes up all the time is to do with maintenance of the health service estate. In the previous budget process, we discussed what is perceived as a maintenance backlog. You said that some of that backlog is being addressed—for example, through delivery of new facilities to replace facilities that have a large maintenance backlog. Where are we with the maintenance backlog?

**Alex Neil:** I will get John Matheson to supplement my answer. Generally, we have a

robust estates management strategy, which we will update shortly, as we do regularly. We have been asking boards to allocate resources specifically to the high risk and significant risk backlog of maintenance and repair. We believe that, by 2017, we will have completely wiped the slate clean on the high risk and significant risk backlog.

Much of what is left—not all of it, but a fair chunk—relates to surplus buildings and land. One reason why the gross figures look so high is that many properties that are to be sold off because they are surplus to requirements have not been sold because of the property market crash in the past five years. NHS Lanarkshire has the Law hospital and Hartwood hospital sites, both of which have been difficult to move because of the state of the property market. The overall gross figure is therefore inflated because of slowness in disposing of surplus property, particularly in tougher areas. It is much easier in some markets—Edinburgh, St Andrews or Aberdeen, for example—to dispose of surplus property than it is in others. However, I think that I am right that we will, by 2017, have cleared the high risk and significant risk backlog. Is that right?

**John Matheson:** The high risk and significant risk backlog will be cleared by 2017. That will be achieved through three measures. One is supplementary movement from resource to capital to increase the capital budget by £320 million over the current spending review period, and continuing into the next period. As a result of that, the formula allocation that the boards will receive to deal with currently identified needs at the high risk and significant risk end of the backlog will also increase. That formula capital budget will increase by 25 per cent between 2013-14 and 2015-16.

We also have in place the capital investment programme. There is the stuff that the cabinet secretary identified that is currently being delivered and which will be concluded in the next couple of years, such as the south Glasgow hospitals project, as well as projects that are advanced and projects that are in the pipeline, such as the Dumfries and Galloway royal infirmary project, which is now down to three bidders and will be at two bidders by January. That investment will deal with the backlog.

On the macro position, the total backlog maintenance has reduced by £80 million over the past year as a result of the investment that I have just described. The capital strategy that underpins that is driven by the overall quality strategy; the capital strategy does not sit in isolation. The planned investments in Dumfries and Galloway royal infirmary, in the new blood transfusion service in Ayrshire and Arran, in the Balfour hospital up in Kirkwall and in moving the sick children's hospital from the city centre to the new Royal infirmary of Edinburgh are all driven by the quality strategy. To return to a point that the convener made on community investment, the significant investment in health centre facilities is also driven by the quality strategy.

**Mark McDonald:** The convener made a point about areas of declining population, but I want to flip that and talk about the area that I represent and the area round it, where significant development is taking place, communities are growing and new communities are being created. That has an impact on the existing health service infrastructure and creates a requirement for new health service infrastructure. What discussions is the Scottish Government having with NHS Grampian and boards in other areas where there is going to be population explosion, or at least an increase in population and demand, to consider how they can cater for that demand?

**Alex Neil:** We have detailed and on-going discussions at every level on that. I speak to the chairs and chief executives of the boards and the acting chief executive of the NHS, and John Matheson and his team at every level are in regular contact with senior management teams in NHS Grampian and every other board. I recognise the particular challenge in Grampian of a growing population and, with that, the challenges with, for example, the labour market, which have an impact on the health service. One of the challenges in Grampian, particularly in the Aberdeen City Council area, relates to nursing home places. There is difficulty in recruiting people to work in nursing homes in Aberdeen because many other jobs are available with higher wages and so on. We are cognisant of that.

On the NRAC formula, we recognise that we have not completed the process that has been started. Grampian is the area where the process has to be completed to reflect the increasing population.

**John Matheson:** To go back to Mark McDonald's previous point, there has been investment in the emergency care centre in the main acute site in Grampian, Dr Gray's hospital is getting additional investment and we have given another £10 million for backlog maintenance investment in acute services in Grampian. Next month, the Aberdeen health village will transfer across. We also have the Woodside, Forres and Tain health centres bundle investment, and the Inverurie project is at an early stage but is progressing well. There are a number of initiatives. We recognise the problem that you highlight, but on capital infrastructure—not just on the acute side, but on the community side—we are working closely with colleagues in NHS Grampian to make progress.

**Mark McDonald:** Cabinet secretary, you make a valid point about the particular pressures in the north-east around recruitment. People can make a lot more money in the buoyant oil sector there than they would make in the public sector, which affects not just the health service but the council, the police and other agencies. Is work under way to consider possible solutions to that localised conundrum?

**Alex Neil:** It is not just in Aberdeen; there are similar pressures in other parts of the country, particularly Edinburgh. In the national health service, pay and conditions for the bulk of workers are generally decided according to a negotiation on either a Scottish or a UK level. There is no provision for regional variations or regional pay, nor would I argue for that, but we recognise that there are pressures. However, those tend to apply more to the lower-grade jobs than to consultants, for instance. Consultants are not likely to go into the oil industry, but that might be the case for other people, especially technicians.

Let me give you an example from the Western Isles. One of the most difficult challenges in the Western Isles is to find a maintenance engineer to work in the health service. The reason for that is not the oil industry, but the success of the renewable energy sector in the Western Isles. Maintenance engineers can earn much more money in the renewable energy sector in the Western Isles than they can earn working for the national health service.

There are undoubtedly challenges in different parts of the country and we try to meet those challenges, but we would not wish to go down the road of regional pay variations.

**Mark McDonald:** I would not encourage you to do so.

**Gil Paterson (Clydebank and Milngavie) (SNP):** From one of the richest parts of Scotland, in Mark McDonald's question, we go to some of the poorer areas, in my question. We appreciate the fact that the health budget for the year that we are scrutinising and beyond is protected. However, have you considered projections regarding the impact of the welfare reform that is taking place on the budget for this fiscal year?

**Alex Neil:** We are considering the impact of welfare reforms at different levels. There is an impact at the operational level, and one of the major issues has been the amount of time that GPs are having to spend writing letters for the Department for Work and Pensions. That has been a controversial and difficult issue for GPs. Although they get paid for most of that by the DWP, it is a very time-consuming activity.

I am more concerned about the impact on the health of individuals. As an MSP for a constituency that covers a deprived area, I know the adverse impact on the physical and mental health of people at the receiving end of many of the cuts. We should bear in mind the fact that disabled people have been particularly badly hit by some of the cuts, which are having a major impact on people's health. It is difficult to quantify that, but we are very much keeping a watching brief on it. Most of the cuts have still to be implemented and we have had postponement, through replacement of the disability living allowance with the personal independence payment's not now being introduced in Scotland as quickly as had been planned.

As far as the overall impact is concerned, I can see the stress that is being caused to individuals by the so-called bedroom tax. People at my surgery have been extremely distressed about how they will make ends meet and how they will feed their families. A single mother in my constituency who has three children with autism was recently left by the Department for Work and Pensions with £18.50 to live on for the week. She was at the end of her tether.

12:00

**Gil Paterson:** Regarding the point that Bob Doris made earlier about the budget, it is very much in the Government's control to protect the health budget, but that has an impact on other parts of the Scottish budget. We understand that. We know that there will be a serious impact fairly soon, caused by welfare reform. Are contingencies in place? Is money set aside, or is there just the budget as it sits at present? Must we work within that?

**Alex Neil:** There is the budget as it is. John Swinney has a very difficult job, given the pressures that are being put on our budget as a consequence of some crazy decisions that are being made elsewhere. For example—and we do not do this grudgingly, given the circumstances—we have allocated £20 million from the Scottish Government budget this year to alleviate the impact of the bedroom tax, and the First Minister has committed the same next year. Frankly, we can ill afford to spend that £20 million, given the tightness of our budget. The overall budget for the Scottish Government this year is about 12 per cent below what should have been expected—on capital, it is 26 per cent below.

It is a very difficult situation, and there is no spare cash. I am not referring just to those funds. We have had to fund the 10 per cent cut in council tax benefit to prevent people who do not have the resources to pay the council tax from ending up in total despair. I feel sorry for people south of the border, because they do not have a Scottish

Parliament to protect them from that 10 per cent council tax benefit cut.

What you see in front of you is the totality of the money that is available to us for this portfolio. I do not anticipate receiving any additional funding whatever for the simple reason that the cuts that are being imposed by London leave us without the extra money. At the moment, we do not have the power to borrow or tax. We are living on a fixed budget with increasing pressures, and there are totally unnecessary additional pressures resulting from the crazy welfare changes.

**Gil Paterson:** I leave you with the thought that, by working a bit smarter, we might be able to do a bit more with the same amount.

**Alex Neil:** We are also restricted by the rules. We would like to do more and, if we had the money, we would do more to alleviate some of the welfare changes, for example. However, in law we are allowed to spend only £20 million to alleviate the bedroom tax. We have no choice. People are calling for a £50 million spend on that, but how can we defy UK law? Reserved legislation says that we can spend only £20 million on that.

**The Convener:** I hope that those who do not totally agree with all of that resist the opportunity to engage in that whole debate, because we have come to the end of this evidence session—unless there are any urgent questions from the committee.

**Alex Neil:** I am just getting some water from Mr Lyle at the last minute.

**The Convener:** He is forever helpful, like Gunga Din.

"You're a better man than I am, Gunga Din!"

There are no further questions. We have had a good session, and it is always a pleasure to have you here, cabinet secretary. Mr Matheson, I thank you, too, for your attendance and for your help to the committee.

We now move into private session, as previously agreed, to discuss whether we can make any progress on the paper before us.

12:03

*Meeting continued in private until 12:44.*

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