The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 20 May 2014

Session 4

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HEALTH AND SPORT COMMITTEE
16th Meeting 2014, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

Rhoda Grant (Highlands and Islands) (Lab)
Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Carol Gillie (NHS Borders)
Alan Gray (NHS Grampian)
Paul James (NHS Greater Glasgow and Clyde)
Michael Matheson (Minister for Public Health)
Gerry O'Brien (NHS Orkney)
Dennis Robertson (Aberdeenshire West) (SNP) (Committee Substitute)
Colin Spivey (Scottish Government)
Felicity Sung (Scottish Government)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The Adam Smith Room (CR5)

Scottish Parliament

Health and Sport Committee

Tuesday 20 May 2014

[The Convener *opened the meeting at 09:32*]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the 16th meeting in 2014 of the Health and Sport Committee. As usual at this point, I ask everyone to switch off mobile phones and other wireless devices because, as you know, they can interrupt the flow of the meeting and can sometimes interfere with the sound system. I add the caveat that some members and officials will use devices such as tablets to look at their papers, instead of hard copies.

We have received apologies from Colin Keir, Rhoda Grant and Nanette Milne. I welcome Dennis Robertson as the Scottish National Party substitute for Colin Keir.

Agenda item 1 is to decide whether to take item 5 in private. As you know, item 5 is consideration of our work programme, which we normally take in private. Does the committee agree to take item 5 in private?

Members *indicated agreement.*

NHS Boards Budget Scrutiny

09:34

The Convener: Item 2 is national health service boards budget scrutiny. Today, we will take evidence from a number of territorial NHS boards. I welcome to the committee Carol Gillie, director of finance, NHS Borders; Alan Gray, director of finance, NHS Grampian; Paul James, executive director and director of finance, NHS Greater Glasgow and Clyde; and, last but not least, Gerry O'Brien, director of finance, NHS Orkney.

The committee has a number of questions that it is interested in getting answers to. I will kick off with a question about earmarked funding, which is an area that we think it might be useful to explore. We have picked up on a couple of issues. For example, we understand that earmarked funding is of particular relevance to NHS Orkney, which gets 35 per cent of its total allocation as earmarked funds. We might have expected that to be reflected in the funding allocations for NHS Shetland and NHS Western Isles, but that is not the case—there are differences. We would appreciate some explanation of why NHS Orkney receives such a high proportion of earmarked funds in comparison with NHS Shetland and NHS Western Isles. Perhaps you could enlighten us on that.

Gerry O'Brien (NHS Orkney): I am not fully aware of the details of the funding of NHS Shetland and NHS Western Isles, but it is true that NHS Orkney receives a high proportion of earmarked funding. There are probably a few factors. We receive just over £2 million in funding for the Highlands and Islands travel scheme as earmarked funds. Given that we receive a core revenue allocation of just under £36 million, that is quite a high proportion. Our primary medical services allocation, which amounts to just over £4 million, makes a significant contribution to the level of earmarked funding. There are a few other smaller earmarked allocations. For example, the allocations for our alcohol and drug partnership and our e-health work total about £1 million. All of that adds up to a significant proportion of our total funding.

As far as your question is concerned, I do not fully understand the differences between what we receive as earmarked funding and what NHS Shetland and NHS Western Isles receive. I assume that that must relate to the share of earmarked funding that they receive as a proportion of their core revenue resource limit. In itself, the earmarked funding does not present any problems for NHS Orkney, because the funding is provided to be used for specific topics and those are the areas that we put it into.

Although the proportion of earmarked funding that we receive is high in comparison with the other territorial boards, that does not present us with any issues. Indeed, in many ways, it helps us with planning. In relation to e-health and the Highlands and Islands travel scheme, we work closely with colleagues, including our Scottish Government colleagues. The fact that the earmarked funding comes through on a fairly consistent basis allows us to plan.

I accept that we probably receive the highest proportion of earmarked funds in NHS Scotland, but that is relative to our RRL position, whereby we receive just under £36 million.

Carol Gillie (NHS Borders): I can provide some background information on the situation in NHS Borders. Our earmarked funding amounts to about £24 million, which makes up 12 per cent of our total allocation. That is a much lower percentage than NHS Orkney receives in earmarked funding. However, the biggest element of that £24 million—just over £15 million—is for the general medical services contract, which is the nationally agreed contract with the general practitioners as independent providers. The second largest element of that £24 million is the £3 million that we allocate to our salaried dentists service. We employ dentists to do general dental practitioner work. If we take those two allocations together, we find that £18 million of that £24 million is for highly specific purposes.

The other £6 million goes on some of the issues that Gerry O'Brien identified, such as drug and alcohol treatment, e-health and the development of information technology. Once the larger elements are taken out, the amount of earmarked funding is quite small and is for specific projects.

The Convener: Does anyone else want to comment on earmarked funding?

Paul James (NHS Greater Glasgow and Clyde): The purposes of earmarked funding have already been mentioned by colleagues. Although earmarked funding makes up a much lower percentage of NHS Greater Glasgow and Clyde's total allocation, it is used for the same sort of purposes. The benefit of having earmarked funding is that it helps to achieve specific objectives. That is the key. In other words, the funding is provided for something and it is used for that purpose. The same is true in Glasgow, although the percentages are very different.

Bob Doris (Glasgow) (SNP): I have a question on another matter, convener; someone else may want to come in first if they have a supplementary on this topic.

Dennis Robertson (Aberdeenshire West) (SNP): I have a follow-up question. I will start with NHS Orkney. Gerry O'Brien mentioned e-health funding; will that lead to an eventual reduction in travel costs? If consultations with consultants are done by Skype, for instance, surely travel costs will diminish quite considerably because patients will not need to go to Aberdeen, for example, to see specialists and the consultants will not need to travel to Orkney either. Do you therefore expect an eventual reduction in the travel costs of patients and consultants?

Gerry O'Brien: Yes, absolutely. That is one of our planning assumptions and we are working very closely with our Scottish Government colleagues on Highlands and Islands travel, for the exact reason that you outlined. We are doing a lot of work to repatriate services to Orkney—principally from NHS Grampian—and we are certainly planning on the basis that we will be able to reinvest that money locally in services rather than spending it on air fares. There should certainly be a reduction in travel costs and a reinvestment of that money locally.

There is another aspect to our e-health work. Although the changes of the biggest magnitude may relate to e-health between us and Grampian, we are also spending a lot of time and doing a lot of work on e-health as it relates to all our islands. We are trying to avoid people having to travel from North Ronaldsay or from Westray, for example, into Kirkwall for an out-patient appointment. We have spent quite a lot of our e-health money last year and this on ensuring that the facilities are available on island and we will continue to do that in future. I am definitely expecting a reduction in travel between mainland Orkney and mainland Scotland, but I am also expecting a reduction in travel time for patients coming in from the isles. All the aspects that you mentioned are certainly true.

Dennis Robertson: That is travel plus accommodation costs.

Gerry O'Brien: All of it, yes.

Dennis Robertson: So you will have better healthcare and patient wellbeing. How much do you expect to save eventually? Surely you have a cost projection.

Gerry O'Brien: A good example is our on-island computed tomography scanner, which will go live later this summer. The gross revenue commitment for that—after we have bought the scanner and kitted out the building—will be about £400,000 a year. We will still not be able to do everything on island, but we estimate that from the scans that we will be able to do on island, we will be able to save about £150,000 a year due to reduced travel for patients, who will not need to go down to Aberdeen for scans. Although there will still be a net investment, that gross investment of about £400,000 will probably come down to a net investment of about £250,000.

We are tending to look at it service by service. As we have made our move into a consultant-led model for medicine, obstetrics and gynaecology on island, we are planning to use the skills of our medical colleagues that we now have on island. We are looking at specific services. We do not have an overall cost projection as we are looking at it service by service and almost specialty by specialty. However, it would certainly be correct to assume that we are anticipating a shift from spending money on travel, accommodation and lots of downtime to providing services directly on island and improving the whole patient experience.

Alan Gray (NHS Grampian): From the perspective of NHS Grampian, there are clear advantages for us in terms of the release of consultant time.

Dennis Robertson: I was going to ask about Grampian.

Alan Gray: If we consider the consultant time that is required to go up, do the sessions in Orkney and come back down, the change is advantageous to us as it will release clinical capacity to do more work in Grampian and the north.

The other advantage—from a clinical, person-centred perspective—is that, over time, we will hopefully be able to hold the consultations with not only the patient but the patient and their GP. The GP plays an important part in the continuous care of patients, particularly in remote locations in Orkney and Grampian. The ability for a consultant to have that consultation with the patient and the GP has long-term clinical advantages in helping that patient to stay closer to home and well for longer. We see the cost advantages but, in the longer term, there are real clinical and patient care advantages in taking on that model. It means that people do not have to travel. Even on the mainland, many people make long journeys for very short appointments and very little clinical benefit.

09:45

Dennis Robertson: So it is difficult to measure the long-term cost saving in terms of wellbeing. Are you projecting a cost saving in Grampian in consultants' time and in the provision that NHS Grampian makes for some of your remote and rural areas by using e-health and consultants in the same way as is being planned for Orkney?

Alan Gray: The biggest saving that we see will come from avoiding costs rather than saving costs.

Dennis Robertson: But surely there must be a cost saving. I know that you want to avoid incurring costs, but there must be an eventual cost saving.

Alan Gray: We will have to identify a number of cost savings as part of our annual budget, so we would hope that there will be an element of cost saving, but part of this is clearly about avoiding future costs through increased activity.

The biggest single challenge that Grampian has to face is a rising population. In addition to having to make savings, we are having to manage population growth. Over the next 10 to 15 years, we will certainly see a rise in the population of people of working age and also of people of retirement age. We have to be minded that we have to provide quality care within our resources and then, I agree, we have to find ways of making cost savings. This will be one avenue that we can use to make the system more efficient.

The workforce will be as much a limiting factor as finance. We need to be able to recruit and retain specialist staff so this will be a way of using that scarce resource more efficiently to benefit a greater number of people.

The Convener: The question that popped into my head when Dennis Robertson was pursuing that line was that a significant investment of £400,000 in the new scanner will obviously benefit the people of Orkney and make for a better patient experience. However, it seemed that the relationship with Grampian was going to free up resources and efficiency. Did you make a contribution to that?

Alan Gray: No, we did not.

The Convener: Is there any sharing of the budget or investment for change that benefits both Grampian and Orkney?

Alan Gray: We work very closely with Orkney—

The Convener: Close enough to share budgets?

Alan Gray: Well—

The Convener: Not that close.

Alan Gray: We do not share budgets, but we cost the services that we provide to Orkney on an open basis with it. In fact, we do not recover the full cost of the service that we provide to Orkney; Grampian carries part of the burden of providing the service to Orkney and Shetland. That is part of our annual budget decision-making process. We work closely with Gerry O'Brien and the executive team in Orkney to help with the redesign of the service so we are part of that journey, and we contribute our thinking and input into that. In a budgetary sense, we work closely with the island health boards to make sure that we provide our resources efficiently in a way that is affordable to both those health boards.

Gil Paterson (Clydebank and Milngavie) (SNP): My question is in a similar vein. I do not think that it relates to island matters per se, but I want to understand the collaboration that goes on. When the scanner is up and running, where will the personnel come from? Will they come from Grampian or will they be a new resource?

Gerry O'Brien: It is a bit of both. We are carrying out a recruitment exercise for additional radiographers on the island. We have already recruited one of the three we need and there are another two adverts out at the moment. They are new resource on island, but the results will continue to be read by the consultant radiology staff in NHS Grampian. The location of the scan will change, but the reading of the scan will not. It uses e-health technology and goes down the line to Grampian to be read.

That is one of the good examples of where Grampian and Orkney work together. The radiology staff at NHS Grampian have recognised that some of the scans that are currently happening in Grampian will happen on Orkney. As we open up our new scanner on island, we fully expect that the overall number of scans will increase, but NHS Grampian has recognised that some radiology time will be freed up. Although we are having discussions about a reporting service, it will not cost the same as a full reporting service. Although there has not been a physical transfer of cash, it will not be a full reporting service.

I would totally support Alan Gray's point. The development of services on Orkney is one of the key elements for us. We have to develop services on Orkney and are keen to repatriate services to Orkney, but we want those to be services that are appropriate and safe to be developed and repatriated there. We need to be mindful of the impact that that will have, because there will be a residual number of cases that we will need to send to Grampian. There will always be a level that we cannot go above in Orkney, because we have no intensive therapy unit facilities and so on. Orkney will always have a dependency on Grampian—that is a good word to describe it. That demands that there be a close working relationship with NHS Grampian.

The Convener: We decided to explore the relationships between health boards and the way in which they are providing services anyway, with particular regard to Glasgow.

Dennis Robertson: I wonder whether—

The Convener: I was going to bring in Bob Doris, to move the discussion along a bit.

Bob Doris: I want to ask about budgets in relation to prescribing by general practitioners and hospitals. I am interested not only in the price assumptions but in the volume assumptions that have been provided to the committee.

I will provide a bit of context. I am sure that a lot of good work is going on across a number of health boards, but when I sat on the Public Audit Committee, we saw a report that praised work that was being done by NHS Greater Glasgow and Clyde on polypharmacy, on the provision of the most appropriate medications and on improvements in care for individual patients, some of whom are constituents of mine.

I am sure that good work has been done elsewhere, but when we see differences in figures, we want to ask why. A table in our committee papers shows a rise in the cost assumption for NHS Greater Glasgow and Clyde's prescribing budget for 2014-15 of 1 per cent, and a rise of 2.1 per cent for NHS Borders. However, the most dramatic figure that jumps out at me is a 16.8 per cent predicted increase in 2014-15 in the hospital prescribing budget in NHS Grampian. That is a dramatic outlier. It might simply be about how money is being accounted for, but an explanation for that would be good.

The general theme behind the numbers—apart from the outlier figure, which needs some closer attention—that I am trying to get to is that, because NHS Greater Glasgow and Clyde has done good work already, its baseline figures will mean that dramatic savings will not flow from any action that it takes. The fact that it has a far more efficient baseline means that the savings will be much more modest. Of the four health board representatives, who feels that their board has squeezed as much value as possible out of polypharmacy and the provision of best pharmaceutical advice for patients, and where are there still savings to be made? How have the cost assumptions been arrived at?

That is not too focused a question, but I think that we need to get beneath some of the figures.

Alan Gray: I am happy to provide an explanation for NHS Grampian's 16 per cent rise. The majority of our predicted spend increase is in the acute sector, as opposed to the primary care prescribing budget. That concerns four main services: cancer, dermatology, ophthalmology and another one that I cannot recall at the moment. The rate of increase is largely to do with population growth in Grampian and the fact that we expect the drugs to be applied to new clinical indications over the next year.

We have a relatively healthy population in Grampian, and there has been an increase in the number of patients who can take fairly aggressive forms of cancer treatments and can go through second, third and fourth-line cancer therapy. Cancer care is a big part of the increase, which

might explain why we are different from Glasgow and some of the other boards. On the GP prescribing budget, we are probably more in line with other boards in terms of the assumptions around volume.

To answer the question about polypharmacy, we are probably just at the start of the journey and are looking at patients who have multiple medications. Within each of our community health partnerships, we have an aligned pharmacist, whose primary role is to work closely with GP practices and to identify variations in practice, including in prescribing, and to work with them to eliminate those variations so that we make best use of prescribing budgets.

Bob Doris: I know that Paul James wants in, but I have a specific question on NHS Grampian.

The good bit is that there are efficiencies to be made by Grampian, for which you are planning. It is good that you have put that on the record. You have started the journey, although perhaps NHS Greater Glasgow and Clyde started two or three years earlier; we will hear more about that in a second.

You mentioned a threefold increase in the pricing budget in hospitals and you mentioned cancer treatment, ophthalmology and another thing that you could not remember—but do not worry about that too much. However, I do not see why those things would be specific to NHS Grampian. New indications for treatment of cancers and other conditions—the new indications are a good thing, incidentally—would befall every health board, not just Grampian, so I am still struggling to understand where the threefold increase for Grampian comes from.

I am not trying to be awkward, but when the committee gets an answer that does not seem to make sense, it is reasonable to come back to the witness. Can you try again on that one? Is there something specific to Grampian in relation to cancer, ophthalmology and new indications?

Alan Gray: I cannot comment on that, because I do not know what assumptions other boards have made.

In Grampian we took advice from our medicines committee. It is not a financial decision; it is based on advice that is given to us by our pharmacy specialists and our clinicians in the hospital. Their past record on predictions is that they have been fairly accurate, particularly around the acute budget, underlying changes to prescribing practice in hospitals, and the cost of prescriptions.

Bob Doris: I am still none the wiser as to why Grampian would be different from any other health board. If you cannot answer that just now, perhaps you could write to the committee. I imagine that you would be very aware if there were dramatically higher rates of cancer in Grampian than there are in other health boards, or if there was a much more significant demand for treatment of certain conditions. I do not quite understand why Grampian is different, so if you could write to the committee with more information that would be good.

Convener—I apologise. I know that Mr James wanted in.

The Convener: We are looking for a response. Bob Doris asked about previous assumptions. Mr Gray responded that they were very close to being correct, and that he is satisfied that the process that NHS Grampian goes through is robust. Maybe other witnesses will comment on that.

Paul James: I do not want to revisit the evidence that I gave last year to the committee, but in our forecasts the time of major off-patent savings is coming to an end. In our 2014-15 plan we have not taken account of the sort of credit that we were able to take account of last year. It is important to recognise that.

I will deal with GP prescribing then acute prescribing. The first point about GP prescribing was correct: our move to generic rather than branded prescribing—which has been one of the things that has underpinned the savings that we have achieved in NHS Greater Glasgow and Clyde—is reaching saturation point. It will be difficult for us to continue to make major savings in GP prescribing, because they have already been made. We can put a tick in the box; that is in the past.

However, new branded drugs will always come on to the market, and there will be opportunities to switch to generics in the future. That is a clinical decision, not a financial decision: it is important to make that point. I do not see the complete end of savings in GP-prescribing land, but I do not see the large savings that we made in 2013-14 recurring in the near future.

On Bob Doris's point, it is fair to say that there is still quite wide variation in GP prescribing practice, even within Glasgow. Through peer group reviews and informing GPs about how their colleagues prescribe, there is always the potential to improve still further. That is active work in Glasgow and it will continue. Other boards can take advantage of that. Therefore, the variation that exists not just in Glasgow but around Scotland gives some opportunities in some other boards. Bob Doris is right to highlight that as an issue in which the committee might be interested.

10:00

On GP drugs prescribing, there is a new anticoagulant drug called apixaban, which will give rise to significant costs for us and is part of our financial plan. To an extent, that substitutes for what we thought would be a big pressure as a result of a drug called dabigatran, uptake of which was not as great as we had expected because there were clinical issues with it. I am not a clinician, so it is not appropriate for me to comment on the clinical issues, but they meant that dabigatran was not as widely prescribed as we had thought it would be. Apixaban is thought to be free of those issues and therefore might well be prescribed more widely in the future, so we have built that pressure into our plan.

It is fair to say that the largest pressure is beginning to occur in acute prescribing. Alan Gray's points were right, although obviously I do not know his figures. In principle, we are seeing much larger percentage rises in the acute medicines bill than in the primary care medicines bill. I do not know whether that trend will continue, but we have certainly put significant funds into acute prescribing in the past few years, and that continues.

My current hobby horse is sofosbuvir, which is a newly approved drug for hepatitis C. It is immensely expensive, not just because of the cost per patient but because of the large volume of patients who suffer from the condition. Glasgow has a disproportionate share of those patients; I think that we have about 17,000 patients out of a Scottish hep C patient population of 40,000 to 42,000, so we have roughly 40 per cent of Scottish patients. As it happens, sofosbuvir will not be used for all those patients, for reasons that I believe are to do with genotypes, although I am afraid that my scientific knowledge begins to run out at that point.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): You are doing well.

Paul James: It is to do with the patients' genetic make-up—the drug will work for some patients and not for others. That means that, as we treat patients each year, we will potentially incur an additional cost of several million pounds. We can debate the exact figures, but people have talked about £16 million or £17 million a year, and it will take us a long time to work through the cohort of patients in Glasgow. That is an acute pressure, which I bring to the picture just to highlight the fact that such medicines are coming through. I can highlight one medicine and the difficulty that Glasgow will have because we have 40 per cent of Scotland's hep C patients and 25 per cent of its funding, but there will be other medicines in due course.

Before the meeting, my colleagues and I were discussing the extent to which medicines will be an increasing area of focus for the committee. Expensive branded medicines will continue to hit health board budgets and we will have to work out what to do about that. I am afraid that I do not have a general answer or solution to give you for the future, but I think that we will face that financial pressure in Scotland for a long period.

With drugs such as sofosbuvir, for which a disproportionate share of patients are in one health board area, we will need to look at how we share risk. I think that it would be inappropriate for Glasgow to have to suffer all that cost and not be able to share it around the rest of Scotland. I have made that recommendation to Christine McLaughlin, whom I think will give evidence to the committee later this morning. I hope that that will be taken forward by chief executives.

The Convener: Before I call others to follow that up—I will get a response from all the panellists—I ask you to address an issue, if it is an issue for you, that the committee was extensively involved in work on. The issue is increasing access to new medicines and medicines for rare conditions that come on to the market. That is working through the system. Is that reflected in your budgets?

Paul James: The details of the new medicines fund have not been made publicly available or even decided on yet. We have made prudent assumptions in our financial plans about the extent to which drugs such as ivacaftor, end-of-life medicines and other drugs will be funded. We cannot give a definitive answer on the amount that will be funded in 2014-15 and 2015-16, because the plans have not been finalised.

The Convener: Claims have been made that thousands of patients will benefit and that there will be thousands more yeses in the system. Have you estimated what that will cost Glasgow?

Paul James: I am sorry: what are we relating Glasgow's figures to? I have merely looked at the expected spend in our drugs budget and have made what I hope are prudent assumptions about the funding that we might receive for some drugs.

The Convener: What is the figure?

Paul James: The figure is £5.9 million.

The Convener: I ask the other witnesses to respond to Bob Doris's general questions and perhaps to address access to new medicines. After that, anyone who wants to contribute will get in.

Gerry O'Brien: I will start by giving the NHS Orkney position. I do not want to repeat lots of what Paul James and Alan Gray said; our process is similar to theirs.

It is important to separate GP prescribing from acute prescribing. In the Orkney figures, we are probably in the same place on GP prescribing as Grampian is—Alan Gray described the position there. We have done the work on generics and we are relatively comfortable with where we have got to on them, although there is always room for improvement. We have a couple of outlying practices where we can do more work and we are engaging with one of our better GP practices to do that, because we are getting into the realms of clinical decision making. The issue is not volume, but understanding why GPs prescribe certain medicines, which we are addressing.

The bigger issue is prescribing in our acute sector, which I split into what comes through the hospital and more specialist drugs, which Paul James spoke about. In the financial plan for NHS Orkney, I have set aside a 15 per cent uplift for specialist drugs, which include many drugs such as those that Alan Gray spoke about, including cancer drugs and the hep C drug. I will not try to say its name—Paul James can say it better than I can. We are definitely seeing an increase.

Even if we take only a few of the drugs that are mentioned in the Scottish Medicines Consortium's "Forward Look" report, which came out at the beginning of this calendar year, the cost pressure on Orkney could be just under £300,000. That equates to just under 1 per cent of the revenue resource limit, which is a massive increase for us.

Like Paul James, I have taken a view with my director of pharmacy on what the situation might look like. In our overall financial plan, I am looking at setting aside an additional £400,000 for drug spend in 2014-15. That reflects the rate of increase, primarily on the acute side and in relation to specialist drugs. For example, we have a particularly high prevalence of multiple sclerosis on the island and the drug spend on that is definitely increasing steadily.

In relation to the rare medicines fund, we are probably fortunate that we have not had a direct impact yet. I keep a close eye on that with our director of pharmacy. Over the past 18 months, we have had no individual patient treatment requests and nobody has applied to the rare medicines fund. If a request was made, that could be a big issue for us. In my £400,000, a notional sum is set aside for that, but I cannot say how much impact the rare medicines fund might have on us.

An added complication is that some of our requests will probably go through Grampian specialist treatment centres. NHS Orkney and NHS Grampian will need to work closely on managing that, because undoubtedly some of the requests that go through Grampian will be for Orkney patients. Our position is very similar to the situation that Alan Gray and Paul James have described. I support Alan's view, given the growth that I see taking place in Orkney in the use of more specialist acute-sector drugs.

Carol Gillie: At the risk of repeating what my colleagues have said, NHS Borders's process for acute drugs is very similar to the process that others have described. We have a medicines resource group that does the horizon-scanning work to identify likely new drugs and to assess potential uptake.

I have included in my return an uplift to my budget. My point is that the baseline might be different. If you have underspent your budget in the past, you have that benefit, so you may potentially acquire a lesser uplift if your baseline is that bit higher.

With regard to GP prescribing budgets, there is certainly much more to be done in NHS Borders. I will give the committee a flavour of what we are planning to do. We have done well on generic prescribing, but we are focusing on areas related to our weighted patient cost. We introduced a system in December 2013 called Scriptswitch—which the committee heard about last year—to help GPs to pick the most cost-effective drug.

We are working with GP colleagues to examine the specific areas of drug spend in which NHS Borders benchmarks poorly. We are currently looking at respiratory drugs. We have—as other boards have—done some work on polypharmacy, which is not only about cost but about good medicine, quality of care and patient safety. To date, we have looked at patients who are taking more than 10 drugs and are at high risk of admission to hospital. That is quite a big basket of drugs, so we still have quite a lot more to do in that area.

On national therapeutic indicators, NHS Borders has applied the same principle to identify the practices on specific drugs that look like outliers, and we talk to GPs about those. We have also looked at waste, which involves focusing on the dose that we give a patient and the use of repeat prescriptions. We have looked at how a patient stops their medication and at the use of nutritional products, for which we have dieticians helping us.

There is a lot more work to be done in NHS Borders on GP prescribing, and we are progressing that over the next year.

Alan Gray: Just for the record, the four areas that I was trying to remember earlier are cancer, digestive disorders, ophthalmology and rheumatology.

In NHS Grampian we have a higher incidence of patients who require cystic fibrosis treatment. Our current annual spend on ivacaftor, which is a drug for cystic fibrosis that is funded through the rare

medicines fund, is approximately £2 million. We have predicted that the drug will continue to be funded through the rare medicines fund through 2014-15; that is the assumption in our plan.

Beyond that, there is uncertainty on future funding for the drug, and we have made the assumption that funding will have to continue within our financial budget. On the question of how much has been set aside for new drugs that are approved by the Scottish Medicines Consortium, we have set aside £1 million for 2014-15.

As we go beyond that, there is a high degree of uncertainty about how the cost will flow through in future years. It could go up to between £5 million and £10 million; that is the degree of uncertainty that we have in the next two to three years. We will have to build that great uncertainty into our budgets, but—as Paul James said—we are waiting for further information and guidance, which will further inform the budget from 2015-16 onwards.

Bob Doris: That is helpful. With regard to benchmarking and rolling out best practice elsewhere, I am reassured that there are still savings to be made. I know that there are rising costs, but there are savings within those costs, which is good.

Paul James spoke about prevalence and the clusters of various conditions that befall certain regions of Scotland more than others. The risk-share scheme is interesting, and the committee might return to that subject when it considers the topic of new medicines.

I have a final question on the pressures on acute hospital prescribing. How much more work can be done around that subject? How much of the pressure is due to prescribing for older patients who are unscheduled admissions, and how many of those could be tackled via preventative work in the community? Should we just expect that acute prescribing will increase, or is there work to be done on that? For example, could the cohort of patients in hospital be smaller in the first place if they did not come through accident and emergency or receive unscheduled care at hospital because social care was stepping in to take the burden? Is there any information about how acute hospital prescribing could be reduced, or should we just expect that that is a significant and increasing part of the prescribing budget? I suspect that the position will be similar across all health boards, so I would like one or two replies to my questions. I am sure that my colleagues will want to ask additional questions.

10:15

Alan Gray: The rise in prescribing is largely in the prescribing of the very specialist drugs that are available only for very small groups of patients. We have seen the greatest pressure in those areas over the past few years. The biggest rises have occurred not through the growth in the volume of prescribing activity, but largely through the increasing prevalence of very specialist drugs that benefit only a small number of patients. We have seen that with the new Scottish Medicines Consortium drug approval process. The drugs are expensive, but they will make a difference for a very small and select group of patients who have particular cancer conditions or other conditions that can benefit from the drugs.

There is no doubt that further work can be done on the integration of primary and secondary care. Work is on-going to reduce wastage and to ensure that people are getting the appropriate medication. There is a danger that we sometimes overload patients with medication. The polypharmacy is very much geared towards ensuring that any changes in patients' medication are reviewed in the context of the entire package of medication that is being given to them. Many older patients have multiple conditions and some of the drugs for them can have counter-effects, so the polypharmacy is focused on trying to ensure that we are doing the right thing for patients and giving them the right bundle of medication so that they have the best outcomes as well as the most effective outcomes in terms of prescribing costs.

Paul James: I agree with what Alan Gray has just said, but I want to throw in an additional statistic. A recent analysis of our medicines identified that 80 or 90 per cent of our medicine spend was on chronic conditions. To answer Bob Doris's question, although the growth is certainly in the areas that Alan Gray indicated, there is a big block of spend on chronic conditions in both the acute sector and the GP sector. Your point is right, in a sense, because if we can prevent chronic conditions there are significant savings to be made. To be fair, it is not just about the medicines bill that is being incurred for chronic conditions. A lot of the GP bill, the acute bill and the community care bill is for what is being spent on chronic conditions. The big question is whether a real reduction can be made in the number of people who have chronic conditions. I am afraid that I do not have any meaningful comment for the committee on that, but it is worth exploring.

Bob Doris: That is very helpful.

Dr Simpson: I am trying to understand this. We have 14 health boards that are all working with individual practices and managing their acute budgets. On the other hand, there are two issues. The first of those is the support that you are getting from the centre—Healthcare Improvement Scotland and the joint improvement team—to ensure that you do not reinvent wheels. NHS

Greater Glasgow and Clyde has had a very successful programme of reducing per capita costs on GP prescribing to a level that, given the health problems in Glasgow, is significantly lower than that of all the other health boards. How much information has come out about how NHS Greater Glasgow and Clyde set about achieving that, which prevents your having to spend endless time in committee reinventing wheels? Is the joint improvement team or Healthcare Improvement Scotland dealing with the matter?

The second issue is that the big difference between Scotland's healthcare system and England's is that we have managed care networks. For cancer, which is one of the growth areas for drug costs, there are only three managed care networks. How is that costing working? There is a managed care network in the west of Scotland that covers NHS Forth Valley, NHS Lanarkshire, NHS Ayrshire and Arran, and a bit of NHS Greater Glasgow and Clyde. How is the budgeting managed? The expenditure is incurred by the clinician at the Beatson west of Scotland cancer centre on behalf of patients in NHS Forth Valley, NHS Ayrshire and Arran and NHS Lanarkshire, so how does that work? Is the system sustainable given that cancer treatment will be one of the big cost pressure areas?

Paul James: I will kick off, but I am not sure that I have much to say on managed care networks. I am not very sighted on the role that Healthcare Improvement Scotland plays, but I have a pharmacy team whose members provide support to GPs and undertake the visits. That team has input to other health boards, so there is sharing of best practice and knowledge. There is always room to extend and improve on that, but the team is not operating completely in a silo in Glasgow. I just wanted to throw that in because I think that it is worth developing, and it is something that we have talked about before.

I am not sure that I can comment on managed clinical networks. I deal with the budgets that are incurred by the Beatson, as you will understand, so that is where my focus tends to be, and we tend not to set a budget at the MCN level.

Dr Simpson: You now have satellite oncology units, and you are going to have a new one in Monklands hospital. Who holds the budget for the prescribing that will be done in Monklands? Is it NHS Lanarkshire or is it you?

Paul James: I think that NHS Lanarkshire will be responsible for whatever operates in Lanarkshire, but I will need to check that. The majority of the budgets operate through our regional services directorate, which is in our acute division. It is run by Jonathan Best, and his budgets are what I would be dealing with.

Dr Simpson: I will come back to that issue in questions on the NHS Scotland resource allocation committee, because I do not think that it is properly dealt with under NRAC either. I am not sure that some of the central boards in Grampian, Edinburgh and Glasgow, which is where the three cancer networks operate, are properly funded. Maybe that is a separate discussion on which you could come back to us in writing if there is more information.

Carol Gillie: A lot of the support for our programme of work on prescribing has come from the quality and efficiency support team—QUEST—which has a work stream on prescribing. I should also inform the committee that there are pharmacy, medical and finance networks across Scotland, through which we share information about successful schemes.

On MCNs, NHS Borders is very much linked into the Scottish cancer area network. In the south-east, any new drugs are considered by SCAN for all the boards in that area. It also gives us advice before the start of the financial year and a forecast of the likely uptake of the new drugs that are on its horizon scanning. We work on an area basis, and SCAN also designs protocols that individual consultants follow across the whole network, so we work together in a number of areas.

Dr Simpson: Do you get a bill from NHS Lothian?

Carol Gillie: Because we share the care of patients, if a patient is seen in NHS Lothian, which is usually the case for people who live in the Borders, NHS Lothian will bill me for seeing that patient and for any high-cost drugs that have been prescribed for that individual.

Dennis Robertson: Mr Gray, you mentioned that you are dealing with a growth in population and you touched on integrated health and social care. Are you projecting that the costs of that growth in population will need to be met through your prescribing budgets on the acute side? I would have thought that the integrated programme would mean that some prescribing would go down to primary care rather than to acute care.

I am also interested in the fact that, with regard to ophthalmology, NHS Grampian is different from other health boards. I understand that there are issues around the ageing population and that you are treating wet macular degeneration with Lucentis—that is fine—but are your numbers so different from those of other health boards?

Alan Gray: It is difficult for me to respond to your last point at the moment because I have not seen how we compare to other boards. I will get back to the committee with a formal written

response on why we are different from other boards in respect of the assumptions.

The integration of services, both within the NHS and between the NHS and local government, will assist us in managing the chronic illnesses that are contributing to the overall health costs, let alone the prescribing costs. We will continue to pursue different ways of managing the growth in that activity.

There is no doubt that, given the population growth that we predict in our board areas, we cannot continue with the same configuration or type of services as we have at present. We have to find different ways of supporting and looking after people with long-term conditions and take preventative measures to ensure that people can live longer at home without the need for expensive intervention and healthcare.

Dennis Robertson: Do you know what the population growth that you mention is predicted to be? How have you come to that conclusion?

Alan Gray: I do not know exactly what the population growth in Grampian will be. I base my view only on the number of housing development approvals that are coming forward and the buoyant local economy. We know, from the activity flows through the hospital, that certain specialisms have seen a rise in activity. We manage that as best we can, in terms of productivity, through our efficiency programmes.

There is certainly a continuing pressure through the growth of the working-age population and the elderly population. We are seeing the greatest growth in the working-age population.

The Convener: This might be an opportune moment to touch on the efficiencies that have been expected over the period. With notable exceptions, the efficiencies were around the 3 per cent mark, and there was an expectation that most boards would achieve them. What efficiency savings are the boards now expected to make, following their discussions with the Scottish Government health department?

Alan Gray: We are expected to achieve 3 per cent efficiency savings.

The Convener: That is still the case. Does that apply to NHS Greater Glasgow and Clyde and other boards?

Paul James: Yes, it does. The savings consist of what we would call cash-releasing savings and productivity savings.

The Convener: We will let the issue of efficiencies versus cuts stick to the wall for the moment.

Boards have informed us of how they will attempt to achieve the efficiency savings. NHS Greater Glasgow and Clyde has suggested that 65 per cent of its savings will come from services. NHS Grampian expects to achieve considerable efficiency savings through its efforts around the workforce, which it says will be equivalent to 32 per cent of the savings. NHS Borders intends to make savings largely in non-clinical support services and in estate facilities. NHS Borders, NHS Grampian and NHS Orkney are talking about making savings in human resources and other shared services, drugs and prescribing.

Does anyone want to speak about any of those suggestions? How will NHS Greater Glasgow and Clyde achieve 65 per cent of the savings through action on services? What does that mean?

Paul James: It is always difficult to categorise savings, whether you are talking about services or workforce redesign. Obviously, the majority of our costs are people. If we are looking to provide 3 per cent savings, some of that will come through efficiencies. We are looking at a cash-releasing target of 1.6 per cent in 2014-15, which equates to £32.9 million. We will get £18.9 million from our acute division, £6.5 million from prescribing and £6 million from our partnerships. There are some other bits and pieces in there, but those are the main numbers.

10:30

The reality of the figures that I have just given you is that we are reconfiguring services in many cases. Some services are relocating from one area to another to make better use of our existing space and the facilities that we have, while some of the changes will be due to skill mix redesign whereby we are saying, “We don’t need somebody quite as senior for that role; we can use somebody more junior.” A whole mix of complicated things is being done. We have tens of different schemes, all of which have descriptions against them.

I do not want to leave an impression that we are cutting a specific service that we desperately need. We have a staff turnover of about 6 per cent in Glasgow, and we can achieve the 1.6 per cent cash-releasing target without making people redundant if we redesign the workforce by looking at the skill mix and relocation. We have the ability not to replace some people as they leave, but we are doing that alongside a redesign.

That might sound like a woolly answer, but it is the truth of how that is being done in Glasgow. If our staff turnover was lower or the target figure was higher, it would be more difficult to achieve it. If we had to make 4 per cent cash-releasing savings, the 6 per cent staff turnover figure would not work.

The Convener: The committee is looking at some of the thinking behind your projections on

savings. I can understand that the new Southern general hospital and the co-location or relocation of services coming out of old buildings at the sick kids hospital and so on are factors. There is massive investment in the new Southern general hospital. What savings do you expect to get from those wider changes to services in greater Glasgow and Clyde? They are bigger changes than not replacing somebody, which only achieves savings of some thousands of pounds.

Paul James: The business case for the new hospital, which was written several years ago, anticipated significant savings that would cover some of the capital charges that will occur when the new hospital is finally handed over. We do not have any major assumptions for the new hospital in our 2014-15 plan, because it will not be handed over to us until the end of January and there will then be a commissioning period before the transfer of patients. The major impacts of the new hospital will be in 2015-16 and not in 2014-15, so you will not see much in my current plan in relation to the new hospital.

The Convener: However, the business plan is no longer valid. Unless I picked you up wrongly, you suggested that it is a historical document. The business plan assumed a number of savings. Do they still stand or not?

Paul James: I think that the business plan would need to be revisited because of some of the savings that were anticipated when it was written. Since that time, we have reconfigured services, so Glasgow does not look the same as it did when the original business plan was written. All that I am trying to say is that savings have been made. Bed numbers have changed and the whole picture is different from how the original business plan looked.

The new hospital will deliver on the intention around which it was built. That is clear. What I am trying to say is that I do not have any good figures in my 2014-15 plan that I can put on the table for you this morning, because the issue that we are talking about relates to 2015-16 and beyond. With the new hospital, sites such as the Victoria and the sick kids hospital, which you mentioned, will be closed and services will be centralised in the new hospital. It will probably be some of the more expensive services that are centralised—some of the specialties—so that we create centres of excellence for Scotland.

The whole picture has changed in Glasgow since the original business plan was written. I am sorry, but that is the reality—

The Convener: I concede that there is a difficulty as regards many of the presumptions that you would like to make, whether that relates to the prescribing budget or any of the other budgets. Prescribing is decided by pharmacists, doctors and the acute sector, who drive all of that. It would be interesting to know how robust the projections can be when all those variables are in play—and that is leaving politics and local campaigns aside. We all plead guilty to that. It must be difficult to get robust projections and to identify areas for efficiencies and savings in that context.

Paul James: That is fair, although the new hospital is delivering on its anticipated budgeted capital cost. The projections were made a long time ago, and the contracts were let a long time ago. The new hospital will be there, almost smack on budget, early next year.

The Convener: You mention the capital charges. They have increased, have they not?

Paul James: The capital charges were anticipated when the business case was—

The Convener: They have not changed.

Paul James: No, they have not—we knew what the cost would be. That is something of which we in Glasgow are genuinely proud. We will deliver a hospital, and it will be on budget—or it will not be massively over budget.

The future operating costs are a bit more of a matter for the future. It will be 2015-16 or 2016-17 before I can come back to you with useful information on that.

Alan Gray: It is helpful, convener, that you have acknowledged that the health business is complex. It is dynamic, with continuous changes. On finance, from my board's perspective, what makes things work is our close working relationship with the services. In the finance team, we work closely with the services throughout the year. Setting a budget is part of an on-going process. Once we set the budget, we still work with staff, because things change. From 1 or 2 April, things change throughout the year.

The important thing is to build that relationship, through working with staff and services all the time. When staff leave a post, we look for opportunities to redesign through the skill mix and through changes. We can make predictions and best estimates, but we deliver on them through our close relationship with staff—clinical and non-clinical—throughout the service.

I am proud of the fact that staff in the health service work closely together, and that people are well supported. Staff understand that they must operate within the resources that are allocated to the boards, but they work closely together, and they have come up with good and innovative ways—sometimes on a small scale, sometimes on a larger scale—to ensure that we can continue to operate and provide the right level of service. We

aspire to do that, but within the resources that are available to us.

The Convener: You suggest that Grampian will achieve considerable efficiency through the workforce, equivalent to 32 per cent of all the savings. It is a difficult environment, and you are not a clinician—you deal with figures.

Alan Gray: Indeed.

The Convener: How many people do you need to shift along or reconfigure to get the 32 per cent of your total savings? There must be a figure somewhere.

Alan Gray: To return to what Paul James said, we have a turnover of staff every year. It is not all about savings. Some of it is efficiency, and some of it is money that we will put back into the system. The difference between the 3 per cent figure—

The Convener: I am not suggesting that you will not put it back into the system. We have left aside the question whether the money goes back into the system, as that would take us all morning to discuss. There is the issue of cuts versus efficiencies, where the money goes back into the system.

You have presented a budget that says that the equivalent of 32 per cent of your savings will come from the workforce. What does that mean? How many people work for NHS Grampian now and how many will work for NHS Grampian at the end of the year? How many jobs will go to make that saving?

Alan Gray: We employ 16,000 staff. We have a turnover of between 6 per cent and 10 per cent, depending on the year. In other words, about 1,000 staff will churn through our system every year. Some of that will not be a loss of jobs; it could be a change in the skills mix. It could involve using doctors as opposed to consultants and using a different grade of staff to deliver the service. Not all of it is about a loss of staff. I am keen to maintain the staff numbers as best we can.

The Convener: However, there is a turnover of 1,000 a year, and not all of them will be replaced.

Alan Gray: That is correct—not all of them will be replaced.

The Convener: How many of them will not be replaced?

Alan Gray: I cannot give you that number, because I do not have it to hand.

The Convener: But it is your budget.

Alan Gray: Yes, but although the budget has been set, we have not set the number of posts that will be affected if we are to deliver the required savings. We will have to work through our plan throughout the year to ensure that we deliver that level of savings. We know that there will be changes in our workforce throughout the year, but I do not know how many staff will be affected or in what areas those changes will be. As those changes happen and as vacancies arise, we will look to redesign the services that are affected. I cannot tell you exactly how many staff or what services will be involved.

The Convener: But your budget does not work unless there are fewer members of staff.

Alan Gray: Correct—well, there has to be less of something. There could be fewer members of staff, a smaller prescribing budget or less expenditure on supplies and services.

The Convener: The important points for us when it comes to the figures that are presented to us are how you arrived at them, how robust they are, what thinking lies behind them and what buy-in there is from the various partnerships. We all know that, in our world, it is easy to discuss such issues in general terms, but it is much more difficult to get people to accept the reality of decisions that involve the delivery of a programme, whether on hospital beds or the number of clinicians or nurses. If budgets are presented that involve savings that will lead to fewer people being required, I do not think that it helps if, in evidence to the committee, people feel unable to say that out loud. Such savings are either in the budget or they are not.

Alan Gray: The budget is set with our services. The budget-setting process that we go through each year involves a very detailed exercise with each service on what their budget allocation is likely to be, which we compare with the cost of the service. Each year, there will be a gap, and we require the services to come up with plans to deal with that. Those plans are reviewed by me as finance director and the executive team to ensure that they are deliverable and are underpinned by things that can be achieved. We review and challenge all of that. That is part of the budget-setting process.

The process of coming up with the numbers in the budget is not done by the finance team in isolation. Discussions take place with the relevant services. A very detailed process sits behind the budget.

The Convener: The fact that, despite all that discussion and hard decision making, you cannot give me a number does not give me great confidence. The budget is either real or it is not.

Alan Gray: Yes.

Carol Gillie: I will describe the process that we go through in the Borders to give you a flavour of

how we arrived at what I call the efficiency programme.

The numbers that the committee has in front of it involve about 30 different projects. We are talking about lots of little projects rather than one large project. We identify those projects by looking at national programmes such as QUEST, which I mentioned, and by benchmarking our services and looking for areas in which there is room for improvement. We work at regional and national level to identify opportunities. We try to make more use of technology and, as Alan Gray said NHS Grampian does, we engage with our staff, patients and services.

As a result of all that engagement, we identify individual projects. Each project is approved by what we call the clinical strategy group, which is made up of clinicians, managers and partnerships. We get buy-in to the individual schemes. There are always risks associated with each of the schemes and, in our returns, we attach a risk rating to them.

In the Borders, we have focused on estate rationalisation and have set ourselves the challenging target of reducing our estate by 20 per cent. That is partially linked to some of the challenges that we faced on capital, but it is also about reducing our revenue running costs. To take that forward, we did a space utilisation exercise and looked at our underutilised accommodation. We have relocated services and linked accommodation to working practices. A community-based service needs less accommodation than an office-based service.

We have set our non-clinical services—our backroom services—a 20 per cent challenge. We want them to use technology to streamline their processes and to make use of the functionality of their systems. A result of that will be a reduction in the costs associated with some of our non-clinical services.

That gives you a flavour of how we get buy-in to individual projects.

10:45

Gerry O'Brien: We go through a similar process in Orkney. If you look at our workforce plan, you will see that the staffing numbers for NHS Orkney will be broadly the same in March 2015 as they are today. However, if you delve down into that, you will see quite a few changes in the composition of the workforce. For instance, as we said earlier, we are recruiting additional radiographers to man our CT scanner and additional nurses for our outreach service within the acute sector, and we are increasing our medical workforce. The numbers in all those areas will go up; therefore, given that the numbers will remain broadly static, the numbers in other areas must come down.

Part of our drive is in looking at what we have called our shared services. I will give you a good example of that. We used to have a laboratory manager on island, but they have now left us and we have entered an arrangement with Shetland to share a laboratory manager and a quality manager. On rough headcount, I am down by one but I have exactly the same service coming into the laboratory—in fact, I have an increased service in terms of quality management.

A big piece of work this year is looking at staff numbers in all our estates and facilities—by facilities staff, I mean the domestics, the porters and the catering staff. We are looking at those areas in conjunction with our HR colleagues and we are about to engage with our area partnership colleagues in preparation for the new hospital that is coming along in four years' time. We are moving towards having generic workers. No longer will we have dedicated porters, domestics and estate staff; instead, we will look for generic workers who can swap between all three of those roles. In a rough headcount, we will probably end up with five or six fewer members of staff. At the moment, we have eight porters, 10 estate staff and about 28 domestics, and I will probably end up with five or six fewer staff at the end of the period. However, as Alan Gray said, that reduction will be achieved through turnover—as people leave the system, we will not replace them. That will allow us to reinvest in other areas.

We are looking at a range of other areas, and we are using the national workforce tools to ensure that our staffing levels are appropriate in all clinical areas. This year, we need to do a lot more work on our rostering systems—we are probably a bit behind the times on the technology—to ensure that we do not have duplication or overlap on shifts and that the shifts start at the optimal times both for the delivery of the services and from a finance point of view.

A big focus for us this year has been the use of locums going into 2014-15. My financial plan allows for a particular recruitment pattern and, as a consequence of that, we will have to use locums to fill the gaps. A big area for us will then be to try to accelerate that recruitment in order to minimise the expenditure on locums. Similar to the Borders, we have about 20 to 25 schemes and—to pick up on the convener's point—some of those will end in our not recruiting to vacant posts in the system.

Overall, our headcount will remain broadly similar between April 2014 and April 2015, but you will see quite a different skills mix if you drill down into it.

The Convener: I think that that answers the question about NHS Orkney being the only health board that is not planning efficiencies through its workforce. Planning efficiencies through the workforce is opportunistic; it is not necessarily planning, is it? An opportunity might come up because someone is leaving, but that is not seeking an opportunity for change in delivery. You cannot say, "We would like to change that department there" or "We would like to lay people off." You have a no compulsory redundancies arrangement in place.

Carol Gillie: A workforce assessment is done for each of the individual projects to which I referred, and from that we can quantify the workforce impact. As Gerry O'Brien said, it is not about reducing the workforce, because there are areas of potential service development and investment. Our workforce plan covers reductions in staffing linked to efficiency and it covers increases in staffing linked to service development or redesign. We have to bring the two elements together, and our workforce plan does that.

Paul James: On whether this is planning or opportunism, I think that, on the whole, it is planning. There will be some opportunism; for example, when people leave, others take the opportunity to redesign the workforce. However, the vast majority of the project initiation documents and business cases that I receive for the savings that I look at refer to skill-mix changes, which have actually been planned. We have created about 500 jobs at the new hospital, and last year we made a conscious investment in nursing to reflect planned changes in nursing ratios. There is much more planning than opportunism. I do not think that it is a case of one or the other, but I point out that a number of significant aspects have been planned, and I have just given a couple of examples of the new jobs that have been created.

The Convener: We need to move on, but you suggested that turnover is the big factor with regard to efficiencies. There is a difference between workforce planning and development, which do not seek to achieve any of the efficiencies that are described in the budget, and attempts to achieve efficiencies through staffing levels.

Paul James: I apologise if I have misled the committee, convener. The 6 per cent turnover figure enables us to achieve those planned savings; it does not drive them. If there is an intention to redesign a particular part of our workforce, such a redesign will be achievable without redundancies because of our staff turnover. That was my point. I apologise if I did not express it very clearly.

Dr Simpson: Perhaps I can clarify things, convener. I have experienced this personally at the Beatson west of Scotland cancer centre, where a redesign of the daycare service resulted in redeployment of 10 staff. If someone leaves, there is an opportunity to redeploy staff in the redesign of another service.

The fundamental point, however, is that the whole service in Scotland experienced a really quite abrupt decline in the number of nursing posts. At one point the reduction reached 2,500, and we expressed considerable concern about that. The reduction is now back down to 500—in other words, the level of nursing staff went down and has come back up again. It is quite difficult to see how that was part of a planned operation, so I would be interested to hear your comments on that. The significant decline in posts that happened in almost every health board were actual losses to the workforce that seemed to be part of an efficiency drive or budget reduction plan. However, they have, I am glad to say, been substantially reversed.

Paul James: I do not think that any of us can make much of a useful contribution to this discussion. You are correct to observe that numbers went down and are now, in a sense, going up, but it is just not correct to say that the move was not planned. All the directors and managers with whom we engage in the budgetary process have produced the plans, and the fact that they have reversed the fall does not necessarily mean that staff have been reintroduced in the same place. You yourself gave the example of the service redesign at the Beatson centre, Dr Simpson. Lots of such redesigns go on; some of them require more staff and some require fewer. It should, of course, be put in the context of the overall financial challenge, but I do not think that it is fair to say that it shows that no planning is going on. The majority of my directors and managers would strongly object to such a suggestion.

The Convener: Is there some kind of optimum planning that you can undertake? Those 2,500 nurses presented you with an opportunity when they volunteered for redundancy and were paid redundancy and pension packages. However, it just seems like you are taking the long way round. You can make a virtue out of it now by saying that those nurses are not necessarily back where they were, but is there not a better way of doing this than making a lot of people redundant and sending them out one door, only for them to come back in through another door to be put in a different ward or in the community, which is what is happening?

Paul James: I see that you are looking at me, convener—

The Convener: I am looking at you.

Paul James: All I can say is that the health service in Scotland is undergoing redesign. There have been many initiatives, some large and some small, and they involve staffing changes. I honestly do not think that you can draw the conclusion that there has been a lack of planning. The reality is that major redesigns are going on all over the place, and what you see in our budgets is a small reflection of that. I just do not link the two things. I accept that staff numbers have gone down and that they are now going up a bit. That is certainly my experience—

Dr Simpson: We are talking about what was a 5 per cent reduction. It was strange that we had such a sudden reduction followed by an increase. I am, of course, delighted with the subsequent increase and I am sure that the nurses are now in different posts, but I find it strange that three years ago you planned on the basis of saving 2,500 nursing salaries and now you have had to increase staffing levels again. I just do not follow the planning mechanism by which 2,500 posts were taken away. I might add that those posts were not immediately replaced with other posts in newly designed services, which is what is now happening.

Aileen McLeod (South Scotland) (SNP): The discussion has probably moved on, because the supplementary that I wanted to ask Alan Gray was on the extent to which NHS Grampian is using the mandatory workforce planning tool to ensure that it has the appropriate staff with the right skills mix in the right place at the right time.

Alan Gray: With our nursing workforce, we ask the lead nurses in each of the sectors to tell us what the predictive tools say about the nursing resource that they will require to manage the services that they deliver. Given the gap between what the tools say and what the nurses say, there is then a second exercise to set out the immediate priorities. Part of the reason for using the workforce tools is that they help with our professional judgments; we are going through an iterative process of reviewing the challenges with nurses in each of the sectors, with a view to making some changes in the nursing workforce over the next year. The board is due to meet at the end of the summer to look at the outputs of that process and, informed by the workforce tools, to make some decisions about further investment in the nursing workforce. We will not be able to match the full resource that will be required, but we will certainly be able to work more to plan over the next few years as we receive additional NRAC moneys, which we will use as best we can to address service gaps, one of which is in our nursing resource.

Aileen McLeod: That was very helpful.

The question that I really wanted to ask was about preventative spend and the potential savings that you expect to make from the various initiatives and projects in your preventative health programmes. I am keen to know more about the extent to which the boards are assessing potential long-term savings from preventative spend; about modelling work that you might be looking to carry out, perhaps in collaboration with others, to help with that assessment and future financial planning; and about progress that you can make in capturing the impact on performance of preventative actions.

I note from the responses that we have received from the boards that there appear to be some difficulties in modelling the savings with any degree of precision, and reference has been made to the potential usefulness of national work in this area. For example, in its response, NHS Borders has mentioned the possibility of using the Scottish public health network or some other appropriate collaboration. I would welcome comments on those points.

Paul James: We have said in our submission that the expectation in our 2014-15 financial plan is that we will not make many savings from preventative spend. We said the same last year, and I think that we will say the same next year. The reality is that we make investments in certain aspects of preventative spend. Earlier, I mentioned the hep C drug, sofosbuvir. Given that it is a cure, buying it is clearly preventative spend, but do we know the savings that will result from that investment and when they will occur? We do not, and we have not made any significant attempt to reflect those savings in the plan. After all, if I were to put those savings in the plan, I would have to say that I could reduce the number of acute beds that I need, or the number of prescriptions that I would expect general practitioners to issue in the future. I simply do not expect reductions in those things in the near future.

That may be because there is a demographic challenge. It may be that all that I am doing with preventative spend is stemming growth that I would otherwise find very difficult to handle. I always struggle with that question. I know that the committee likes that question, but that is the reality of our financial plan. It would have been unwise of me to have reduced my budgets to reflect any savings that are coming in. We see a level of demand and we spend all the money that we get on meeting that demand—and we would like some more, please. However, it does not feel true to me to say that we can just reduce our budgets because we are spending money on sofosbuvir, anti-smoking action and so on. That may not be what the committee would like to hear, but it is an honest answer.

11:00

Alan Gray: I agree. We recognise the importance of taking action to prevent long-term and chronic illnesses within the population. It is something that we will certainly have to do if we are to manage the demographic challenge that we face. The challenge that we face, as financial professionals, is to put that budget-setting process in the context of savings, reduction in budgets and reconfiguration of services.

We want preventative measures to be an integral part of all health service interactions, whether the interaction is a GP visit, a hospital visit or activity in our schools. There should be a concerted effort to educate and assist people to manage their care in the longer term, but it is difficult for us to predict how we can reflect that in a budget. I suspect that further work could be done on modelling what could be achieved over a long period, but we are a bit away from reflecting that in a five-year plan. It is an important point that we must address, but it is difficult for us to address it as part of our budget-setting process.

Carol Gillie: I was the one who mentioned preventative spend, so I should come in here. I absolutely agree with my colleagues. We try, so that we know that we are having success, to measure the success of preventative spend by outcomes that we can measure, including increased breastfeeding rates, immunisation uptakes and so on. As Alan Gray said, that very much links to the healthier population that will, potentially, help us to deal with the demographic challenge that we face.

I support progressing the modelling that colleagues have mentioned, although to be honest, NHS Borders does not really have the capacity or skills for that. However, there is a real opportunity; modelling would not only tell us about outcomes in the longer term but might inform how we design our services and the treatments that we have to give, based on preventative spend and in relation to changing referral patterns in the future. I would welcome such modelling, but it would need to be done nationally.

Gerry O'Brien: I probably do not have much to add to what my three colleagues have said. Carol Gillie mentioned the QUEST, which I think stands for quality and efficiency support team. The QUEST has recently established the health economics network, to which I think all the boards have signed up.

I have discussions with my director of public health and we are in the same situation as Carol Gillie. If I am being absolutely honest, we do not have the internal capacity or skills to do the modelling that is required to assess the impact of preventative spend.

In Orkney, we have a particular issue with alcohol-related admissions. We do a lot of work through our local drug and alcohol partnership and with the third sector, and we put a lot of preventative measures in place. Could I sit here today and tell you how many bed days of admissions that has prevented? No, I could not. However, we need to get to that sort of understanding. I totally agree with Paul James; even if I could come up with a figure—100, 200 or 300 days—I do not think that that would ever lead me to the point at which I could say that I can now take a bed out of the acute system. What I would actually say is that it would give us an opportunity to replace the treatment for which that bed is being used at the moment with another treatment.

As Carol Gillie said, the important point is that we have to understand all the flows through the system. From a purely financial point of view, however, I do not think that we are even close to the point at which we can start planning financially for the impacts of preventative spend. That point has to come, though.

Bob Doris: Aileen McLeod might have to some extent mopped up, in her supplementary, this question about the workforce planning tool. It follows Dr Simpson's questions on budgets and trends in nursing numbers over the years. Can I get an assurance that the workforce planning tool, the emerging workload management tool and the bed management tool—which have been agreed in partnership with unions and Government—are used and followed, and that the budgets that you then set are underpinned by the outcomes of use of those planning tools?

Rather than debate nursing numbers three years ago versus numbers two years ago or one year ago, I want to be sure that when you are planning your staff headcount, you are using the agreed planning tools to inform that planning. I agree with Paul James that there will undoubtedly have been planning in previous years, but perhaps not enough careful consideration was given to it in the process. The new planning tools change the landscape in which you make the clinical, infrastructure and budgetary decisions for which you are responsible. Do you actively use those planning tools and have they changed how you do your planning?

Carol Gillie: My director of nursing uses the nursing workforce planning tools. I know that new tools that cover different areas continue to come out, but we do that exercise annually. Other tools that you mentioned are just emerging, so I cannot comment on them at this point. Certainly, from the nursing perspective, the workforce planning tools are used and we build the results in to our local delivery plan.

Gerry O'Brien: I agree. We, too, use the nursing workforce planning tools annually. In the past weeks, we have run the small wards tool. We have a quirk in Orkney in that we have neither a medical ward nor a surgical ward—we have a combination—so we have to work around that. Output from planning tools goes through our area partnership forum and underpins all our budget-setting exercises.

Paul James: I agree with my colleagues. The nursing workforce planning tools are more advanced than the other tools and are in current use. As I mentioned earlier, we made an investment last year in nursing and that has continued because of the expectation about nursing ratios, using the nursing tools. That is all under the control of our nursing director. The planning tools do, indeed, impact on our financial plan.

Bob Doris: I am sure that the situation is similar in NHS Grampian.

Alan Gray: Yes. I spoke about the workforce planning tools in response to Aileen McLeod's earlier question, so I will leave it at that, if that is okay.

The Convener: A couple of issues are on our horizon in relation to the integration of health and social care, the change fund and the integration model.

I will throw a cat among the pigeons. You may have heard that the Convention of Scottish Local Authorities wants to cap your budget a wee bit and take a bit of it because—I will act the role of COSLA to see whether I can get a reaction from the directors of finance from the health boards—you are not handing over any share of that budget and you do not share the vision of delivering the services.

However, there is buy-in right across the board on the need to deliver more services in the community, and there is a frustration, which has been expressed very strongly by COSLA, around how we are going to make that happen and how we are going to share it and get that integration going. What are your views on that?

Paul James: We have a meeting in Glasgow involving the six local council directors of finance, me and a few other colleagues; a lot of work is going on with regard to integration. On finance, in some councils there is an expectation that there will be a significant shift of money from the acute sector into the community sector. I am not convinced that we know whether that will happen yet, because problems such as delayed discharges and the problems around them have to be solved because they clog up acute capacity and therefore incur cost. We also have to consider the average length of stay within the acute sector and whether that will be reduced as a result of shifting people through the system more quickly and then back into the community, where they need the appropriate care.

We have yet to see whether there will in the acute sector be meaningful reductions in cash terms that can be transferred to the community. Under integration, people will consider whether it would be more efficient to provide commonly the community health services and social care services that have come from the partner councils and health boards. Integration helps us to achieve that.

There are three parts to that equation: the acute bit, the community health bit and the social care bit. Putting the community health and social care bits under one chief officer in one health and social care partnership means that we can expect redesigns to come through in future years.

The shift in demographics that I mentioned earlier hits all three parts of the equation. If we expect increasing numbers of people to live longer and, therefore, to require community health services, social care and acute care, one part of the equation will be substantially reduced in order to shift the funding around. I am not sure that we are yet clear about that. I know that it is part of the agenda, but merely to stem the increase in acute care would be a real achievement. For the health and social care partnerships to take on their responsibilities for delayed discharges in particular, and ensure that we are able to get people into the community in the right setting would be a real achievement.

The Convener: So, you are suggesting that any extra money is in that area and that integration can be achieved through efficiencies in the delivery of local government services.

Paul James: I am saying that, if we combine community health and social care—forgetting the acute sector for the moment—and run the service as one team of people addressing the needs of the community, efficiencies should emerge. How do we do that? We have not seen the plans, but at the moment that work already takes place in our community health and care partnerships, which are already integrated, and I think that it will continue to take place under further integration. However, it is right to consider the needs of the population across the piece and to ask how to integrate the pathway and the demand on it and to ensure that we have a cross-system perspective on the matter.

The Convener: Local government representatives say that they need the efficiencies that they are creating now just to maintain their services because, unlike the health service

budget, the local government budget is not protected.

Paul James: I do not disagree with you. I am sure that colleagues around the table will share the view that we are all under financial constraints. It is a challenging time for us. There is austerity throughout the United Kingdom, which affects councils and health boards. You are right that councils seem to have borne a larger brunt of it in percentage terms, but there is no doubt that we are all under financial constraints. I have tried to describe some of the future issues, but I cannot get away from the constraints that we are under; that is just the economic reality of the world that we are in.

Alan Gray: The important thing on integration is the strategic plan. We need that plan, and the coming together of health and social care gives us a great opportunity to produce it together.

There are things that we can do almost immediately on the better integration of services, not only between health and social care but between our primary and secondary care services. There is no doubt that we can make some early moves towards efficiencies and benefits, but we need to bring the plan together and it will take a bit of time to do that. The plan will set out how we can transform our service delivery, which has the potential to release capacity from the acute hospitals, but it does not currently exist in a form that would give us confidence that that resource can be released quickly.

There is no doubt that, over time, we will have to invest differently and to think about how to reconfigure services—we might need to provide more in the community—but we need to do that together. For me, integration offers a great opportunity to come together and plan jointly. Health and local government both face difficult financial circumstances. We always predicted that, as we went towards 2015-16 and 2016-17, we would all start to feel that the situation was very difficult. Health will feel that it is difficult in those two years, but that does not mean that we should stop.

The integration agenda is about coming together, developing a mutual understanding of one another's position and having a real focus on making integration happen. It is about supporting the people on the ground in delivering services, because they want some help in bringing things together. We can make a lot of progress without necessarily shifting resource through better integration. That is the theme for me: it is about how to bring the integration agenda together.

In the end, we will consider how to change the configuration of services in the long term and how the resource should then be deployed. Those are my thoughts on what health and social care integration offers, both immediately and in the long term.

11:15

Carol Gillie: I have nothing to add to that, other than to say that health and social care integration is an opportunity and that we are just at the start of the process.

Dr Simpson: Today, there are 837 beds blocked because of delayed discharges and the number of occupied bed days is something like a third of a million. Those are big figures. Council budgets are indeed under greater stress, because they have had no protection and no increase. Councils are expected to take that up with the new four-week and two-week targets that are coming in. I fail to see how they can do that. I should declare an interest: my wife is in charge of health and social care in a council, and she does not see how in heaven's name it can begin to deal with that with a budget that is being cut—although Stirling Council has dealt with it.

I have a question about the use of planning tools in relation to health and social care integration. Since 2009, we have had the integrated resource framework or IRF. I am surprised that that is not publicly—or, at least, not widely—known. It allows people to do benchmarking in relation to how much they are spending on care homes, GP prescribing, hospital prescribing and readmissions. It allows them to benchmark against the data for Scottish patients at risk of readmission and admission—the SPARRA data—and so on.

The IRF is a fairly simple framework that each community health and social care partnership in each local authority must have available in order to plan. Do they all have them? Does each of the Glasgow CHSCPs that are about to come into being—or the shadow partnerships—have that data? Does each of the boards provide that data? The data comes to the board, not to the council. Is the framework a useful tool?

Paul James: I will answer for Glasgow. Yes, the partnerships all have access to that data. There is work to be done on developing the data and on understanding useful benchmarks, particularly on community health activity. We tend to have more useful benchmarking on the acute side than we do on the community side. The partnerships have access to the data, but there is room for improvement in the data as we proceed with integration. ISD is fully aware of that and is trying to develop that database so that we get more meaningful information to support planning.

Alan Gray: The IRF data is a great start, although we have some further work to do to build

confidence in it. It is at a very high level. It is very helpful in allowing us to consider spend, for instance by GP practices on various services. It is a useful starting point—in that respect, it is great—but we need to start to use it. That is the key thing; we have not used it together. As we come together on the joint strategic plans, which we will need to have in place as we start off with the new integrated arrangements, that data will have to form part of the information that informs where we could potentially make changes and how that could be transacted through a service change process.

Carol Gillie: In the Borders, we have an integrated resource framework model, which is run jointly by the local authority and ourselves. Both organisations have access to that data. We have been working to improve the quality of the data, particularly with regard to some of the community information.

To date, we have used the IRF for information sharing across the two organisations. It has also been used for some of the change fund projects. It is coming to the fore, particularly in relation to the strategic plan that we are writing jointly as part of the health and social care integration process. We have developed the IRF, although there is more to do. We are picking that up as we proceed with the integration agenda.

Gerry O'Brien: In Orkney, we obviously have only one partnership, so the data is available but, as Carol Gillie said has been done in the Borders, we have used some of the change fund money over the past three years to create a post that is dedicated to the partnership. The person in that post is responsible for collecting and validating both council and health data. I appreciate that we have further to go, but we are using the available data for planning purposes, and that will underpin the development of the strategic plan—which I agree with Alan Gray is key—over the summer months, so that we can move forward on that agenda.

The Convener: I have a final question on the NRAC formula, as we have representatives from NHS Greater Glasgow and Clyde and NHS Grampian here. Do you have any comments on the robustness of the model, the assessments that have been made or the balance of need? I think that Alan Gray is tempted to answer.

Alan Gray: We have accepted the NRAC formula as the current basis for allocating resource within the health system in Scotland. It has a population base that is adjusted for morbidity life circumstances. NHS Grampian is probably the board that is furthest away from NRAC parity, although we have now agreed a three-year plan to move to within 1 per cent of parity by 2016-17, assuming that our population does not continue to rise. At the beginning of the year, we found ourselves £35 million under NRAC parity.

The double challenge that we face in Grampian is that, even when we get to parity, we will not get funded at the same level as other areas, because of the healthy state of our population. The population of Grampian makes up 10.7 per cent of the population of Scotland, but when we are at NRAC parity, we will get 9.7 per cent of the resource, so Grampian's overall allocation will be less than the percentage of the population when it is adjusted for morbidity life circumstances.

We have accepted the NRAC formula and are working closely on the plan for the next three years, and at least we now have certainty about the NRAC additional moneys that we will get over that period. However, that presents a challenge for the board in continuing to manage all the requirements of service delivery with a resource that is less than the NRAC sum that we are entitled to under the formula.

We face that significant challenge every year, which means that we have difficult choices to make about what we can and cannot do. The level of efficiencies that we have had to achieve has probably been higher than the level that most boards in Scotland have had to achieve because of that relative funding position.

The Convener: Is the balance between population and need the correct one?

Alan Gray: It is difficult to say whether a healthier population requires less healthcare. One could argue that a healthier population has similar demands, or different demands. The healthy state of our population means that people could probably go through fairly aggressive forms of cancer treatment, for example. A more middle-class population will also access services in a different way, so I am not sure about the link with the NRAC morbidity life circumstances calculation or about whether our needs are less than those of any other board in Scotland, but that is the situation that we have to work in.

We have agreed to the NRAC formula and we are working with it. The formula can be adjusted and is subject to regular review and refinement, and that has had some benefits for Grampian. A remote and rural factor was added in, which was advantageous to us, as it recognised that in Grampian and other more rural board areas there was a higher cost linked to remote and rural working. The NRAC formula has some flexibility and I am part of the group that reviews it regularly, so I know that it has the potential to be adjusted over time to reflect changes.

The Convener: Is that a formal adjustment or is it an on-going process?

Alan Gray: It is an on-going process. The formula is rerun to get to parity; you cannot suddenly move to a different position.

The Convener: Mr James, you said that 40 per cent of those with hepatitis C are in the Greater Glasgow and Clyde area. I presume that we could predict that a majority of the cancers and strokes in Scotland are also in that area. Do you feel that the formula as it is currently structured meets the needs of Greater Glasgow and Clyde?

Paul James: The group that Alan Gray referred to is the technical advisory group for resource allocation, which I sit on along with others, and the formula is indeed dynamic. It is rerun occasionally, and the major influence on it is population, so if the population is wrong, the formula comes out with a different answer. Population data is based on the census, and the census mid-year estimates are updated by the National Records of Scotland. We found that there was a significant shift from the last mid-year estimate of the previous census to the 2011 census.

As a result of that, the notional allocations of funding for boards changed. Ours changed by about £20 million. I do not know the figures for the other boards, but they all changed. The notional allocation for NHS Lothian changed quite significantly. The distance from parity, or the amount of funding that we get compared with the notional allocation that comes out of the NRAC formula, shifted because of the census. It is always possible to criticise a population-based formula because, at its heart, it relies on population figures and, if those population figures shift, the funding that we would all expect to get also shifts.

The formula may suffer from that flaw, but can you think of a better model? We have to find some way of funding the boards, so there is a level of acceptance of the formula. Does it reflect such things as the risk share that was referred to earlier in relation to sofosbuvir? No, I do not think that it is responsive enough to do that quickly when a new drug comes out. The funding plans for boards are usually published fairly well in advance, and we can normally predict where we are and know where we stand, but the formula cannot respond quickly, so we need to find other mechanisms to deal with such issues.

A risk-sharing arrangement, to which the chief executives of health boards sign up, as in that example, seems to me to be the right approach to dealing with such cases. A board might get its 25 per cent share of the funding, but it might have to bear 40 per cent of the costs of a particular treatment, so the 15 per cent surplus could be shared out. It is necessary to have a combination of funding mechanisms. Some, such as NRAC, are long term, and some are more short term, to deal with things such as the risk share requirements.

The age/sex distribution probably works reasonably well, because I assume that it is based on known population numbers, but do the excess costs of supply adjustment and the morbidity life circumstances adjustment work well? We would probably say that the excess costs of supply adjustment should pick up the sofosbuvir costs, but it is longer term, so it does not. The formula is good for what it does, but we will never get it dead right and arguing to the nearest penny on a funding formula has got to be a mistake. I would say that we need alternative mechanisms to deal with risk share problems such as those that have been mentioned.

The Convener: Thank you for the time that you have given us this morning and for engaging with the committee. We appreciate your attendance.

11:28

Meeting suspended.

11:33

On resuming—

Teenage Pregnancy Inquiry

The Convener: Agenda item 3 is the committee's inquiry into teenage pregnancy. Members will recall that the committee published its report on the subject in June last year and we received the Scottish Government's response in September.

I welcome Michael Matheson, the Minister for Public Health; Felicity Sung, national co-ordinator: sexual health and HIV; Gareth Brown, head of the blood, organ donation and sexual health team—[*Interruption*.] I am sorry; my script says that we are joined by Gareth Brown, but he is at the back of the room. We can call on him if we need to. We are also joined by Colin Spivey, team leader in the Scottish Government's learning directorate. Welcome to you all.

I invite the minister to make a short opening statement.

The Minister for Public Health (Michael Matheson): Thank you, convener.

I take the opportunity to welcome the committee's efforts to highlight teenage pregnancy as an area of further focus. I appreciate the recommendations that the committee made in its wide-ranging report and would like our dialogue in this area to continue. It is important that the committee is engaged in the work that we are doing on teenage pregnancy across government, most notably through the teenage pregnancy and young parents strategy.

The data shows us that rates of teenage pregnancy have reduced in all age groups over the past four years. As I mentioned when I gave evidence to the committee previously, that is a significant achievement, and I would like to pay tribute to those who have worked tirelessly to support our young people and thus achieve such results.

In the light of that reduction, some people might ask why we need a teenage pregnancy and young parents strategy. The improvements that have been made in sexual health have had a major impact on unintended pregnancy among young people. That will continue to be a priority and an area of investment under our sexual health and blood-borne viruses framework but, as the committee rightly acknowledged, it is the wider determinants and interventions to which we now need to turn our attention.

A great deal of good work is already being done in that area, as is made clear in the evidence that was submitted to the committee. Some of the work that we need to do will involve bringing those elements of best practice together. That is true in relation to policy and to the work that is being done across local government, NHS boards and the third sector. We are delighted that Professor John Frank of the Scottish collaboration for public health research and policy has agreed to chair the strategy's steering group. His vast experience will be invaluable, particularly in looking at the wider determinants associated with teenage pregnancy and health inequality.

We intend that the strategy will focus on three key aims: to continue to reduce rates of teenage pregnancy; to respond to and support young women who become pregnant; and to support positive outcomes for young parents. We do not underestimate the breadth of work that that represents, but we are confident that the partners on our steering group provide the range of expertise and enthusiasm that is needed to take forward the strategy effectively and positively.

I am more than happy to respond to any points that the committee wishes to raise.

The Convener: Thank you, minister. Bob Doris has the first question.

Bob Doris: When we carried out our teenage pregnancy inquiry, we visited Smithycroft secondary school in Glasgow. One thing that struck me was the positive contribution that the young mothers unit there makes not just to the lives of the children and the mothers in the unit, because there is a wider benefit for the whole school.

I mention that for two reasons. Depending on where someone is in the country, such provision might not be available. Does the Scottish Government have a feel for the extent to which local authorities should provide such high-quality specialist units instead of—for want of a better description—mainstreaming provision for teenage mums in secondary schools?

My experience is that young mothers who have been through the process are among the best informed about developing a sexual health and relationships strategy, so I will sneak in a second question. What role do young mothers who have been through the life experience of falling pregnant and getting on with the job of being a mum while being a teenager have to play in informing a sexual health and relationships strategy?

Michael Matheson: As a number of committee members did, I visited Smithycroft secondary school in Glasgow, which is based in the east end but supports young mums from different parts of the city. I was very impressed by the quality of the work that it does and the intensity of the programme that it undertakes with young mums.

As we discussed the last time that I gave evidence to the committee, our approach is to consider how we can not only build on the work that we have done to reduce unintended pregnancies among teenagers but support young parenting for those young women who become parents, who we know can face certain barriers in accessing services. We want to look at what we can do to ensure that our colleagues in local authorities who are working with us in this area do that much more effectively, and the approach that has been taken at Smithycroft is a very good model. One aspect of developing the new strategy lies in determining how we can build on the types of things that we can learn from Smithycroft and use them in different local authority areas.

Although the steering group will decide what will be in the strategy, we do not intend to propose one model that must be applied across all local authority areas—we want to allow for flexibility. There are key principles around the services that should be made available, and those principles should underpin how services are designed at a local level.

The new strategy is intended to work on the good progress that we have made around reducing unintended teenage pregnancies and consider what further measures should underpin the work that is carried out at a local level by local authorities, health boards and third sector colleagues to support young women who become parents.

We know about certain factors around that. A key aspect of the approach taken at Smithycroft involves maintaining young women in education. There had been a tendency for young women who became pregnant while still of school age to drop out of education, and there are consequences from that. If we can provide those young women with the right type of support at that point, so that they can make a positive choice and can go on to a positive destination, that not only helps the young mother, it improves the outcomes for the child.

It is not a question of using one particular model, but the Smithycroft model highlights the good principles that should underpin the delivery of services for young parents.

Bob Doris: I agree with that. I had written down "flexibility and choice at a local level". Smithycroft is clearly an excellent example of where a local authority has got the planning of support services for teenage mothers right. The school is excellent at promoting positive parenting with the children.

I asked how the experiences of mothers could be fed into any refreshed strategy. Previously, there was a lot of talk about the fact that relationship education in the very early years—at primary school—covers a variety of factors that can lead to people making either informed or uninformed choices later in life. The mothers whom we met love their children dearly and are making a wonderful success of parenthood. The point is to learn from what they think did or did not go wrong in their experience of not just education but their wider relationships, their interaction with local youth services and so on. If you are still thinking about it, that is great, but will there be a mechanism to feed in the direct experiences of teenage mums?

Michael Matheson: The steering group that Professor Frank is heading up has a range of individuals on it, including a representative from Smithycroft who is involved in delivery of the service, and they will use their experience to feed in directly to the group's work. The steering group will determine the best way to gather the evidence that it requires and who it will engage with; we are not prescribing that. However, we have put together a wide-ranging steering group to start the process that will take place over the coming months.

I have no doubt that the steering group will wish to engage directly with young parents. How that is facilitated is obviously a matter for the group. Once the group has drafted its paper, there will be a consultation exercise before any strategy is finalised. That will provide an opportunity for individuals to be involved. I am more than happy to consider how we in the Government, when we consult on the matter, can build into the process an opportunity for young mums who have experienced some of the services that are provided to comment on what is contained in the draft strategy.

As I say, one of the individuals who was involved in developing the Smithycroft project is involved in the steering group that will develop the new strategy.

Bob Doris: I will perhaps come back in later on but will let some of my colleagues in for some questions first.

11:45

Dr Simpson: First, I welcome John Frank's appointment. His is an excellent appointment, and I am sure that he will do a great job for the Government and for Scotland on this issue.

Minister, as you will know, one of the things that I carp on about is benchmarking and variation. In our report, we discussed trying to explore two things, one of which was having outcome data at a local level. When I visited Oldham on behalf of the committee, I was extremely impressed by the disaggregation of the data down to individual schools, which set those schools a challenge.

Some of them thought that they were doing extremely well until they saw their data, when they were horrified. The pressure, both from parent-teacher associations and the schools' governing boards meant that the schools developed policies and were very responsive to the local support that they were getting.

My first question is about the disaggregation of data and the localisation of target setting in respect of outcome data regarding teenage pregnancies or repeat pregnancies. Oldham was an interesting case. In the initial data, the figures were well below the average for England. The Government minister went there on a visit, caught the members of the local group when they were together and said, "Look, you've got a big problem here. We need to see you moving towards the average." Ways to support the area were explored, and Oldham moved up to the average. For an area with considerable deprivation, that was an exciting development.

What are you doing about disaggregating data, so that an individual school knows the challenges that it faces over time? What about the challenge faced by local authorities or the new health and social care partnerships in relation to outcome data for pregnancies and repeat pregnancies? There are other things to consider, including long-acting contraception. Oldham had to be measured against a whole series of measures.

Michael Matheson: One important aspect of the new strategy is that the work that is done under it is evidence based. The data plays a very important part. I will perhaps bring in Felicity Sung to explain a wee bit more about the work that we are doing around data. We are currently doing work to consider how we can disaggregate the data down to a much more localised level, and we are trying to manage some of the unintended consequences—issues around confidentiality—that could arise when the data is right down at the level of individual schools. That approach will allow us to focus much more on where we need to take action on particular issues.

It is important to utilise the data effectively and to learn from experience in other areas. In Lothian, for example, some work has been done to consider the history of young mums in school and how long they had not been attending school for. There was a clear pattern in when people's level of attendance at school dropped to a certain point. There was a clear link, albeit not directly causal. Once we have established or identified such issues in the data, we must ensure that they are acted upon, not only in Lothian but also in Glasgow, Dundee, Fife and other areas. Part of the work is to ensure that we get the data down to that level, and another part is to utilise the data.

I am keen for the new strategy to have targets that are set at a national level but which can be utilised at a local level. I am also keen for it to be outcome focused. Access to data is extremely important in that respect.

Felicity Sung can give you a wee bit of further information about some of the work that we are doing around disaggregating the data.

Felicity Sung (Scottish Government): One of the things that we are using to ensure that our strategy is based on the right outcomes and that we can measure those outcomes is a logic modelling process, whereby we consider the outcomes that we are working towards and the activities that we might undertake to achieve them. Part of the process involves considering what data we would need to measure and working out progress against achieving those outcomes. We are doing that piece of work at the moment. It is a really good piece of work, as it gets all the stakeholders involved in discussing what they want to achieve and how that could be measured, and what resources and tools are available to measure that data.

A further issue is identifying gaps and considering how we might look for the statistics or evidence that we need to measure those gaps. Therefore, it is not just a matter of measuring the things that we can measure, if you see what I mean.

Another part—once we have the statistics and we know what we want to measure—is about the level that we can take the data down to. As the minister says, we have to be careful about when data becomes disclosive and how we measure that process. However, I know that some areas, such as NHS Tayside and the local authorities that it works with, are already looking at data at school level and at community level, which is an extremely effective way of looking at local rates, outcomes and so on, so it is about using not only our modelling process but the experience of other areas that have already been effective in reducing local rates.

Dr Simpson: It might be worth while to make contact with Oldham and find out how the individual schools coped with the confidentiality issue that you have highlighted and managed not to create problems around that. The process seemed to work there—I do not know why it worked or how it worked. I acknowledge the dangers that you are talking about.

I have another question but I will come back in later with it.

Michael Matheson: We are more than happy to take away that particular point and look into it. Alison Hadley, the expert who was involved in the strategy in England, is a member of the steering

group and I imagine that she would have been involved in the Oldham work—either directly or indirectly—so we can flag that up to the steering group.

The Convener: On causal factors of teenage pregnancy, the minister referred—quite rightly—to the progress that has been made. The ISD figures that came out after the committee report show the significant drop in the teenage pregnancy rate in the under-16 age group between 2009 and 2010. The rate reduced from 7.1 per 1,000 to 5.7 per 1,000—from 616 pregnancies annually to 492—which surpassed the national target. Do we understand what happened in that period to lead to that dramatic reduction in the under-16 age group pregnancy rate? What lessons can be learned that can be applied in future?

Michael Matheson: As I am sure you will appreciate, there is no single factor. A whole range of factors can be highlighted over a number of years, because the teenage pregnancy figures have been on a downward trend for the past four-plus years. In part, the drop is due to some of the education work that has been taking place around positive destinations for young people. Advice on and access to contraception have also helped. The types of advice and support that are available in schools are another factor. All those factors contribute to the drop. Trying to isolate one particular factor is probably not possible; all of those are areas where there has been a much greater focus on this agenda and I have no doubt that they have played a part in the reduction in the figures.

The Convener: As a committee, we recognise the direction of travel over the years but that is quite a significant drop in a year, from 616 pregnancies annually to 492—from more than 7 per 1,000 to about 5 per 1,000. Something happened in that period. Has any work been carried out to find out whether something significant was going on during that period to give us that drop or should we expect falls such as that to continue? Should we expect the number of teenage pregnancies to fall by 100-odd next year? Is that the trend?

Michael Matheson: There is a downward trend but there was a step change in the period that you referred to. I am not aware of any specific work to look at why there was a particular drop over the course of that year, other than that it was part of that downward trend. The three areas that I mentioned are probably the main contributory factors.

Another element might be that when there is a slightly higher starting point, there can be such step changes when different policies are taken forward. Once we see such a reduction, the challenge is to sustain that to get the figure as low as we would want it to be. The figure has come from a slightly higher point and is getting lower, which is the direction that we want it to go in, but I cannot pinpoint for you an exact issue—

The Convener: The reduction took place between 2009 and 2010. Do we have updated figures that show that the positive trend is continuing at that level?

Michael Matheson: The next set of figures comes out on 24 June. Those figures will update us on the situation.

The Convener: Okay. Thank you.

Richard Lyle (Central Scotland) (SNP): I have two questions for the minister. I know that you have been asked before about the first issue that I will raise, which is about Roman Catholic schools, and that you have been considering the matter, so perhaps you can give me an answer. The committee drew the Scottish Government's attention to the dispute between NHS Greater Glasgow and Clyde and the Scottish Catholic Education Service. In response, the Scottish Government said that, following the enactment of the Marriage and Civil Partnerships (Scotland) Bill, it would engage with the SCES and the NHS sexual health promotion specialists network to refresh education circular 2/2001, which governs the conduct of sex education in schools. Can you update the committee on the outcome of the engagement? Has the dispute in Glasgow been resolved? What progress has been made on refreshing the circular following the enactment of the bill?

Michael Matheson: We have engaged with the Scottish Catholic Education Service and NHS Greater Glasgow and Clyde on the matter and the guidance has been revised. However, at this point differences remain between the SCES and NHS Greater Glasgow and Clyde. I will bring Colin Spivey in to expand a wee bit on the educational aspect.

It may be that some individuals in NHS Greater Glasgow and Clyde will not get to a point of agreement with the SCES on these matters. We must respect the fact that there is a difference of opinion between them on the matter. It is not for me to force the SCES to accept a particular viewpoint from NHS Greater Glasgow and Clyde. Some officials in NHS Greater Glasgow and Clyde believe that certain things should be provided in Catholic schools but the SCES does not agree with that position. However, we have engaged with both parties and have revised the guidance to try to address some of the issues. Does Colin Spivey want to go into more detail?

Colin Spivey (Scottish Government): Yes. I will update you on the revision of the guidance. We undertook a six-week engagement with

stakeholders on the draft guidance, which was available on the Scottish Government website and was sent out to key stakeholders. We received approximately 60 responses from national organisations and about 10 responses from individuals. The main issue that came out of the engagement exercise was about the parental right to withdraw children from specific sexual health lessons. Views on that issue were polarised between various organisations. On the basis of that engagement exercise and the comments on the draft guidance, we are close to having a revised document, which ministers will consider shortly. The intention is that we will issue the guidance before the end of the school year.

You referred to the specific issue involving the Scottish Catholic Education Service and Greater Glasgow and Clyde NHS Board. As the minister said, it has unfortunately not been possible for them to resolve their differences during the engagement process, although officials have met both parties as part of that process.

12:00

Richard Lyle: My other question is along the same lines; it is on sexual health and relationships education—SHRE.

The committee recommended that the Scottish Government should undertake a full review of the provision of SHRE in schools, but the Government rejected that call on the ground that reviews were carried out in 2008 and 2010. In its response to the committee's report, the Government stated that the reviews showed that provision and training were patchy. It went on to say that it believed that that was still likely to be the case, but that it did not believe that a further review of provision would add to the evidence base. It highlighted that it was a matter for local authorities and headteachers to decide what was provided in schools and what training was given to teachers.

Are you aware of any improvements in the consistency and quality of SHRE? Given the autonomy of local authorities on this matter, will the delivery of such education always be variable? What can be done to improve the consistency of what is being delivered?

Michael Matheson: Although another review has not been carried out, some of the guidance on how to conduct such education in schools has been revised. In addition, the educational material that is available to teachers has been updated. The code on the conduct of SHRE is there to help to achieve greater consistency in how such education is delivered in schools. Colin Spivey will be able to provide a bit more detail on the practical aspects of our work.

Given that two reviews have been carried out in the fairly recent past, we felt that a full review would not be appropriate at this point. The revision of the guidance on how to conduct SHRE should help us to address some of the inconsistencies, and the new material that is being provided should allow us to ensure that staff in schools have the material that they need to deliver such education. I invite Colin Spivey to talk about the process that was gone through.

Colin Spivey: There are a number of points to make. As the minister said, the code on the conduct of SHRE is in the process of being revised and we are very near to concluding that exercise.

It has become clear through the engagement process that there are still concerns about the consistency of what is being delivered. That is in line with the messages that we got from the 2008 and 2010 reviews. We recognise that there is a need to do something about that.

We believe that the revised code will be the jumping-off point for a relaunch of that facet of the curriculum. In particular, a package of the materials that are currently available will be launched at the same time as the revised code. Education Scotland will pull those materials together in a coherent package, which will be launched jointly with the revised code. In addition, Education Scotland is considering holding an event at the start of the next school year to focus on the issue.

More broadly, there is representation from the learning directorate on the strategy group that the minister mentioned and we expect the provision of educational materials to be a key factor in the group's considerations. It is also worth mentioning that, since the reviews in 2008 and 2010, the curriculum for excellence has been introduced and the SHRE materials have been revised and made available.

Richard Lyle: Thank you.

The Convener: It sounds as if the Government is very busy. The minister is not being attacked, because he has not been in his current job since 2008. I do not view the situation that Richard Lyle described as a disappointment to the committee; I think that there is agreement with the committee. In 2013, the committee found that the educational experience of young people was patchy. The Scottish Government found that it was patchy when it carried out reviews in 2010 and 2008, so we do not need another review. We all agree that the delivery has been patchy. Why has it taken since 2008 and the committee's inquiry into teenage pregnancy in 2013 to reach a point at which we all agree that the delivery of SHRE for

young people throughout Scotland is not what we would want it to be?

Michael Matheson: There were two different reviews. The 2008 review was on secondary school provision; the 2010 review was on primary school provision. The reviews dealt with different parts of the education system—

The Convener: I understand that; it may be what is in your brief, but Mr Spivey told us what both reviews found. The Scottish Government, which agreed with the committee in its response in September 2013, said that we did not need more reviews to add to what we know, which is that provision is patchy. There is no disagreement here and there can be no hiding behind one review as opposed to another. We had reviews in 2008 and 2010, and the committee reported in 2013. We all agree that provision is not good enough. Why has this taken since 2008?

Michael Matheson: I cannot comment on what happened in 2008, because I was not in my current post—

The Convener: I absolve you of all responsibility for that—

Michael Matheson: I do not know whether Colin Spivey was involved in the process. He might be able to comment on what happened in 2008.

Colin Spivey: I cannot comment on what happened in 2008, but I can say that it is not as if nothing has happened between 2008 and now. A number of things have happened. I referred to the review of health resources in education; and curriculum for excellence has been introduced. Curriculum for excellence is a key element. I know that the committee was concerned about whether the focus should be on relationships rather than biology; curriculum for excellence places high importance on relationships in the area of education that we are talking about.

There has been progress over the period. That might be reflected in the reduction in teenage pregnancy figures, which has been mentioned. However, it is quite right that we continue to listen to stakeholders, as we have done through the engagement exercise around the review of the guidance. Stakeholders and the committee tell us that provision is still patchy, and I have tried to indicate what we intend to do as our next steps on that.

The Convener: Yes, but when will any of that have an impact on young people in education, if the launch is in 2015?

Colin Spivey: Sorry, I am not sure—

The Convener: You had the committee's report in 2013, to which you responded. You are working through the situation, you have spent weeks and months bringing various groups together, and you expect to launch something more co-ordinated next year. Is that not what you said?

Colin Spivey: The guidance is being launched at the end of this school year. It will be launched by the end of June 2014.

The Convener: This year.

Michael Matheson: Yes, this year. You were perhaps referring to the strategy, convener, which will be launched next year. It is worth saying that the strategy will consider education and how to reinforce our approach in that regard. It is the strategy that will be launched in 2015.

The Convener: Right.

There has been less agreement about involving young people themselves. At the heart of Richard Lyle's question was young people's experiences of sex education—biology versus relationships, what is relevant and so on. The committee recommended that the Government seek young people's views, given that young people told us that they had not had a great experience—maybe it was ever thus. I do not think that the Scottish Government was in full agreement. It seemed to qualify how we would involve young people in relation to the types of services and education that they feel are relevant.

Michael Matheson: There might be a difference of views here. At committee, I suggested the possibility of auditing young people's views—if the committee felt that to be useful—on how sexual health and relationship services are offered in schools. The Government is considering how that can be taken forward in order to harness young people's views. We are very much with you on the matter.

The Convener: I am referring to the written response to the committee's report, which was perhaps less than enthusiastic. However, we might have moved on with you about how we might proceed.

Michael Matheson: I suggested auditing young people's views and the committee seemed quite supportive of that.

The Convener: How would you do that?

Michael Matheson: How, mechanically, would we do that?

The Convener: Yes.

Michael Matheson: I imagine that we would probably work with a third sector organisation, which would carry out that work for us, working with young people through a questionnaire and interview programme to get their opinions and

views. That would be fed into how we develop policy.

The Convener: When is that planned for?

Michael Matheson: We are taking forward that piece of work now; we are considering how to develop that further.

We are very much in favour of young people being able to inform and guide policy in this area, using their experience. An audit is a good way of going about that and finding out from young people exactly what their views are of what happens in school, what works, what does not work and what would help to improve matters.

The Convener: When will the information be available to the committee?

Michael Matheson: I do not think that we have a timeframe for when it will be available to the committee.

The Convener: Has the work been commissioned yet?

Michael Matheson: No, it has not been commissioned yet.

Gil Paterson: I will go in a slightly different direction. I am actually in favour of babies and pregnancy—that is where I am coming from. Just in case the *Daily Mail* says that I am in favour of young people and children engaging in sex, I had better say that that is not what I am saying—not at all, in fact. We should carefully and meaningfully educate children at all ages. That is my preference.

I was fairly taken on—the committee was fairly taken on—with Harry Burns, before we had taken any evidence. During evidence on another subject entirely Sir Harry explained how the pilot projects in family nurse partnerships were rolling out. Could you tell us how you see the family nurse partnerships engaging and what impact they are having on young people after a pregnancy, once the child is born? That is my first question.

The committee had the good fortune to meet some young women aged—I am guessing—16 to 18, who had had a baby and who had been supported. Unfortunately, there were no males there—it would have been interesting to hear what they had to say.

To reiterate my first question, what impact have the family nurse partnerships had? My second question is, how are family nurse partnerships being rolled out in this regard, throughout Scotland?

Michael Matheson: We have a commitment to rolling out family nurse partnerships to all the territorial boards. So far, the partnerships are in place in seven of those boards. Further roll-out is planned in another two. The following year, there will be roll-out in the other board areas. As far as the end point is concerned, we hope that all boards will be providing family nurse partnerships by 2015.

Like you, I have met some of the staff involved, as well as a range of parents, in different parts of the country. I was struck by how valuable they have found the input, given that the partnerships are for a specific group.

As far as some of the early family nurse partnerships are concerned, we are now at a point at which parents have graduated from the programme. Evidence has been gathered from their individual experiences, and that can help to inform how other family nurse partnerships in different health board areas can learn from that experience. Some boards have been ahead of the game in family nurse partnerships. In particular, Tayside, one of the first areas to have family nurse partnerships, has built up a considerable level of experience.

We can use that experience to inform other board areas that are developing family nurse partnerships. It is a positive way of working with young mums at an early stage in their pregnancy and through the two-year period, to support individual mothers and babies and to support families using other measures that can help them to enter education or employment or to tackle housing issues. By bringing together other services that can help, the family nurse is able to work in a collective way with people to guide and support them.

12:15

A randomised controlled trial of family nurse partnerships is currently taking place in England and it is due to report at the end of this year. That will be interesting, and once we have seen the outcomes from that trial we will consider how we should use that information to evaluate the progress that we have made in Scotland and what further work can be done around family nurse partnerships.

Family nurse partnerships are not the only model, but they have a positive contribution to make. There is a clear feeling among the parents and staff I have spoken to that those who have engaged in the programme have benefitted. It is also worth keeping it in mind that the level of retention in family nurse partnerships is good, in that we do not have lots of young mums and families dropping out. Remaining engaged is a key part of the programme and how effective it can be, and some of our health board areas have had a good experience of maintaining those levels of engagement.

Gil Paterson: Views have been expressed about the negative impact on the provision of health visiting services of recruiting nurses for the family nurse partnerships, which has left a gap and has taken resources away from health visiting services. What are your views on that? Can you clarify the situation?

Michael Matheson: Health boards must try to manage the roll-out at a pace that avoids or minimises the risk of that happening. We are also considering who can be a family nurse in a family nurse partnership, to see whether there is scope to extend the role further. Health visitors have often been attracted to that role, and we are now looking to see whether we can extend the range of individuals who could become a family nurse in a partnership. We are in discussions with those who are involved in the partnerships about how that can be achieved. The pace at which we roll out the programme is important to how we manage any change in staffing levels for health visitors and other nurses when staff choose to become family nurses.

Gil Paterson: Are there any worries or concerns in the background, or are you comfortable with the shape that the programme is taking and with the movement from one service to the other? Is it leaving a draught behind, or is it under control?

Michael Matheson: Short-term challenges will always be created. For example, if an experienced health visitor chooses to become a family nurse, simply recruiting another health visitor does not necessarily fill the gap because the experience is lost as well. There is always the potential for such changes to create short-term challenges in some areas, but getting the pace right allows the change to happen in a managed way. Rather than say, "You've got to have your family nurse partnership by next month, irrespective of the impact that that may have on your health visiting capacity," we must make the change in a managed way.

I am not naive about the fact that, if a health visitor of 20 years' experience chooses to move into a family nurse partnership and their post is filled by a health visitor who is newly qualified, it will be difficult for the new person to fill the gap because 20 years' experience has been lost. We need to manage the programme to avoid causing any local instability. It is important that health boards manage and plan it, and the programme is being rolled out over a number of years to allow that to happen.

Bob Doris: I return to SHRE in schools. In some schools, particularly secondary schools, such education might be delivered by a pastoral support or guidance teacher. In some schools, every teacher will be a front-line guidance teacher and will take on that pastoral responsibility. Therefore, there are various skill mixes, particularly in secondary schools, in the delivery of such education irrespective of the guidelines. In primary schools, the teachers that pupils get will provide such relationship advice.

I will focus on relationships again. An educationist might be exceptionally good at teaching physics, chemistry or history, but a different skill mix might be required to teach relationship advice in school. I appreciate that provision is sometimes patchy, but we need to drive up standards and build capacity among staff, and I would monitor that by asking Education Scotland to take a view on the quality of such education in schools. I am not suggesting that every school in the country should immediately have the inspectorate in to inspect SHRE—of course not. However, to get a flavour of the quality of the support that staff have been given to enable them to give effective relationship advice, Education Scotland might touch on the matter when it carries out routine inspections of schools in areas where there is a higher prevalence of teenage pregnancy and young mothers of school age. The committee will agree that relationship advice should include the clinical and biological aspects, as required, to enable the young people to make informed decisions. Your view on that would be helpful.

I also ask for your view on something else. As a former teacher, I think that teachers sometimes get a hard time. Young people have a variety of relationships in life and, for some of them, the most positive ones are not always at school. Those who are most at risk of having unplanned pregnancies are perhaps the ones who are disengaged from school. We need good-quality youth provision. In primary schools, we need early intervention and good relationship building. However, those who are most likely to have an unplanned pregnancy in secondary school might not engage particularly extensively with the school or their wider network but might engage with good-quality youth provision.

Has the Government given any thought to how we can identify the areas where young people are most at risk of having an unplanned pregnancy, to the need to bolster good-quality youth provision in communities—which includes funding—and to how we monitor and map out some of that?

I hope that that is a helpful question.

The Convener: Your job is done for you, minister.

Michael Matheson: There is quite a lot in there.

Bob Doris: Sorry about that.

Michael Matheson: I am sure that it is not lost on the committee that the subject is now called

relationships, sexual health and parenthood education and that the word “relationships” comes first in the title for specific purposes. I will bring Colin Spivey in on some of the specific issues. As we have highlighted, one of those is the materials that teachers have. The guidance and the code of conduct for teachers on the provision of that education are also extremely important.

Some teachers may be more given to that area of education than others, and it is important to have it delivered by good educators rather than by reluctant educators who are delivering it because they are forced to. How it is managed in an individual school setting and the leadership that is shown in its delivery in the school are extremely important.

Your point about the importance of youth work in the context of young people who have disengaged from education being at greater risk goes back to the point that Richard Simpson made about the use of data in this area. I have mentioned the work that we are doing to disaggregate the data. We want to continue that to a point at which we can pinpoint the existence of an issue much more effectively. Once we have identified that the rate of teenage pregnancy is higher in a particular area, we need to look at what is happening in that area and what action needs to be taken at a local level. Youth work is an aspect of that. We need to establish whether there is an issue with how education is delivered in a school or with how health, social work and other services are engaging with young people. Once we have that level of detailed data, we can consider the best approach to the issue and adopt a much more focused approach.

We might need input from education or health, or we might need to get third sector organisations involved. That would be determined on the basis of what was happening in the area in question. Youth work could be part of the solution. The availability of disaggregated data will allow us to develop a much more tailored response in places where there are particular issues and to adopt an evidence-based approach rather than just put in provision that we think might make a difference without knowing that it will. Such data will also allow us to evaluate and measure the impact of any actions that we take and to determine whether they result in a change over the following two to three years. That sustained input will be necessary. As Richard Simpson said, getting data at that level will be crucial in supporting such work locally.

That will require a multi-agency response. It will require a response from the health service, local authorities, the third sector and, in some cases, national Government. Your point is well made. The data will be key in unlocking the issue of where we need to take concerted action and what that action should be.

Colin Spivey is probably better placed to give you more detail of the materials that are available to teachers and the work that is being done with teachers to deliver such education in schools.

Colin Spivey: I will pick up on a number of issues. You mentioned the appropriateness of certain teachers delivering parts of the curriculum. I think that you mentioned physics teachers—

Bob Doris: I was not singling out physics teachers.

Colin Spivey: I understand the point that you were making.

One of the fundamental reasons why curriculum for excellence represents such a huge step in education is that, under it, health and wellbeing are the responsibility of everyone who is involved in learning. Physics teachers, guidance teachers, school catering staff and janitorial staff all have a responsibility for health and wellbeing, and a key part of that responsibility relates to relationships. Changing people’s mindset so that they take on that responsibility is a key aspect of delivering improvements in that area.

You mentioned the role of Education Scotland. The delivery of health and wellbeing is a core aspect that Education Scotland considers during each school inspection, and it is one of the elements that it reports back on. We might be able to pick up whether an opportunity exists to establish a closer link in the discussions that take place on the strategy, as Education Scotland is on the strategy group. That is an interesting and useful suggestion to pursue.

Delivery in schools is down to local authorities and schools themselves. That is consistent with our general approach to learning. I do not think that we would want to be prescriptive and say that a particular teacher with a particular responsibility in a particular area should deliver a particular provision. It often boils down to who is most comfortable and best placed to deliver the type of education that we are talking about, and I think that that is probably quite right.

12:30

Dr Simpson: I thank Gil Paterson for raising the issue of health visitors. You will remember, minister, that, in answer to a written question that I lodged, you estimated that, once we have rolled out family nurse partnerships, half of the 350 appointments to those partnerships will be health visitors. I made a freedom of information request to the health boards on the training of health visitors, and I am concerned that we will not be replacing them even with less experienced people.

I very much take your point that there will not be a like-for-like replacement.

When the workforce plans come out in June, will you be able to update us on that? I know that health visitor training is a matter for individual health boards. I am not convinced that they are considering replacement as they should be doing.

My question is a very short one on contraception. When we discussed the issue before, we raised a point about ulipristal acetate, the long-lasting emergency contraception. You indicated that you have a short-life expert working group looking into it, which is going to make a recommendation. Could you tell us where we are with that? It is now eight months since it was generally approved.

Michael Matheson: On your first point, the cabinet secretary has set up a nursing advisory group specifically to consider issues around health visiting, and the group is due to report in the near future. I hope that that will address some of the concerns that you have raised. I recognise those concerns and the importance of health visitors.

On the specific issue that you raise about the medication, NHS Health Scotland commissioned an expert group to consider the matter. The group considered a number of different issues, and it has since reported. It was in discussions with Community Pharmacy Scotland on that. If it would be helpful, I would be more than happy to get a full, detailed breakdown of the outcomes and recommendations from that expert group, which would allow the committee to consider the issue in more detail, instead of giving you a quick run-through of the key bullet points.

A draft national patient group direction—PGD—is being developed as part of the recommendations of the expert group, and I would be more than happy to give you a much fuller, more detailed breakdown if that would be useful.

The Convener: We appreciate that.

Dennis Robertson: I have a brief supplementary question in relation to what Bob Doris was asking about, and perhaps also in relation to an earlier question from Richard Simpson, regarding the data. Are we aware whether there is a shifting trend in young people becoming sexually active? If so, do you know what that trend is? Is there a geographical difference?

Michael Matheson: Some research indicates that young people are being exposed to information at a much earlier stage than might have been the case in the past, largely through being able to access information much more readily than was previously the case. There is research to demonstrate that children are being made aware of these things at a much earlier stage.

There are particular areas where we know, from the current national statistics that we gather, that there are issues around teenage pregnancies. Some of the work that has been done under the present strategy has been focused on those areas, and we know where they are. Getting the data down to a further level will allow us to be much clearer about the individual areas where there are issues that need to be addressed more effectively.

Dennis Robertson: Are you suggesting that exposure to information is itself impacting on when young people become sexually active?

Michael Matheson: No.

Dennis Robertson: The question was whether we know the age range of young people who are becoming sexually active.

Michael Matheson: I am not aware of it, but Felicity Sung might be aware of some specific research in that area.

Felicity Sung: We have some information from the health behaviour of school-age children survey, which is an international survey for which we have a Scottish arm. That gives us some information on young people's sexual activity. I would have to get the specific figures, but the proportion of young people under 16 who are sexually active has not changed noticeably for some time. It is obviously very difficult to get specific information on young people's sexual activity. Furthermore, it depends on what we mean when we are talking about sexual activity.

Dennis Robertson: I appreciate that.

Felicity Sung: The data are quite difficult to come by. However, we can examine some proxy measures that might give us the information. As the minister says, we can consider the matter further, as there are some interesting data, particularly from the health behaviour of school-age children survey, that can give us some useful information.

The Convener: There are no further questions. I thank the minister and his colleagues for their attendance.

We need your final agreement to this, minister, although we have sought to arrange this behind your back. We delayed your attendance here by about half an hour from the expected time. Committee members have time pressures, with other meetings that they have to attend at this time. Therefore, we suggest that we do not proceed with the next evidence session on today's agenda and that we postpone it until another

occasion soon. If you agree to that, we will end the meeting at this point.

Michael Matheson: Of course—I would be more than happy to do that.

The Convener: Thank you for that, minister, and thank you once again for participating in this morning's evidence session, which has been very interesting.

Meeting closed at 12:36.

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