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Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 3 September 2013

Session 4

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HEALTH AND SPORT COMMITTEE
24th Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor Marion Bain (NHS National Services Scotland)
Simon Belfer (NHS National Services Scotland)
Ian Crichton (NHS National Services Scotland)
Rhoda Grant (Highlands and Islands) (Lab)
Peter Reekie (Scottish Futures Trust)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Tuesday 3 September 2013

[The Convener *opened the meeting at 10:13*]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the 24th meeting of the Health and Sport Committee in 2013. Please turn off all mobile phones and BlackBerrys as they can often interfere with the sound system. Some members are working from iPads. They mean no disrespect by doing so; they are not checking emails or anything like that.

Under the first item on our agenda, I seek members' agreement to take item 3 in private. The item concerns the consideration of potential candidates for the post of budget adviser. I also seek members' agreement to take in private future consideration of our approach to the budget, as is normal practice—that will likely happen next week—and of our report to the Finance Committee when we reach that stage. Do members agree?

Members *indicated agreement.*

Public Bodies (Joint Working) (Scotland) Bill: Stage 1

10:15

The Convener: Item 2 is our first evidence-taking session on the Public Bodies (Joint Working) (Scotland) Bill. I welcome to the committee three witnesses from NHS National Services Scotland: Ian Crichton, the chief executive; Simon Belfer, the director of finance and business services; and Professor Marion Bain, the medical director. I also welcome—last but not least—Peter Reekie, the director of finance in the Scottish Futures Trust.

The first question comes from Gil Paterson.

Gil Paterson (Clydebank and Milngavie) (SNP): Goodwill towards the concept of integration comes across from people who come before the committee. Most people express a need for integration to happen. Why has the Government gone for legislation? Might that approach lead to a breakdown in the goodwill that is needed to make integration work?

Ian Crichton (NHS National Services Scotland): Do you mean legislation in relation to NSS's area or legislation in general?

Gil Paterson: I mean legislation to make joint working function properly.

Ian Crichton: It probably shows that the Government's patience to wait for people to get there themselves is limited. I do not think that we need legislation for us to be able to work together; during the past year, NSS has done a lot of work to improve the way in which we work with other public bodies without there being such legislation. However, over probably the past decade, the evidence is that without a bit of a push, the public sector finds it difficult to integrate.

Gil Paterson: The committee has heard from many places about the good work that has been going on in Highland. It looks as if there is a way to achieve integration without having to twist folks' arms. Has the Government looked at the Highland experience? Has it perhaps overlooked the possibility of ensuring that the Highland model works effectively, rather than introducing legislation?

Ian Crichton: I am not an expert on the bill but, as I understand it, it provides that people will be able to choose from two different models: some kind of body corporate that is created between two existing bodies; and a model such as Highland has adopted. The Government seems keen to allow local choice in how integration actually happens. The role of NSS is a little different. We

are trying to support that effort, regardless of the choice that people make locally.

Gil Paterson: You mentioned local choice. If people backslide or cannot make up their minds about which model to choose, will the Government step in and say, "Enough is enough. You need to go ahead, and this is the model that you must use"? Has the Government got the balls to do that?

Ian Crichton: I think that that is a matter for the Government to comment on.

Gil Paterson: Okay. Thank you.

Aileen McLeod (South Scotland) (SNP): Part 2 of the bill will enable National Services Scotland to extend its services to other public bodies. In June, the Public Services Reform (Functions of the Common Services Agency for the Scottish Health Service) (Scotland) Order 2013 came into force. For clarification, will the witnesses from NSS say whether the provisions in the bill differ from those in the order?

Simon Belfer (NHS National Services Scotland): The provisions are largely the same. The idea was to enable us to start having conversations with other parts of the public sector by putting in place the reform order as a stopgap, with the approach then being properly codified in the bill.

There are a couple of areas in which there are differences, which we will take up with the people who drafted the bill. The definitions of "services" and "customers" in the reform order are slightly different from those in the bill. Those are small, technical differences, which we will happily take up as the bill progresses—I can go into more detail if you want. However, the provisions in the order and the bill are largely the same.

Aileen McLeod: Do you have plans to extend your services?

Ian Crichton: It is important that we ensure that the committee understands why we wanted the reform order in the first place. We knew that the bill was coming, and we know that Scotland will integrate its health and social care during the next decade. If there is to be an integrated landscape in future, in which the national health service will be quite different—and particularly if new bodies are to be created between existing ones—it will be important that we have the room for manoeuvre that enables us to give support more broadly. That was a key reason why we wanted the reform order.

Another reason was that we felt that we could help public bodies make use of the range of services that we provide, without generating significant incremental cost. Given current budget constraint, we thought that there were opportunities in that regard. The order provided us with a stopgap, which allows us to operate and to start to get to know people beyond the health service. The bill will build on that, to enable that to be substantively the case in the new Scotland.

Aileen McLeod: What capacity is there in NSS to extend services?

Ian Crichton: It varies, depending on the area that you look at. We provide a broad range of services—I am sure that the committee knows this, but we should ensure that there is a common view of the spectrum—from the Scottish National Blood Transfusion Service to the central legal office, national procurement and information technology services. We are responsible for health information and informatics.

Our capability in those different areas varies. Let us take the CLO—the lawyers. For us to provide services beyond the NHS, we will probably need to add one, two or three lawyers, depending on demand. We charge people on a cost-recovery basis for the work that we do and we do not need to change the systems or the way in which people are trained, so we have something that is ready to go. We can compare our capacity in that area with, for example, our health facilities capability. The nutrition guidelines that the health service uses, which Scotland has put a lot of money into, are just as applicable for care homes as they are for the health service, so we can use stuff and incur almost no more costs. How far our capacity can extend or push really depends on the service that you are considering.

Aileen McLeod: Thank you. That is helpful.

Rhoda Grant (Highlands and Islands) (Lab): What plans does NSS have to extend into areas that other public bodies cover?

Ian Crichton: Our planning is evolving. We have spent the past year getting to know a lot of other public bodies, because fundamentally we want to provide a helping hand. We have constrained capacity, so we have been keen to channel capacity where it makes sense to do so.

We have been working with a few local authorities on IT contracts. IT in the public sector can be challenging; it is a very technical thing to buy and often the people who are selling it understand the market better than the people who are buying it do. We have good specialisms in areas such as telecommunications and can bring significant benefits to bear in that regard, so we have been able to support local authorities on IT and contracting.

Probably the best example in that regard is the Scottish wide area network, which is the first element of the McClelland reforms—it relates to very technical, complicated procurement. We have

taken the lead on that across the whole sector. We expect to continue to play a role in supporting the McClelland reforms as they roll out across Scotland.

We are helping a couple of local authorities with data linkage. In an integrated Scotland, we will want health information to flow across bodies better than it currently does. There is a lot for us to learn about how local authorities manage information—and a lot for local authorities to learn about how we do that. We need to start working with other sectors to join things up. That is another example.

We do not currently have a plan that says, "We will go after this number of bodies and this is how we will do it."

Rhoda Grant: I am trying to get to the bottom of why legislation is required. What was in place previously that prohibited you from doing what you are describing?

Ian Crichton: The actions of my body were restricted to the national health service. We were not allowed to operate beyond the NHS.

Rhoda Grant: Okay. Am I right in assuming that you would enter into other areas and work jointly only on invitation? Would that be part of the agreement between a local authority, for example, and NSS?

Ian Crichton: There are two elements to that. First, we need to be invited in. As far as local issues are concerned, there is no public body to which we would provide a service that did not ask for it. We can provide national expertise but make it available locally. That is not something that we impose.

The other element of control over our operations comes through Scottish ministers' discretion around whether we can act in a certain area. A specific part of my local development plan for NSS this year lays out the areas where we will operate over the next 12 months on behalf of Scotland. An example of that is the Scottish wide area network that I mentioned. Even with the Scottish wide area network, the contract is left as a framework, so it does not force people who do not want to be involved on to it. Everybody who is in on it is a volunteer.

Rhoda Grant: You said that you operate on a cost-recovery basis. Do you speak about and negotiate that with the authorities concerned prior to carrying out the work?

Ian Crichton: One of the things that changes with the landscape is whether there is a need to tender. In health, we do not need to tender for the business that we provide because of the way that the funding flows from the Parliament. The situation will be more complicated if we start to operate beyond the health service, and our lawyers and Scottish Government lawyers are examining that.

The Convener: Richard Lyle is next.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I would like to pursue the information technology side of things—

The Convener: Richard Lyle! [*Laughter*.]

Dr Simpson: Sorry.

Richard Lyle (Central Scotland) (SNP): I thought that Dr Simpson had changed his name there.

Coming from a local authority background, I am aware that many councils are concerned about the bill. We all know the reasons why the bill has been introduced. Ian Crichton mentioned the Government's frustration regarding social care. Will each area make its own decision on how much it wants to put in? Is it all or nothing? Is it a matter of identifying the problem and of saying, "Here is where we are falling down, this is how we're going to fix it, this is how it will work, and we won't need to debate who will pay for that, because we'll put the money in"? Will local areas be able to make their own decisions, or is everything in social care going into the pot?

Ian Crichton: I can talk only from our perspective. We provide support where people feel that they need it. I will give an example from the health service. Last year, we put together a property framework—frameworks 2—which gives us a list of contractors that we have been able to vet and with which we have been able to agree pricing up front. We know that there will be value for money, with penalty clauses around things being delivered late and so on. That framework is then made available to any public bodies that want it so that they can draw from it for their own benefit. Previously, that would have just applied to health, but it can go beyond that. The starting point is what the public body needs.

Let me give another example. One non-departmental public body decided over the summer to take on the NHS Scotland central legal office for employment law work. It is doing that because it thinks that we can provide a better service than its current lawyers. We will be cheaper, because we are not out to make a profit. The NDPB trusts us a little bit because we are in the public sector, which is refreshing and nice to know. Sometimes in the integration debate, the view seems to be that nobody gets on, but I do not subscribe to that. Everyone with whom we have been working has been positive and supportive. The key thing is that we are an option—we are not imposed.

Simon Belfer: There are two parts to the question. What will go into the integration pot will be for the local authority and the local health board to decide—whether they adopt the lead agency model or the body corporate model. Part 2 allows us to offer services if requested or required by a body other than the health board. It also enables a local authority to use us. Those two things are slightly different and separate. There would be a discussion where we stated the services that we offer and asked whether the body was interested. We would have a normal discussion, a negotiation and an arrangement around those services. That is quite different from saying what must go into the integration pot, which will involve the local authority and local health board. Does that help?

Richard Lyle: Yes, thank you.

10:30

The Convener: I call Richard Simpson.

Dr Simpson: It is confusing to have two Richards. I apologise to my colleague, Richard Lyle.

I want to pursue the IT side. We have not made the huge IT mistakes that have been made south of the border. However, we have a rather fragmented system, and it seems from Simon Belfer's description that that will continue. For example, the NHS Fife Scottish care information store cannot be accessed by consultants in Tayside—and that is just the NHS element. Once we put health and social care together, there will be an even greater problem, unless there is some agreement about the form of IT. There will be 32 community healthcare and social care partnerships, so the system will be even more fragmented.

We can add to that the fact that we have just wasted £56 million on e-care. That is not your responsibility, but if you are going to get into that area you should be aware that the track record on the local authority side is not all that great, either. After six or seven years, e-care has not delivered—it has failed.

There is a third element, which is the issue of privacy and confidentiality for the patient. I have been and continue to be concerned that the terms of the judgment in the European case of I v Finland have yet to be met in Scotland, because we have only a retrospective system of identifying breaches in confidentiality. The judgment in the I v Finland case said clearly that systems of patient consent to time-limited access should be introduced, but those are not being introduced in Scotland, where we rely on a retrospective system.

If we add social care to that, as well as pharmacy, which is also looking for access, as are other prescribers such as optometrists and podiatrists, the potential access to confidential information becomes a major issue. Will the bill allow you to be any more prescriptive or directive in ensuring that the principles of confidentiality are maintained, and that systems are integrated and speak to one another so that we do not have fragmentation? Those two elements are at either end of the problem.

Ian Crichton: I shall make an initial response and then hand over to Marion Bain.

You are right to say that the issues in that area can be boiled down to three key things that Scotland needs to think about. The first is information governance, and you have mentioned responsibility for patient privacy. There is also responsibility to ensure that, if we have the information, it joins up and protects people. Those two sides of information governance are challenging.

The second element, as you also rightly pointed out, is that there has been extensive systems fragmentation over time, primarily because a lot of different bodies have responsibility for buying what they want. Sometimes they have bought the same systems from a supplier who picks each of them off, and sometimes boards have bought things that are cheap but which might not have a lot of resilience behind them. Therefore, we have had a fragmented scenario. In health, the situation has significantly improved over the past five years with convergence of patient management systems. IT for general practitioners has really been separated into two different areas, so on the whole there has been a degree of convergence in the health service. That could be quite useful for what is coming.

More important than the systems—because systems can be interfaced—are the standards. Scotland now has a big opportunity to ensure that we secure decent standards. If we can sort out those standards, it does not matter whether people have different IT systems, because they will at least all be operating to the same level and doing the same kind of things. We have made some progress, but there is more to be made. Given that we support such efforts, I would welcome more direction on standards. McClelland gives Scotland the opportunity to do some of that, but Marion Bain knows more than I will ever know about the information governance space.

Professor Marion Bain (NHS National Services Scotland): I agree with all those comments. We know that there has been a problem over many years. In answer to the question, I do not think that it is our role to be prescriptive about such things, but the bill will

allow us to be supportive in moving the agenda forward. Actually, the issue is a really good example of why we as an organisation are so keen to be involved in this space.

Part of our current role within the health service is not just to provide the specialist IT expertise but to put that alongside the information governance, so they go hand in hand. In the part of our organisation that deals with IT, we have information governance specialists as well as IT specialists—alongside clinical input—which allows us to have systems that provide what people need in caring for patients. That is the sort of area where, having built up our support for the NHS, we could naturally support the broader health of Scotland by being able to apply the approach to the whole health and social care agenda, so that we get that safe sharing of information for the benefit of the public, with everyone having the confidence that confidentiality is being adequately considered.

In many ways, that is a good example of why we in NSS are very keen on the bill and on the work that is already being done. We feel that we will be able to take some of the things that we are already established in, which provide real benefit, and allow them to be applied more widely.

Dr Simpson: Well, I look forward to that.

Bob Doris (Glasgow) (SNP): First, as a tiny supplementary to Richard Simpson's question, I want to ask about where NHS National Services Scotland fits in. Even prior to health and social care integration, there is still a lot of fragmentation of IT systems within the health service. The situation will not be changed by the bill, which I understand is more about how you will be able to use some of the good work that you are currently doing with local authorities and other public bodies. Should there always be the ability to have local decision making about IT systems? In a nation of 5.3 million people, should the 14 health boards still have the ability to buy 14 different IT systems? Surely to goodness, as we move forward, there should be some central co-ordination of that.

Ian Crichton: I mentioned standards, and I think that standards are more important than systems. What is required to run hospital and community resources in Orkney might be quite different from what is needed to run services in Glasgow, so there would be a danger in prescribing everything centrally. The centre needs to get better at having a clearer strategy, such as through the e-health strategy board. The strategy needs to be increasingly clear about our route map, if you like, but I think that there has been more clarity in recent years. There would be a real danger in prescribing everything from the centre.

As with most things in life, there needs to be a balance. We need to ensure that everyone is clear about the standards and then, as people go to market to procure, a body such as ours can be really useful—we have some heavy hitters who have expertise in such procurement exercises—in ensuring that procurement is done properly. We are used to supporting the health boards in that space.

Bob Doris: I will not indulge myself by asking further supplementaries on that, although it is an area of interest.

I want to ask about the different corporate structures that will emerge from health and social care integration, particularly for health boards. I have to admit that I was unaware of those until I started looking at the bill in more detail. I do not know all the details, but I hope that Mr Reekie will be able to help us with the provisions on the disposal of surplus assets by health boards. What are the current constraints? How will the provisions on health and social care integration address some of those constraints?

Peter Reekie (Scottish Futures Trust): As you will know, part 3 of the bill has a couple of provisions that are very relevant. On disposals, we are particularly keen to see health boards and local authorities being able to work a lot more closely together on their property strategies, both for building new facilities and for the disposal of facilities that are no longer needed.

Often it would be possible to get a better deal on the disposal of assets by bringing packages of things together that would be more interesting to private sector development partners. Members will be aware of this from their own localities, but it can be the case that, for historic reasons, different bits of the public sector own parcels of land that are next to each other, such as where a health centre is situated next to a council office. If we find that those become surplus because of a reorganisation in a town or village, the ability for a local authority and health board to enter into a joint venture with a private development partner for the disposal of those assets could increase their value and be of benefit to the public sector.

Currently, a local authority can go into a limited liability partnership, which is the sort of corporate structure that the private sector often uses in such situations, with the private sector and work out mutually agreeable risk and reward sharing over a period of time to redevelop the property. Because of the structure of the current legislation, health boards are not allowed to become a member of one of those limited liability partnerships. If such an agreement is set up as a company, health boards can be in; if it is set up as a limited liability partnership, they cannot. That is an anomaly in the current legislative structure. Relieving that

anomaly and allowing bodies to work better together in an LLP structure, which is recognised as being a good corporate form for this sort of thing, would be a useful enhancement of what health boards are allowed to do.

Bob Doris: When I was preparing for today's meeting, I read that health boards' ability to provide services or enter into joint infrastructure agreements with neighbouring health boards is also quite constrained, but that that will change under the bill. Could you say a bit more about that, particularly about where the barriers might be at the moment, or could you describe a potential infrastructure venture that could not go ahead with the current arrangements but which would be able to go ahead following integration?

Peter Reekie: Again, this is about efficiency and giving us the ability to do things commercially as efficiently as possible. In the hub programme, for example, if a health board is buying two or three small health centres, there are a number of reasons why it might make sense to package those into a bundle. If we are developing a design, build, finance and maintain contract over a number of years, the costs of the legal and financial advice for a transaction and the costs of running that agreement are not huge, but they are significant. Therefore, if we are able to bundle together two or three small health centres into a single transaction, that will just be plain better value.

If all those three health centres are in the same health board area, buying them is really easy to do. We can have a single contract and it will all work really well. If we have a hub territory that spans a number of health board areas, as we do, and we would like to bundle together a couple of health centres that are in different health board areas, that is more tricky, because one health centre is not allowed to contract on behalf of the other for the provision of that facility.

In the north area, we have managed to get around that. NHS Grampian and NHS Highland are working together in Forres, Woodside and Tain; they have a single procurement agreement for three health centres. However, we have had to use a slightly complex structure in which one contract has two clients, and that has caused more legal thinking than would be required if one health board was able to take the lead and enter into a contract for the three health centres, allowing the other health board to occupy one of them afterwards. Allowing that to happen would just make things simpler.

Bob Doris: Okay. Can I just make sure that I am clear about this? I represent Glasgow region, and under the hub model, in the area of Glasgow in which I stay, Woodside centre is going to be rebuilt, as is Maryhill health centre and one in the south of the city. I assume that they will all be packaged together to get the best deal for the public purse. I know that nothing is plain sailing in this world but, would the contract for the venture that you have just described to me have been far easier to pull together if it fell within one health board area?

Peter Reekie: Yes, if it was all within one health board area. A single client would make the contractual structure much simpler. There would be one contract and one client. In your example it would be Greater Glasgow and Clyde NHS Board and Hub West Scotland. In the north area that I was talking about, and Forres, Woodside and Tain health centres, NHS Grampian and NHS Highland were trying to bundle projects together, and the ability for one of the health boards to act as a lead would have made that a lot easier.

Bob Doris: It is always dangerous to ask a question without knowing the answer to it, but if you needed to build a health centre in a location that made it geographically suitable to provide services to patients from two different health board areas, could you do that under the current structure? Will that change with the bill?

10:45

Peter Reekie: I think that the ability of health boards to provide services to one another is considered separately from the bill. That is not my area of expertise, but I know that it is possible for health boards to provide medical services to patients from outwith their areas.

The Convener: Richard Simpson and Nanette Milne have supplementaries.

Dr Simpson: Part of the purpose of integration is to allow different services to be co-located. For example, at the Broxburn and Fauldhouse centres, which were quite expensive, health services are integrated with social services. Such integration is extremely important but, beyond that, integration is also about allowing the benefits people to provide services from the same place. As well as providing the flexibility for health boards to co-operate as you have described, will the bill provide the flexibility for local authorities and other agencies such as the Department for Work and Pensions to contract jointly for buildings from which co-located services will be provided?

Peter Reekie: One of the most powerful points of the hub programme is that it allows local public bodies, particularly health boards and local authorities, to procure and occupy facilities together. There are several good examples of that on the ground. Not far from here, Hub South East Scotland has just handed over the Wester Hailes healthy living centre, which brings together NHS Lothian, City of Edinburgh Council and some third sector organisations in one facility. Primary care

and outreach consultant clinics will be provided alongside social care and children and families services. It is our belief that shared facilities and co-location can be a catalyst for integration; they do not necessarily have to follow on behind it.

To address one of the points that was made earlier, NHS Lothian is providing the IT and the City of Edinburgh Council the facilities management across that facility, although it is probably occupied 60:40 by the health board and the council. There are good examples of integration being facilitated through a hub arrangement in a shared facility.

Members might also be interested to know that on the other side of the country, in Eastwood, we have just worked with NHS Greater Glasgow and Clyde, Renfrewshire Council and Architecture and Design Scotland, through Hub West Scotland, to come up with a reference design for an integrated health centre that brings together local authority and primary care services in one place. That work has involved two of Scotland's top architects—BDP and Gareth Hoskins Architects. The results of that reference design will be on our website so that people in other areas across Scotland will be able to piggyback on it and use it as an exemplar for designing buildings that bring services together.

Dr Simpson: That is extremely welcome. The bill will allow you to put together a contract across health boards. Will you be able to do that across local authorities as well, or can you already do that?

Peter Reekie: That can already be done between local authorities and health boards.

Dr Simpson: Can it be done between local authorities?

Peter Reekie: I believe that that is possible, but such overlap is less of an issue for us in hub contracting arrangements.

Dr Simpson: Right, but if, for example, three health centres were to be co-located with three local authority services but two different local authorities and two different health boards were involved, would the current legislation or the new bill allow you to put all that together so that one health board could contract on behalf not only of the other health board but of the two local authorities? Unless we get full integration, we will go only part of the way to addressing the issue.

Peter Reekie: I confess to not knowing the detail of whether local authorities can act on behalf of one another in the same way that the bill will allow health boards to do, but I can find out about that and provide you with some written evidence, if you would like me to.

Dr Simpson: That would be very helpful.

The Convener: We heard in the bill team briefing that the legislation puts health boards on a similar footing to local authorities. I will sneak in with a supplementary here. We have already discussed co-location and assets. Will giving health boards powers that are similar to those of local government enable them to form arm's-length companies and other such bodies, as local authorities have done in order to deliver leisure and other services? Is that a possible consequence, or is it not envisaged?

Peter Reekie: It is not envisaged as a natural consequence of the bill. Part 3 specifically allows health boards to enter into different corporate structures, but it really refers to the possibility of a board becoming a member of a limited liability partnership as well as a company. Health boards can already co-invest or become part of companies that exist under the Companies Act 2006, and the bill extends that provision to include LLPs and other corporate structures.

Nanette Milne (North East Scotland) (Con): I have a regional interest in the issue. I think that I am right in saying that the proposed health centre at Inverurie in Aberdeenshire is to be bundled with another one in Highland. How is the lead board determined when such projects are set up?

Peter Reekie: A range of factors are involved in the decision. One factor might be which board in the bundle has progressed furthest with its project; another might be the range of skills and experience of the teams in the different health boards. The decision could be made simply on a value basis, with regard to which project carries the balance of the capital value. There are no specific arrangements in place.

Nanette Milne: Once the lead board is chosen, how much impact will carrying out that function have on its time and resource requirements?

Peter Reekie: That would be very project-specific. Project management and commercial resources will be required for all the projects. Overall, the whole is less than the sum of the parts, so all the boards acting together will need less overall resource than they would if they were acting separately. The lead board will obviously be required to lead on the project management and commercial aspects of the deal, although running those through the hub will minimise the impact in comparison with that using more traditional procurement models, because the partner will already be in place and much of the documentation and commercial agreements will already be tied down.

Nanette Milne: Finally, once the project is complete and the buildings are there, where does responsibility for maintenance thereafter lie? Does

it remain with the lead board, or is it split between the two boards?

Peter Reekie: This type of structure is envisaged mainly for contracts that will be let on a design, build, finance and maintain basis, so the maintenance of the facilities will become the responsibility of the delivery partner for the next 25 years or so.

Mark McDonald (Aberdeen Donside): We discussed disposal of assets earlier, including some physical assets, which could include land. Many local authorities are land-rich, but I am not sure whether any health boards have large amounts of land in their portfolios.

It would be interesting to know where we are in identifying surplus assets that health boards currently hold. How many of those assets could the legislation potentially unlock?

In a situation in which capital moneys are tight, additional capital can be realised through the disposal of assets and the reinvestment of capital receipts. Has any work been done to identify surplus capital assets that are not disposable at present as a result of the blockages that you have identified?

Peter Reekie: A lot of work is being carried out on identifying surplus assets in individual local authorities and health boards, and those bodies now have very good sight of their potential surplus assets now and in the future. We are trying to deliver a more integrated look at those assets and are working with a number of health boards and local authorities on place-based reviews. In other words, we are looking across the whole assets of a health board or local authority in a town or part of a city to find out which areas it would be best to develop and which it would be best to dispose of. It is not that the bodies themselves do not know what they have or where it is; however, by bringing them together, we can sometimes create better value or a more integrated future plan.

I do not have figures for the total ability to increase value through what you might call the marriage value of bringing together sites across Scotland, but I can tell the committee that bringing together parcels of land and certain elements of assets often increases their value and that allowing this to happen can only be a good thing.

Mark McDonald: In that case, is it fair to say that this is less about allowing the disposal of assets that currently cannot be disposed of than it is about maximising the value of those assets by allowing these kinds of arrangements between local authorities, health boards and the private sector to take place? Is it more about maximisation than about unlocking the ability to dispose of assets?

Peter Reekie: Yes, it is about maximisation. However, in the process of maximising value or allowing bodies to jointly plan what they want to do and the order in which they do it, there will be investment as well as divestment and certain things could become possible commercially that would not have been possible before. Property developers talk about what is above and below water; that waterline moves and if by bringing certain sites together we can add value to them and take them above the waterline, we can allow things to happen that would not have been able to happen before.

The Convener: Do any other members have questions?

Rhoda Grant: Going back to Peter Reekie's comment about procurement and pulling things together, I should say that, aside from that, part of the Health and Sport Committee's role is to look at health inequalities. Part of health inequalities is the inability to find a job. If you bundle such contracts together over such a huge area, you will actually stop the workforce being part of the bidding process. When you think about, say, building a health centre in Glasgow, how do you calculate the entire cost to and what is best value for the public purse? How do you make work available and open to those in areas in deprivation who need it?

Peter Reekie: I do not think that by bundling projects together you affect which individual does the work on the ground at different sites. All of our hub companies have to advertise and compete their contracts at a lower level, and the competition for what we call tier 2 contractors will bring in the most appropriate and value-for-money contractor to each opportunity. In the past, a very high number of contracts have gone to local small to medium-sized enterprises—for example, well over 80 per cent of the contracts for the Drumbrae project in Edinburgh were delivered by local SMEs—and given the nature of the construction industry and how it delivers these things some of those packages will be subcontracted out again to very small-scale entities local to the individual project. It is important in, say, mechanical and electrical packages that there is a good amount of design integration, and that design will be carried out by a larger-level regional contractor that might well be able to cover three health centres.

Rhoda Grant: Are they forced to do that by whatever has been written into the contracting process?

Peter Reekie: Yes. Subcontract tendering is written into the contract, as are key performance indicators for community benefits and jobs and training places on every single project that is delivered through hub.

11:00

The Convener: Concerns have been highlighted about what you can do with regard to procurement and so on, but I suppose that what we have been asking about is your evaluation of a bid at a local level. I acknowledge that the construction industry is free-flowing and reaches across the whole country and that people in my constituency will benefit from a project in Edinburgh, but the fact is that more and more local construction partnerships are being set up in our constituencies and are requiring contractors to take on local apprentices or local labour at the appropriate level. Is that sort of element prominent and costed in each of your contracts?

Peter Reekie: Absolutely. It is prominent in every contract.

Bob Doris: I was only going to make a comment, convener, but I now also have a question to ask. I moved into a new house a year ago now and the builder is still on site—

Peter Reekie: It wisnae me.

Bob Doris: Everything that happens with the house is dealt with by a subcontractor, who is often locally based. Only one large construction company in the whole of Scotland has direct staff; in every other case, the work is subbed out, usually to local firms. I think that it is important to put that on the record.

Given that the hub model is about greater buying power, have you been able to put more community benefit clauses into contracts than you were able to before? Has the amount of community benefit increased because of your increased buying power? In other words, have you been able to drive down prices at one end and drive up community benefit at the other end? I would certainly be interested to find out whether that has been a feature of this approach.

Peter Reekie: The hub model gives us a long-term relationship with the development partner and the ability to say to them, "This will affect your future workload as well as this individual project, because you need to show that you are meeting all of our KPIs on employment and training in order to get the future pipeline of work that you want from hub." By linking that long chain of projects together and allowing people to see where future work is coming from and to plan for that through community partnerships and long-term relationships with local subcontractor supply chains, we deliver not only better value in cost terms but, in my view, better outcomes for communities.

Bob Doris: I know that there has been a bit of drift in our scrutiny of this issue, convener—

Mark McDonald: Just a tad.

Bob Doris: However, that response was very helpful.

The Convener: Do you monitor and evaluate those outcomes?

Peter Reekie: Indeed we do.

The Convener: You might want to share that interesting information with us.

Those are all the questions that we have this morning. On behalf of the committee, I thank you for taking the time this morning to attend the first of our many evidence sessions on the bill.

As previously agreed, we now move into private session.

11:03

Meeting continued in private until 11:13.

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