The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 8 October 2013

Session 4

Tuesday 8 October 2013

CONTENTS

HEALTH AND SPORT COMMITTEE
29th Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Rachel Cackett (Royal College of Nursing Scotland)
Malcolm Chisholm (Edinburgh Northern and Leith) (Lab) (Committee Substitute)
Annie Gunner Logan (Coalition of Care and Support Providers in Scotland)
Donald Harley (British Medical Association Scotland)
Kim Hartley (Allied Health Professions Federation Scotland)
Matt McLaughlin (Unison Scotland)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 3

Scottish Parliament

Health and Sport Committee

Tuesday 8 October 2013

[The Convener *opened the meeting at 09:47*]

Subordinate Legislation

Food Additives, Flavourings, Enzymes and Extraction Solvents (Scotland) Regulations 2013 (SSI 2013/266)

The Convener (Duncan McNeil): Good morning and welcome to the 29th meeting in 2013 of the Health and Sport Committee. As usual at this point, I remind those present to switch off mobile phones, BlackBerrys and other wireless devices, as they can often interfere with the sound system. You may have noticed that some of the members and officials are using iPads and other tablet devices, but they are doing so instead of using hard copies of the meeting papers—we are not just googling or doing emails.

We have apologies from Richard Simpson. Malcolm Chisholm is with us as the Labour Party substitute.

Agenda item 1 is subordinate legislation. We have one negative instrument to consider. There has been no motion to annul and the Delegated Powers and Law Reform Committee has drawn the committee's attention to two points, the details of which are in members' papers. If there are no questions from members, is it agreed that the committee has no recommendation to make on the instrument?

Members *indicated agreement.*

The Convener: Thank you.

Draft Budget Scrutiny 2014-15

09:49

The Convener: Item 2 is the annual process of scrutiny of the Scottish Government's draft budget. This morning we will have a round-table discussion involving stakeholder organisations. As usual, I will invite guests and members to introduce themselves, although there are well-kent faces here this morning. As always for this type of session, I will give priority to witnesses who want to speak. They will be given the advantage in that regard.

I am the MSP for Greenock and Inverclyde and convener of the committee. On my right is Iris Bosa, the committee's budget adviser.

Bob Doris (Glasgow) (SNP): I am a Glasgow MSP and deputy convener of the committee.

Donald Harley (British Medical Association Scotland): I am deputy secretary of the British Medical Association Scotland.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I am the MSP for Edinburgh Northern and Leith.

Nanette Milne (North East Scotland) (Con): I am an MSP for North East Scotland.

Annie Gunner Logan (Coalition of Care and Support Providers in Scotland): I am from the Coalition of Care and Support Providers in Scotland.

Gil Paterson (Clydebank and Milngavie) (SNP): I am the MSP for Clydebank and Milngavie.

Aileen McLeod (South Scotland) (SNP): I am an MSP for South Scotland.

Kim Hartley (Allied Health Professions Federation Scotland): I represent the Allied Health Professions Federation Scotland.

Rhoda Grant (Highlands and Islands) (Lab): I am a Highlands and Islands MSP.

Rachel Cackett (Royal College of Nursing Scotland): I am a policy adviser for the Royal College of Nursing.

Richard Lyle (Central Scotland) (SNP): I am a Central Scotland MSP.

Matt McLaughlin (Unison Scotland): I am from Unison Scotland.

Mark McDonald (Aberdeen Donside) (SNP): I am the MSP for Aberdeen Donside.

The Convener: Thank you all for that. Bob Doris will start off the session with a couple of questions.

Bob Doris: The draft budget shows a cash increase in the forthcoming year of £267 million, which is a 2.9 per cent increase in cash terms but a 1 per cent increase in real terms. I have taken those figures from the briefing that the Scottish Parliament information centre prepared. Of course, within any overall increase for a budget, there will always be increases and decreases for individual budget lines. I will pick out two of those that will perhaps start a discussion among our witnesses. There is a small fall in the health improvement and health inequalities budget for next year, although it is planned to go up in 2015-16. However, the detection of cancer budget will increase by 8.3 per cent in the forthcoming year.

The Government has made decisions for those two budget lines, but there is a range of budget lines. I am interested to know whether the witnesses think that the Scottish Government has got the balance just about right. I am particularly interested to know your views on the two budget lines that I identified. Generally, though, do you think that the balance is just about right? More important, if you do not think that the balance is just about right, it would be helpful if you could say where you would move the money from within the budget. We would all, as witnesses, politicians and parties in the field, like to see increases, but that money must be sourced from somewhere. Do you think that the Government has got the balance right in a rising budget? Where would you reprioritise, if you decided to do so?

Rachel Cackett: It is a really hard question to answer. The difficulty is the same one that we have had for a number of years, which is that it is very hard to put together the narrative that goes around the decisions on why budgets have been allocated as they have and why changes have been made from what we might have expected from the comprehensive spending review initial plans to the budget that we have today.

It was great to have the level 4 detail a little earlier this year so that we could go through it and have a better understanding from the Government of why some decisions have been made. However, it is very hard to follow when quite a lot of lines say that the budget has gone down due to efficiencies that will not affect productivity but no elucidation is given of what exactly that means. It is an issue of trust: that is what we are told, so that is what we must believe.

Inevitably, I would pick up on a different line from the two that were given, which is the nursing education and training line, in which there is an £11 million decrease from what we expected. We understand some of the rationale for that in the change to the one-year job guarantee, but for me that is just one area in which the continued disconnect between the very good priorities that the Government has set for health and the way in which the budget is presented comes to the fore.

We put in our submission two areas where we thought that that money could be reinvested to meet exactly the Government's priorities: investing in health visitors for early intervention, for which there has been significant cross-party support; and looking more creatively at our integration proposals. It was not that long ago that we were sitting around this table discussing that issue and a demographic that is going to mean an increasing need to provide complex clinical care at home 24/7. We have to think creatively about how we train our workforce to do that. It is therefore a shame to see £11 million lost from the budget rather than being redirected. There is no way within the narrative to explain why that decision has been made, so I come back to saying that your question is very hard to answer because of how the budget is presented, although I know that we have sat around this table and said that previously.

Donald Harley: We welcome the protection that the Government has afforded to the national health service budget. Nevertheless, we recognise that pressures will be created by health inflation, which means that progressively less will be able to be delivered. There needs to be a degree of honesty about that with the Scottish public and we hope that the politicians will be leading that public debate about what can be provided within those falling budgets.

It may be that the existing configuration of services is not the most efficient way of doing things and difficult decisions may have to be made as regards how current services are configured.

The Convener: Honesty and difficult decisions—Kim Hartley?

Kim Hartley: The AHPF welcomes the shift in balance and the drive towards prevention and addressing health inequalities. The budget line that Mr Doris mentioned is very helpful in that regard. Our concern, which we want to explore, is about how that money is distributed and how it is used efficiently. We also need to think about how we ensure that the best use is made of the funds that come from such pots to engage the full capacity and capability of the workforce. It would also be helpful if the committee could consider the robustness of what happens once those short-term funds come to an end.

Bob Doris: That shows the problem that we all have when scrutinising budgets—there is no cost-free option. If we decide to reprioritise, we all have to say who the losers would be.

I was interested in Rachel Cackett's comments on the budget line for nursing education and training. I am aware that there is a developing

workforce management tool—that is the extent of my knowledge of it, I have to admit. I know that there is also a bed management tool. Do you expect that future budget lines for nursing education and training will be informed by that workforce management tool? If you do, does that give you some comfort and security for the future in relation to strategic planning for the nursing workforce and the budget lines that would underpin that?

Rachel Cackett: There is quite a lot in there. To unpack some of it, I note that there are a number of nationally agreed nursing and midwifery workforce and workload planning tools and we have been supportive of their development. From next year, the tools will be mandated for boards to use. There are issues around what that mandate means. We have been quite strong in saying that it is not about running a tool in one ward and then extrapolating from that to conclude that, because that ward comes up with a particular figure, that is what the figure should be everywhere.

There is still some ironing out to do, but it is definitely a positive development that there is some evidence base that includes professional judgment over what the whole nursing team should look like. What those tools do not do, for example, is tell you the skill mix between unregistered and registered staff, so professional judgment is still needed there. Of course that skill mix sometimes becomes an issue about cost—that is our concern.

It is certainly true that we hope that workforce planning that is done in a really rigorous way would better inform our student planning process. Clearly, that is a significant part of the nursing education budget line, which covers students up to the point of registration.

We still need to work out how we deal with the postgraduate end of training for nurses, particularly as we will require nurses to work at very high levels of competence over the coming years. At the moment, we do not have a central budget for postgraduate training—as, perhaps, other parts of the profession do. A lot of the responsibility for training is therefore pushed back down to board level. Of course we then have the issue that boards have a huge amount of pressure on them to make ends meet when they have financial targets to hit and increasing health cost pressures.

If we want a strategic approach to future nurse education, the workforce planning tools should help and they should give us a better idea of what we need, but we should also be thinking about a strategic overview of postgraduate education in order to get the specialist nurses in place. We do not have that yet, so we still need to do some work in that area.

10:00

Kim Hartley: The budget line to which Mr Doris referred is for nursing, midwifery and allied health professions. Patients need multidisciplinary teams around them and services to which medical staff and colleagues in other professions can refer them. Rachel Cackett talked about a formula for nurses; the workforce planning tool needs to look strategically at the whole team that operates around the individual.

How is the decision about how budgets are used made at central level? For example, if a pot of money from central Government is going to health inequalities, what conditions apply? What capacity and capability is being engaged, and how are projects playing out in relation to the multidisciplinary team, to meet the outcomes that the budgets seek to deliver?

Matt McLaughlin: I want to back up what my colleagues said about the education budget and answer Mr Doris's question. I think that many people in the Scottish health service are breathing a sigh of relief in the context of Francis and other developments south of the border. If we are to avoid such issues getting into the news in a Scottish context we need to accept that investment in education and training for staff is critical. I am talking about training for all staff, from domestics and care assistants right up to senior clinicians.

It is sad that education and training budgets are often the first area to be sliced when financial pressures come along. We need a bit of a rethink on that, because we must invest in our current staff and in the staff who will come into the service, who will be key.

Rachel Cackett: I make an additional point, given the other work that the committee is doing and who is around this table. The tools that we have, which are welcome, are not yet for every setting. They are NHS tools. We have to bear in mind that policy is moving towards a very different way of providing services across health and social care, in which nurses, AHPs and others will be located elsewhere and employed by other employers, who are not included in the current approach. The tool gives us a better sense of what we might need in NHS settings, but it has not yet been extended to give us a sense of the training that we might need to do for a much broader way of providing health services in future.

Annie Gunner Logan: On a slightly different point, much of the budget documents and the resources that they discuss relates to services for people who require care—I say that because of Bob Doris's point about health improvement. However, if we consider the recommendations of the Christie commission on the future delivery of

public services, it is clear that we need attention to be paid to activities that will keep people who do not currently require care out of the system. Attention needs to be paid to the upstream prevention agenda, to keep people out of care.

We have been focusing on specific aspects of that, such as the change fund—I do not know whether that will come up in members' questions later. Much is to do with the decisions that are made about budget allocation locally rather than at national level. The important question for us is what levers are in the budget to ensure that such activity will be funded and will happen. We still have some doubts about that.

Donald Harley: On health and social care integration, I echo witnesses' concern about the temporary nature of the change fund and the sustainability of activity for successor organisations when time-limited funding has expired.

It is unlikely that there will be a huge downshift in complex elderly admissions to secondary care. Such care will still need to be resourced in much the same way as it currently is. At the same time, expectations of primary care, and general practitioners in particular, are rising. Of course, that is against the backdrop of a real-terms reduction of almost 2 per cent in the funding for GPs. It is therefore very difficult for GPs to meet all those expectations from their own resources, so that aspect needs a fundamental re-examination.

The Convener: Does Bob Doris want to come back in?

Bob Doris: No, I should let some of my colleagues in. Those answers have been helpful, particularly on workforce planning.

The Convener: We have covered many of the areas that we needed to cover in a wee bit more detail. Malcolm Chisholm can go next.

Malcolm Chisholm: We have already touched on integration and health inequalities, which are two subjects in which we are particularly interested. If I am allowed, I might go back to those topics in a minute.

The prior question—which the Finance Committee has asked us to look at—concerns the extent to which the budget links up the targets and indicators with the budget lines. I find the area of health quite confusing. The national performance framework, with which the witnesses may or may not be familiar, contains a lot of health indicators, but there are also specific indicators in the quality strategy, as well as the HEAT—health improvement, efficiency, access to services and treatment—targets. I find the plethora of targets and indicators quite confusing.

It would be a good idea in principle to decide which key health indicators we will focus on and to tie them to budget lines. If the indicators were to move in the wrong direction, that would be an argument for increasing a particular budget line. Does anyone have any thoughts on that?

If that seems a bit abstract, perhaps health inequalities would be an illustration. If tackling health inequalities is a key objective for health and for Government more generally, and that is not improving significantly over a long period of time, does that suggest that we should be targeting more resources in that area?

As Bob Doris said at the beginning of the meeting, the line for next year is going down. Should we be trying to home in on specific indicators and targets, and matching those up with the budget? If that is the case with health inequalities, what can be done more effectively to deal with the problem, which does not seem to be getting any better?

The Convener: Are there any takers?

Donald Harley: We would obviously support a role for targets, but we have a long-standing concern about the overexpansion of targets across the NHS. It is a truism that you get what you measure and not what you do not, and, in a time of diminishing resources, the worry must be that the combination of targets and low resources has the potential to create some of the drivers that were evident in the Francis report on the Mid Staffordshire NHS Foundation Trust.

Annie Gunner Logan: I agree with Malcolm Chisholm. To bring more confusion into the discussion, we are about to embark on a series of national outcomes for integration, in addition to all the different measures that Malcolm Chisholm mentioned. We will also have a review of the national care standards for social care. It is becoming increasingly difficult for people who make budget allocation decisions to match up budgets with indicators and targets, because there is a plethora of them.

Colleagues have occasionally remarked in meetings that I have attended that these things sometimes work against each other. As long as we have process-driven targets around waiting times and so on, that inhibits our ability to free up resources for some of the decommissioning and upstream activity that I mentioned earlier. Some clarity is needed on the question of whose targets they are anyway. That would be helpful for people who are working in the system

Kim Hartley: I could not agree more that there is a plethora of targets and outcomes, and we are forgetting the early years outcomes for children and young people. That is the state of play. [*Interruption*.]

From the AHP Federation's perspective, linking the budgets to those targets and indicators brings us back to that, but it depends on how we think about it. Which inputs will deliver those outcomes, and where do we put the budget? We have not answered that question clearly, or we keep changing the answer, and that is why we get such a situation.

We might not be reaching the targets because we do not have the correct mix in order to deliver them, but the funding may be fine. There are lots of decisions to be made in that respect but, if we are trying to achieve objective A, the inputs, including resources, are key, as is what we do with the financial resource and what we spend it on in order to deliver the outcome. There is probably, or possibly, a disconnect between the indicators, or the measurement of indicators, and what happens with budgets.

Rachel Cackett: The small child who we can hear next door in the crèche is probably expressing the frustration that a lot of people feel in trying to make this work. I once made the mistake of trying to map the indicators that I thought our members in the health service had to try and work through as they decided how to deliver services, and I ended up with the most extraordinarily confusing map. I sat back, not understanding how anyone can do it.

We should have a tool for prioritisation. We keep coming to the committee, and the committee keeps saying that we must make difficult decisions and prioritise an ever-limited set of funding. Without absolute clarity on what those priorities are, we tie the hands of the people who provide services on the ground who have to make those decisions.

I have two things to add. First, I very much welcome the protection that health has, but we are about to move into a very different landscape. We ran a survey of community nurses last year, and 69 per cent of them responded that they felt that pressures on their teams had increased because of social care cuts. We have to keep remembering that if we cut social care and squeeze the balloon in one place, it will come out somewhere else. The more we integrate, the more that will be the case. We have to think in the round about what that means with an integrated budget.

The second issue, which I have not quite understood as yet, is mentioned in our written evidence. At the moment, the committee is looking at two lines of allocation, essentially. One is the core funding to health boards, which they spend to create their basic service. The other is the non-recurring specific lines that the Government uses. Those are often linked to HEAT targets to help pump prime some of the work.

With regard to moving to joint strategic commissioning, where the expectation is that the priorities will be set locally depending on local need, I have not yet understood how future budgets—should the Public Bodies (Joint Working) (Scotland) Bill go through—will allow for that level of central targeting of resource, rather than allowing decisions on how a general pot of money is spent locally. I do not think that we have quite worked out how that will emerge as the budget process changes and as integration—I presume—goes further down the line.

Matt McLaughlin: I will pick up on both of Malcolm Chisholm's points. On the link between indicators and budget lines in this or that book or in this or that framework, it is indeed absolute torture to try and get a sense of that. In part, that is about the NHS being a big beastie, which does a whole stack of different things. It has varied interaction with people, from very low-level interaction involving school nursing assistants right up to new hearts, new lungs and other life-saving interventions. We need some measures. People have commented that, the minute that we start to create targets, we create an industry to prove that we are meeting those targets. That is a major danger.

I can give two quick examples. We are aware of some of the challenges in Lothian regarding the waiting list problem there. In order to meet the target, we are throwing money, and wasting money, putting services out to the private sector that do not need to be there. As I understand it, the waiting list is not going down. There is a massive question around efficiency, how we use services and how we are pressed to meet targets just for the hell of meeting a target.

There is another thing that happens in a more acute setting. For example, NHS Greater Glasgow and Clyde has almost permanent consultants on the board, who are working to assist the board in meeting the clean hospital targets. You might argue that that is a good thing, but one might also question why, in terms of efficiency and use of money, we are having to almost permanently buy in that resource.

10:15

At the same time, one fundamental challenge to efficiency is the fact that it takes more than six weeks to get a protection of vulnerable groups check for a domestic, while domestics need to give only one week's notice. As a result, there are more domestics leaving the system than we can ever get into it and people are failing to meet targets in some areas. These are big questions and I do not necessarily think that the proper answer or solution is simply to set a target.

As for the integrated care and health and inequalities agenda, I am sure that others have mentioned a feeling of putting the cart before the horse and that people are out doing stuff before proper legislation and direction have been put in place. That is an issue if we are keen to examine inefficiency. At the moment, a lot of people are talking about process and structure and next to no one is talking about quality outcomes. The fear is that, if we start to impose more initiatives and targets on the system, we will get a cost-driven rather than a quality-driven exercise and I hope that this Parliament and this committee are more interested in quality-driven outcomes in order to tackle inequality. Education has already been mentioned and, as we know, investment in education is key to tackling health inequalities.

Finally, from a health perspective, we need clinical and staff governance around all this to ensure that the quality and, indeed, professional quality agenda remains part of the direction of travel. That is a major risk for us at the moment.

The Convener: As Bob Doris made clear in his opening question, we are looking at all these issues through the narrow focus of the budget. At the moment, however, we are also considering legislation on integration and have had opportunities to take evidence and comment on many issues, including care for the elderly. However, the question is whether the budget in general seriously supports a more preventative strategy and promotes the preventative approach and service integration that everyone says we need. Does this budget play its part in delivering a priority that everyone, it seems, agrees with? What in this budget is significant, is different and will make the step change in bringing about these preventative strategies and successful integration?

Donald Harley: In many ways, the budget is moving in the right direction; indeed, I am sure that we all aspire to the preventative care that you mentioned. However, the trouble is that having to move within relatively fixed funds turns the process into a bit of a Chinese puzzle and moving resources to a certain area might well weaken another.

At the moment, we are concerned about unscheduled and unplanned care, having seen the very laudable time to treatment guarantees against the backdrop of a system that is working at maximum capacity—and, with the very high bed occupancy levels, often above what it was actually designed to deal with—and the knock-on effects of all that with healthcare acquired infections and so on. It also creates multiple choke-points in the system with regard to the social care sector's ability to receive and take out people at the other end and we are concerned that there is no flexibility to deal with urgent care alongside long-term and planned care.

We are moving into the winter season, when, as I am sure committee members know, there are increased pressures on the system and spikes in demand, but we are worried that we are failing to keep pace now. Laudably, the Government has made funding available, but we are not sure that it will be enough, and the spikes could cause real problems with urgent care demand.

The Convener: We have had evidence in other inquiries about the budget shift from the acute sector into the community. Does anyone see that significant shift from the acute sector and primary care to the community? Does anyone want to take that question?

Rachel Cackett: I go back to my original point. The budget does not give us enough detail to be able to track whether that is happening, including the shift from the acute sector into the community. A significant proportion of the budget goes in the core grants to health boards, and the committee has made separate inquiries into how those boards have chosen to allocate funds locally. The areas in which the funding is specified form a relatively small proportion of the overall health budget.

The level 4 detail is quite interesting, when you start looking at specific budgets, for how often it is possible to see that money has been transferred to health board responsibilities, which presumably means that that is part of their uplift. The expectation of what boards will do for their core funding is increasing as the healthy working lives programme and additional waiting times funding move to core funding. We can start to see where some of the pressures are arising, but I am genuinely struggling to answer your question because the budget does not give us enough detail.

Annie Gunner Logan: I am sure that the committee is already aware that Audit Scotland is in the middle of a study of reshaping care for older people and the change funds up to this point. The specific focus for Audit Scotland will be the extent to which the balance has shifted from acute to community care. That study is on the way. I think that it will be quite rigorous and it will give the committee some of the answers that it is looking for.

On the question about where the budget is in all this, I come back to it being part of the discussion on the Public Bodies (Joint Working) (Scotland) Bill, and I know that there are tensions around that between what the Scottish Government wants to do with its budget and how much discretion it wants to give to local partners to make decisions within the context of joint strategic commissioning.

So far, and anecdotally, there are some signs that things are starting to shift, but I do not think that the shift is anywhere near to being on the scale that is expected.

There is also concern that some of the change fund has been used to fund short-term preventative interventions, so once the change fund stops, so will they. The change fund was supposed to be a kind of lever to shift the bulk of spending that was behind it; it has, in fact, been used in creative ways, but almost as an isolated project fund. That is the difficulty that we have.

The Convener: I asked the question because the committee sees legislation being used and initiatives being set up to change the culture. We looked at the budget to see whether it would drive the change. How serious is the attempt to move to a preventative agenda and the integration that we need?

Annie Gunner Logan: I guess that we can, if we look at the budget in the context of other policy initiatives, such as single outcome agreements that now require prevention plans to be added to them, see that that is the general direction of travel. I suspect that the frustration that everyone, including the Scottish Government, feels is that we can set the conditions for something but it might not actually happen. The challenge is in how we drive behaviours.

Richard Lyle: I have listened intently and I should not miss the chance to comment on what Matt McLaughlin said earlier. I have several questions, but perhaps when you are answering the first one, Matt, you might want to say whether you think that NHS Scotland has too many targets set by politicians that are then criticised by other politicians.

The main cost pressures that are identified in the budget are pay, demographics, new technologies, new drugs, volume and maintenance. What is the panel's view of last week's announcement that there will be no pay rise for staff in England when, at the weekend, Scotland's Cabinet Secretary for Health and Wellbeing gave the commitment that there will be a pay rise in Scotland?

Matt McLaughlin: I am happy to take both questions, convener.

Civic Scotland would welcome politicians being more on the same page and doing less better, rather than arguing the toss over whose budgets or targets are right. As I said in opening, the NHS is a big complex service and it is a service that we all hold dear in our hearts. We must start to reshape some of the discussion about the quality of outputs and about the patient journey and patient experience, rather than it being about traffic light systems and screeds and screeds of paperwork. We can always do with having fewer targets, better delivered.

We have gone on record as not supporting the English Secretary of State for Health's recommendation to the NHS pay review body, which will obviously set the pay level. I was at least content to hear the Cabinet Secretary for Health and Wellbeing confirm over the weekend that the Scottish Government will honour the existing 1 per cent increase, but let us be absolutely clear that that is not a pay rise for health workers in Scotland, but a continued pay cut. A number of analyses suggest that NHS workers have lost somewhere in the region of 10 per cent of their earnings in real terms over the past few years. I hate to use the word "welcome" when talking about a pay cut, but we certainly acknowledge the Scottish Government's commitment to honouring the existing PRB agreement, and if there were to be an opportunity for us to increase that, we would gladly take it.

Rachel Cackett: To back up what Matt McLaughlin has said, we are now waiting for the PRB recommendations. The RCN and the staff side generally have made submissions to that United Kingdom negotiating exercise. What was interesting for me this year was reading the paper that the budget adviser to the Finance Committee wrote about the impact on economic growth of the continuing downward spiral in real terms of public sector pay. She was referring specifically to Scotland, but I do not think that the situation is different anywhere else in the United Kingdom, and our members would want a UK deal for a UK workforce.

Annie Gunner Logan: In the world that we are living in, the health and social care workforce is employed by a diverse range of organisations, not all of which are in the public sector, and a substantial proportion of staff in the voluntary sector have had pay cuts and have not had pay rises for a very long time, because of the pressures that are being rehearsed ad infinitum with the committee in relation to procurement, tendering and downward pressure on voluntary sector budgets. We sometimes need to look at those discussions in the context of the wider workforce, because we are not talking only about a public sector workforce any more, and we should raise in those discussions the commitment to a living wage. That is important, but the commitment is not going to be extended to contracted providers who work to deliver public services. The gap between those workers and others continues to widen, which is a real cause for concern.

The Convener: Does anyone else want to comment? The BMA must have something to say on the issue, given its submission.

Donald Harley: I would very much echo what Matt McLaughlin said. You do not need me to rehearse the arguments that staff in the NHS have been working under increased pressure in the past few years against a backdrop of diminished resources and real-terms pay cuts, which is hard to bear and fairly demoralising. We recognise that there is no intention in Scotland to follow the unprecedented changes that have been proposed south of the border, and that must be welcomed, but we also need to look at the backdrop to which Matt McLaughlin referred.

The Convener: Perhaps we can come back to some of the other issues that flow from that, such as the Scottish GP contract, particularly with the integration of care. We have applied scrutiny in the past to budgets that boasted that bank nursing was down, overtime was down, and so on.

10:30

We all welcome the confirmation on salaries that is now part of the mix. However, it does not resolve some of the issues that have been raised in submissions to the committee, such as the fact that nursing numbers are down and posts are unfilled, and that there is an increase in bank nursing and in overtime. What is going on in that regard, and in relation to the GP contract, which does not match our ambition for GPs' involvement in integration and in other areas?

Donald Harley: You mention GPs in particular. As the committee will be aware, GPs are, for the most part, employed not by the NHS but as contractors, so essentially they are managing small businesses. Although they are a relatively well-rewarded segment of the population, they have nevertheless experienced a significant decrease in their net drawings in the past seven years, against a background in which their practice costs are rising inexorably. They are absorbing and bearing all those increases at the same time as they are being asked to do more and more.

A third of the GP population are aged 55 and over, and are looking at the exit door. That is the reality. If you keep on squeezing and squeezing, and there is no recognition of that fact, people will ultimately vote with their feet. We are potentially facing a crisis in manning general practice; I hope that that will not happen, but the potential is certainly there.

Rachel Cackett: RCN Scotland's submission focused to some extent on the change in nursing numbers over the past few years. Although we have seen a welcome—if very slight—increase in NHS nursing numbers in the most recent statistics, there has, as the convener pointed out, also been a rise in the temporary filling of posts.

I can assume only that we cut hard and fast as budgets became tight, because pay is one of the biggest budgets—if not the biggest budget—that NHS boards have to deal with. We have to reorganise services and do things differently. In a post-Francis-report world, people have realised that we need to bring the staff who deliver the front-line care back on board, given that we know that there are parallels between the number of nurses available to care for people and the quality of outcomes.

Although we welcome the slight increase, we can see that the change in the nursing budget line to which I referred earlier is related to the fact that we have for a number of years—until last year, which was welcome—cut the number of nurses who are going into pre-registration education. That is now coming through in the budget, because we are not having to spend so much on bursaries.

The risk is that we keep going back to boom and bust on numbers, which tends to go with the economy. That is not a sustainable way forward for the NHS, particularly given the demography that we are looking at and the pressures that we are putting staff under, whether that is in the acute sector or in the—hugely reformed, it is to be hoped—community sector.

Kim Hartley: It is always distressing to hear about cuts that are affecting our health colleagues. That takes us back to the idea that, if we want a particular outcome, we have to think about who we need in the team to deliver it. The AHPF believes that we need balanced teams. If there are changes in the balance of nursing and medics, we need to balance the other members of the team and the workforce.

That brings us back to the earlier discussion. I want to highlight the fact that AHPs have experienced cuts of up to 20 per cent in their budget at various times, and we do not have bank or maternity cover. Where workforce issues arise concerning doctors, I ask that the view be widened to include the rest of the health team—I am talking about the workforce that delivers the key outcomes. There are particular issues for groups such as AHPs that have not necessarily had the same profile with regard to workforce formulas and so on. Because they are not profiled, the experiences of those workforces are not as well known.

Matt McLaughlin: I want to pick up on Annie Gunner Logan's point about many care workers not being public sector employees but contractors. Of course, Unison supports proper pay for all people in the service. We can make a direct link between the living wage and tackling health inequality. That issue is often missed in the debate.

I have some sympathy for the Scottish Government on the pay issue that was raised earlier. There is a disjoint in the information that is provided. There is a suggestion that we now have more nurses than we have had in recent years, and when we add up the numbers that health boards say they are employing, that is the conclusion that we might naturally reach. However, when we delve below those figures, and look at the whole-time equivalent and the head count of people who are in post at a particular point in time, the information suggests something slightly different.

In June this year, NHS Greater Glasgow and Clyde had somewhere around 1,800 whole-time equivalent vacancies, predominantly for nurses, in its workforce. That is the highest the figure has ever been. When people are saying that there are more nurses than ever, it appears that there are fewer nurses in wards, delivering services.

To back up that general view, that is why nurse bank costs and excess hours costs have been going up, particularly in NHS Greater Glasgow and Clyde during the past 12 months. Yesterday, I started to pull some statistics down from the Nursing and Midwifery Council that suggest that there are fewer registered nurses and midwives in Scotland than there have been in previous years. If fewer nurses are registered with the NMC, that is quite a telling statistic and it suggests that, somewhere, the information that is coming from the Scottish Government to the Scottish Parliament is out of kilter, so we need to do a significant piece of work on that.

There is a fundamental issue about staffing levels in general, but specifically there is an issue about nursing levels, especially given that the percentage of nurses and midwives in the NHS makes up a significant chunk of the workforce. The staffing costs, or pay bill, is about 50 per cent of the budget for most health boards. Boards that are faced with financial pressures find it much easier to manage those vacancies through the system than to make financial savings. I do not think that they will admit to it, but that is what is happening. There is vacancy drag in a number of areas right across the system, and it is impacting on efficiency, cost and quality, which are all key, as we go forward.

On the general debate, the other day I looked at some information that shows that a service redesign seems to suggest that registered nurses starting to work a 14-hour day is the way forward. Apart from the fact that that would breach the working time directive and have a direct impact on the quality of care, is that the message for the future? I certainly hope not.

Donald Harley: Yesterday, there were a couple of excellent articles in *The Herald* about junior doctors' working hours, which reflects a culture in the NHS of playing with numbers. On paper, we are meeting the working time directive and everything is fine, but the reality is that rotas are constructed to cover the gaps that were created by the efficiency savings, and people are working 90 hours at a stretch and weeks of seven 12-hour shifts. That is neither good for their health and wellbeing, nor for the health and wellbeing of the patients. Ultimately, that needs to be looked at.

Richard Lyle: My second point is about maintenance, but it is mainly targeted at energy consumption. Before coming to Parliament, I had the luck to be involved with an out-of-hours doctor service and worked in various hospitals. The one thing that struck me as I went through those hospitals during the day and at night was the amount of energy that was consumed. Lights were left on all the time—there was no system that put the lights off when you went out of a room and on when you went into a room. Are we doing enough to reduce energy consumption—which is another high cost, and it is getting even dearer—in hospitals or the NHS as a whole to facilitate savings that can be put into pay or NHS services?

The Convener: Are there any takers?

Matt McLaughlin: I think that health boards genuinely struggle with that issue. Before they had the national buying consortium, they regularly looked at the energy providers and tried to get more kilowatts per pound. On capital maintenance, all boards have boiler maintenance programmes, and when they do rewiring or refurbishment they try to get the best piece of kit that they can for the money that they have available.

New builds have helped—it is arguable that gains have been wiped out when we have done private finance initiative or public-private partnership projects, but that is perhaps another debate. It might help if boards were encouraged to do a bit more spending to save. The challenge is the big political agenda—for example, if someone is told that they need to wait an extra week for their hip operation but an office is getting triple-glazed windows. A number of years ago, local authorities got some ring-fenced spend-to-save money. That might be a way of tackling the energy efficiency agenda and might be worth investigating.

The Convener: Richard Lyle makes the point about the efficiency drive—£270 million was taken out of the health service in efficiencies, and we have to do about 80 per cent of that again next year. What will be the impact of that?

Rachel Cackett: I notice that the committee has picked up on last year's Audit Scotland report on that. When it was published, the Auditor General

said that the low-hanging fruit has gone and that boards are having to be ever-more creative in coming up with the savings that they have agreed with Government. Our submission highlights some of our work on looking at the savings plans on the basis of the financial agreements that were made at the start of this year as well as the achievements of last year. We wanted to identify the sustainable savings, as opposed to the one-off savings that Matt McLaughlin mentioned, when boards hold vacancies open for an extra two months to save a bit of salary, which is not a sustainable way forward.

Boards face a really tough challenge to continue to make the savings and to make up for the sustainable savings that they did not make the previous year. We have talked about targets—boards have to meet an annual target, but some savings can be very long term. Matt McLaughlin talked about investing to save in terms of energy. The difficulty is that some savings will not come to fruition within the timescales that have been set for boards to make them.

We keep coming back to the point that we do not genuinely know whether what is called a saving is a saving in the technical sense of being a cash-releasing efficiency saving. Savings are sometimes just a way of cutting things out of a budget by top-slicing it to make it work. That puts pressure on front-line staff to work out how on earth to deliver what is expected of them with a smaller budget from the start of the year. I do not envy boards, as we keep going back to them with the same request: make recurring efficiency savings.

As I said, the level 4 detail reveals that the inflationary uplift that is given to boards is often consumed by the additional responsibilities that go with non-recurring funds starting to drop and by responsibility transferring across. There is continual added pressure. Should boards be efficient? Of course they should—I do not think that anyone could say otherwise. However, the way that we manage the targets perhaps requires a little bit more creative thinking.

10:45

Annie Gunner Logan: I will make a point about efficiency. Particularly in the context of integration and what we have been saying about prevention and upstream activity, the system, rather than its individual outlets, needs to be efficient. Why would someone continue to drive efficiency in an institution that could be closed if we could find a way of keeping people out of it? We should not consider efficiency in narrow terms—whether this hospital or that clinic is efficient—because the whole system needs to be efficient.

I certainly agree with Rachel Cackett that something that is called an efficiency might not turn out to be one. A city council—I shall spare its blushes—imposed a 5 per cent budget cut on voluntary sector social care budgets last year. That was sold to the council on the basis that it would come out of efficiencies in administration. However, if the voluntary sector budget is 85 per cent workforce costs, demanding a 5 per cent cut to admin actually means a 30 per cent cut. It simply cannot be done.

We have a lot of experience of sustaining efficiencies that are, in fact, serious cuts, which, to go back to the previous discussion, come out of our workforce, unfortunately.

Rhoda Grant: I will wheel us back a bit to how we spend the budget and how it determines the direction of travel. Donald Harley mentioned accident and emergency, which I will use as an example.

The direction of travel, which has been stated publicly and to which everybody is signed up, is to shift the balance of care from acute care into community care. We have a budget line on winter planning, but more and more people are coming into A and E, so the impact of the policy and spending direction has been the exact opposite of the intention.

Why is that? What can be done differently? What can we do with the budgets to change the direction of travel?

Donald Harley: The reasons are many and complex. You will be aware that an expert group is currently considering unscheduled care. In the BMA, we are doing some internal work on that as well.

The reasons for the situation include things such as bottlenecks in the system. If there is nowhere to receive a discharge, it flows backwards all the way from the discharge through the acute receiving services back into A and E, where it causes a bottleneck.

A and E is always open so, if people are not aware of other options, they will head in that direction. Work is going on within NHS 24 to try to take some of that pressure off, but one of the concerns that we have had heretofore is that the system is quite risk averse and, therefore, the easiest thing to do is to point people towards accident and emergency.

From time to time, people allude to GPs doing more. It is not that the GPs are unwilling to do more—in fact, they already provide most of the out-of-hours care—but if we want them to do more over and above the lengthy, high-pressured hours that they already do, we are looking at an

expansion in general practice and commensurate resourcing.

There are a lot of issues in the mix and it is not easy to give a glib answer, but the situation certainly cannot be ignored. The people who work in A and E—and those in acute receiving—say that the system is getting towards breaking point. It is already hard to recruit people to work in A and E.

We have problems now, but an even greater long-term problem is building up, because it takes some kind of dedicated person, if not a saint, to want to work in an environment that is so intense and in which they will constantly work over their hours and face a lot of physical and emotional demands—it is full-on. People in nursing and medicine say, "Well, actually there are easier ways to do my job and earn a living."

Long term, we need to make emergency care a more attractive place for professionals to work in, and we need to look at all areas, to ensure that more treatment happens in a planned way, rather than in an unplanned way. Of course, some of that is to do with patient education. A lot more could be done in that regard but, in many aspects of health and healthcare, patient education goes only so far because not everyone wants, or has time, to hear the message. All those areas need to be looked at.

Kim Hartley: In relation to pressure on A and E, occupational therapists did some work on how to reduce demand for A and E services. Over the three months of that project, 126 admissions were prevented. It was a small project, but it is an example of how we can start doing things differently, by thinking about who can relieve the demand on our nursing and medic colleagues in A and E, instead of carrying on doing more of what we currently do to meet demand.

We need to optimise the use of current capability and capacity. That takes me back to the question about efficiency. What capability and capacity, for example in the AHP workforce, are we not currently capturing? How could using that capacity prevent people from falling, having to go into a nursing home, developing aspiration pneumonia or having to be admitted to acute care? Those are the sort of things that we need to think about. There is an awful lot that we could do to prevent people from getting to the crisis point at which they must go to A and E.

I think that it was Rachel Cackett who talked about the need to think creatively. We have to start doing things differently, by introducing different people into preventative care. We have to stop thinking that healthcare starts with doctors and nurses, when people become seriously ill. The prevention and tackling health inequalities agendas are all about that. We must start asking whether we are using the capability and capacity of the whole workforce, including AHPs, to do preventative work. We argue that we are not currently doing so, because we still just deal with people as they come through the door. We need to get better at preventing people from even thinking about coming through the door.

Rachel Cackett: I agree with much of what Kim Hartley said, which goes back to Annie Gunner Logan's point about efficiency. We need to think about the whole system. I am pleased that, through the unscheduled care expert group, people are looking at how we improve the flow not just through hospital but in and out of hospital, from and to the community. The headlines on A and E are justified. There are huge pressures on A and E, because it is easy to see—A and E is the front door to the acute sector, which is open 24/7 to people who are in the greatest need. What goes on behind the scenes in relation to the flow through is just as important, in some ways, and adds to the issue.

I agree with Kim Hartley. I do not envy the Government. It is trying to invest money to deal in the short term with a crisis that is happening now, but we have to guard against throwing money at what we already know, because what we already know is not working as well as it could do. We need to think outside the box about how to invest in services, so that we can get people through more quickly, ensure that discharge goes well and prevent people from going in in the first place.

The issue links directly to the integration agenda. If someone is sitting in A and E who needs to be discharged but cannot be, because for some reason health and social work have not linked up and no social worker is available to do the discharge planning and get the person out quickly, we have a problem.

That goes right back to the front door of the hospital. If we have a problem with out-of-hours services in some rural areas, and we know that we do, why are we not thinking creatively about it, as Grampian is? We could be developing nursing roles into delivering those out-of-hours services and having an impact where we know it works. We are not always looking at the system in the round in the way that Kim Hartley suggested we do.

I understand that we are coming under pressure now because we are heading back into the winter, which makes things hard. We have beds that opened last year that did not close during the summer. Where is the capacity that will allow us to deal with a flu outbreak this winter, for example? We have to think about that creatively—and quickly.

Annie Gunner Logan: One of the key drivers, if not the key driver, of the integration project is to reduce emergency admissions. That goes back to what Rachel Cackett and I said earlier about the need to look at the whole system. When we look at what is happening to social care services, we can see some of the answer. Care packages are being cut, or people are being charged more for them, and people are having pressure piled on them by welfare reform. Enormous cost pressures are being put on the community support services that exist to keep people out of hospital, so, as night follows day, there will be more pressure on the acute system.

I come back to the point that I made at the beginning. Although the change fund is all very welcome, there are not enough levers in the budget to force upstream spending. That is what needs to happen.

The Convener: Yes, it is a familiar problem. It is certainly not new to anyone who has been interested in discussions at this committee or at previous health committees. The Kerr report on accident and emergency—it was not by Andy Kerr—identified some of the issues. However, we still have 15-minute visits. If no one is looking after people's hydration or nutrition, they end up in hospital with urinary tract infections and do not come out.

We know all that. The frustration for committee members is that we have already identified the problems, and we are looking for a budget that drives improvement. Annie Gunner Logan has said that the budget is not a game-changer in any way. Is it a step towards the preventative agenda? Is there anything in the draft budget to encourage us to think that we are making a step change?

Annie Gunner Logan: Yes—if you combine the draft budget with the discussions that have already been had in this committee and elsewhere about integration. Joint strategic commissioning involving all the stakeholders will be where integration happens, if it happens at all. I am sure that the committee has had cabinet secretaries before it saying that the key to integration is that money will lose its identity once it gets into an integrated pot. It will no longer be money for social care, acute care or primary care; it will just be money that will then be directed at the activities, services and supports that will deliver the outcomes. That is where it will happen, if it happens at all.

I echo some of what my colleague Martin Sime told the committee a couple of weeks ago. It is not the cash that needs to lose its identity; it is some of the characters locally.

Kim Hartley: Picking up on what Annie Gunner Logan said, does integration at the local level incentivise boards to do the long-term thinking and stick with the programme when they have a successful project that has short-term funding? That is basically it. Does it incentivise boards to stick with that work? If the conditions attached to gaining access to that money do not do that incentivising, the way that boards behave will not change.

The Convener: That is what is frustrating me this morning. How do we get to that long-term thinking? Given the way the budget is set up, it is difficult to do workforce planning. We have to take £270 million out of the system in efficiencies. We have already discussed outcomes and targets and so on. Given the budget that we have been presented with and its focus on targets and everything else, how do we create long-term thinking? Some witnesses have said that the budget is preventing it. Matt McLaughlin is next on my list, so I put the question to him.

11:00

Matt McLaughlin: To answer your first question, for all sorts of reasons the budget is a steady-as-she-goes budget. We need to recognise that its significant characteristic is that it is a more-for-less budget—as all budgets are in the current climate.

To take your second point, thankfully I am not a politician. You are the people who are elected to drive this agenda forward. We can offer advice and opinion—you will get plenty of that—but ultimately it is politicians who need to take a view.

In an ideal world, you would devise the quality service and then ask, "How much will it cost me?" rather than look at how much you have and then at what you need to do.

In a kind of side thought, that takes me to the debate that Robert Calderwood, the chief executive of NHS Greater Glasgow and Clyde, kicked off a few years ago—which still goes around the chief executives' group—about when we in the NHS will be asked to stop doing something. When we stop doing something, we can start to create extra money or extra efficiency, or get to a level playing field.

I would not imagine that anybody would want to sit here and say, "This is what we should stop doing," and I will not sit here and do that. We are all users of the service and we all have views about it.

Annie Gunner Logan made a fair point about losing some of the personalities. As I said earlier, the challenge with the integration debate is that people are arguing about process, structure, how many bums they can get on seats, who has voting rights and who does not have voting rights, and I suppose that those things are kind of important.

However, if the ultimate objective of integrated social and adult care is to prevent people from needing to go into acute hospitals for a long period, to tackle childhood obesity and smoking-related illness, and to do all the things that we would want to do in this country, at some point we need to stop the process debates and get on with devising a structure that delivers. I think that we can deliver it but it needs people to be bold, innovative and a bit brave, and to stop pandering to the vested interests.

Kim Hartley: Absolutely. Vested interests, but we are all in this—[*Laughter*.] It is a collective activity. I stopped myself in time.

The Convener: Thanks for that.

Kim Hartley: There are the arguments about bums on seats but the issue is not bums on seats but the brains, knowledge, skills and experience that are part of creative thinking. Someone is making decisions about how the money is distributed from the central pot and someone is making decisions about how the money is spent locally. Well, let us ensure that all the knowledge, skills and experience—the capacity and capability available to the people around that table—are well understood so that creative decisions are being made. It might sound like a discussion about bums on seats but it is actually a discussion about the intelligence that goes into making these decisions.

Rachel Cackett: I would answer the convener's question with a number of points. I would agree with what Matt McLaughlin has been saying throughout the session. If we are going to improve care, we need to rationalise our priorities around a set of quality outcomes. We need to be really clear what those outcomes are and not keep proliferating outcomes, indicators, HEAT targets and so on. That needs to come from the top.

We then need to find a way of making clear how budgets go towards meeting those outcomes, which we have not quite made a step to nationally—nor locally in a lot of places, although there are pilots on how that might be done better, which is really welcome.

The budget must be more transparent so that we are really clear where efficiencies are being made and that they are genuine efficiencies. Where responsibilities and money are transferring from non-recurring to recurring funding, that needs to be absolutely clear so that we know the hand that NHS boards are being given to deliver what is being asked of them.

If we could rationalise the quality outcomes that we are aiming at, we could also rationalise the number of groups that are currently operating. At the moment, we have a genuine commitment to try to do something differently; everyone has the pressure at their shoulder to do that. One difficulty is the number of separate, disparate groups that are being set up to consider the matter. We have difficulties populating them all, and I cannot imagine, looking around the table, that we are on our own in that respect. The number of different groups looking into workforce issues is enormous; we can sit round a table pretty much every day of the week with a group that is considering what to do with the workforce. How do we bring that together in a whole-systems approach such that we are efficient not only in how we deliver things but in how we have discussions about how we deliver things, so that we are not setting many trains running in different directions at the same time that will not link up at the front line?

The Convener: I will bring Rhoda Grant back in again in a moment, but the issue was whether the annual budget process is a barrier to developing longer-term planning.

Rhoda Grant: Going back to what people said about the money for winter planning, could that money be better spent in providing services to keep people out of A and E, or are we just managing the crisis that is happening? There is not the funding to deal with it, therefore we have to spend up front to deal with the implications of that lack of funding back in the community.

Rachel Cackett: Boards have been asked to produce unscheduled care plans, which includes winter planning. We will never get away from the fact that, sometimes, winter planning will be crisis management. Linking winter planning to a much more strategic overview of how boards will deal with unscheduled care is a welcome move forward. We need to see what comes from that and how that comes into operation. Under the auspices of the expert group, there are some moves away from simply funding a crisis in bed numbers every year come the winter.

Have we got it right? Not yet, clearly. However, there are some encouraging steps being taken along the way.

Rhoda Grant: There are things that you cannot plan for, such as a bad winter with a lot of snow, when more people pitch up at A and E because of falls and breaks. There could also be a flu epidemic. Some things will happen, but my understanding is that a lot of people are pitching up at A and E inappropriately, who could have been dealt with elsewhere, or for whom steps could have been taken to prevent them from going in in the first place. That is where we need to have the spending.

Mark McDonald: It seems like a long time has passed since I put my hand up to speak, but I want to return to an earlier point around health inequalities. When we are considering the health inequalities heading in the budget and the health

inequalities agenda, is there a risk that the health budget is the wrong budget to be looking at? Generally, the health service comes into contact with people after the point at which health inequalities have manifested themselves. The question is whether it is appropriate to look at the health budget in terms of the health inequalities agenda. If so, at what point in the health budget do we consider the issue? What other budgets should the committee be considering? I do not mean examining them, as it is not our role to do that, but what other budgets should we have cognisance of with regard to the health inequalities agenda?

Matt McLaughlin: It is a fair point. We know that health inequalities concern much more than the direct interface with the NHS. We generally accept that the NHS, on the acute side of the house, deals with the product of health inequalities, so the point is correct. Arguably, the integration agenda should drive us to a point at which housing, work, education and other things are considered more holistically in the health inequalities debate.

However, people out there—particularly our primary care colleagues—do a lot of work on health inequalities. That applies from GPs down to staff nurses, who will take bloods or change a dressing in someone's home, for example. A big frustration of health visitors and district nurses has been that they feel that their work is not valued from a health inequalities perspective. They do a lot of soft work with people and families on the health inequalities agenda that is hard to quantify. If the committee was minded to pull together some of those strands and get a more holistic view, that would be an interesting exercise.

Rachel Cackett: An issue for the committee is how it looks beyond the health budget to other areas that have an impact. If we are looking at health inequalities, how can housing not have an impact on somebody's sense of equality and their wellbeing?

As Matt McLaughlin suggested, there is a limit to what the NHS can do to reduce inequalities. The committee's deliberations on health inequalities have shown what a complex and intractable difficulty that is for Scotland. However, the health service has a particular contribution to make to very early years intervention. We know that the health service has a role in preventing ill health from developing by supporting parents and very young children. As a universal service, the health visiting role should be in and among that all the time.

I have spoken about our disappointment with the nursing education budget. Our health visiting population is ageing faster than any other nursing population; we still do not have anything like enough health visitors going through the system to ensure that we have a sustainable universal service. We welcome the additional checks for children, but they mean that case loads are heavy. We have vacancies that are proving hard to fill.

The health budget could have directly shown a far greater emphasis on the upstream activities that Annie Gunner Logan talked about. If we can get that right, over generations we could knock on the head an awful lot of the problems that we currently see.

We welcome the additional money for the family nurse partnership that is in the health inequalities line. That support is well evidenced and targeted, and we are delighted that it is rolling out to communities to support very young first-time mothers. However, we have debated before the fact that the family nurse partnership is very targeted and specific about who can be involved in it. Such jobs are attractive for health visitors, because they involve small case loads, fantastic education and interesting work. We must retain enough health visitors with appropriate case loads and the right coverage to provide a good, universal preventative service.

Kim Hartley: The allied health professions could not agree more that we should consider budgets in the round. Rachel Cackett talked about early years intervention. There are instances of a disjoint locally—which is perhaps mirrored in how funding is distributed centrally—that involves early years funding. I will use an example from my profession. Projects in which speech and language therapists work with young children so that they are ready to learn at school are stopping; the money for them comes from local authorities.

We are back to the question of how health inequalities money is being spent. In the distribution of that money, do we take into account all the capabilities and capacities? How do we ensure that the disjoint that happens locally does not happen nationally? It is incredibly challenging for the committee to achieve that. Doing something to encourage and enable consideration of budgets across the piece would help incredibly at the local level, to ensure that the right people play their part.

11:15

Annie Gunner Logan: The Scottish Government is to be commended for its attempts to break down local silo thinking but, perversely, the budget itself is constructed as a series of silos. For example, it has always struck me as rather odd that the committee's focus is on chapter 3, which, although it sets out the health budget, also mentions health and social care. However, social care money is covered only in chapter 12, which relates to local government. I have always found

that rather peculiar. Indeed, going back to the national performance framework, I think that it would make much more sense to follow Malcolm Chisholm's point about constructing the budget and to align spending with some of the targets and outcomes that the Scottish Government has set itself.

On the question of health inequalities, the local government budget really requires some scrutiny; for example, it would be useful to examine some of the money that is being put into mitigating the impact of welfare reform. I am sure that the committee has heard from a range of people about the reforms' potential impact on health and health inequalities.

When it comes to the budget, I always look for the third sector stuff; after all, that is where a lot of community support comes from. There is a great deal of enthusiasm and support for the third sector in the budget documents, but when you actually chase the money down the various rabbit holes you find that not a lot of it is going into the sector and I wonder whether the committee can help us with that. Crucially, the third sector will be involved in commitments with regard to the change fund and decisions on how that money is spent.

Mark McDonald: That was very helpful. Obviously some of the budgets that have been highlighted are the responsibility of other committees, but I do not think that it would hurt for the committee to consider how we might influence other committees' scrutiny of the health inequalities agenda.

Another issue that ties into the health inequalities agenda is the shift to preventative spending and whether that is manifesting itself in how budgets are being spent locally. I often feel that we close the door after the horse has bolted because we discuss the high-level figures, which are then distributed to health boards, and then we get the health boards in and ask them, "So how did you spend that money?" Perhaps we should have that discussion in advance of their spending the money. What is the prevailing view among the witnesses of the way in which the health boards use the money that they are given to cultivate a preventative agenda at the front line?

The Convener: I am sorry, Mr McDonald—I was just asking the clerk to note down one of the points that you made.

Mark McDonald: That is exciting. That has never happened to me before.

The Convener: You made a good point about not just focusing on how health boards have spent the money that they have been given. Perhaps, instead of looking back, we could start our process by asking them about their plans for the next year.

Has anyone looked at the equality statement in the draft budget? No? Well, that will be your homework then. When Matt McLaughlin raised the issue of equalities, I recalled that the budget contains an equality statement, and we would welcome witnesses' views on that, if they are not too burdened.

Mark McDonald: I just wanted to say, convener, that there was a question at the tail end of my previous point.

The Convener: My apologies, Mark.

Mark McDonald: That is okay. I asked how a preventative agenda was being cultivated at a local level.

Kim Hartley: A range of AHPs have taken up the opportunities offered by short-term funding projects but, as the Health and Sport Committee will, I hope, soon find out from its survey on speech and language therapy, there has been a retraction in the workforce delivering some of that preventative work. Moreover, because the projects are short-term in nature and are not being continued, the issue is, as we say in our submission, what happens to them.

The shift has not necessarily happened. We have still not made the leap to thinking creatively at a local level about how we use the money to exploit fully the available capability and capacity.

Mark McDonald: How is preventative spend modelled? We often receive representations from a range of organisations—Kim Hartley and I have discussed this in the past—that say that, if we spend £1 on something, we will save £X elsewhere. What modelling is being done to analyse whether that actually happens so that when the health board spends £1 on speech and language therapy, for example, it can analyse whether it will save £X in two, three or four years' time?

Kim Hartley: I do not know, but I suppose that the primary message is that the professional bodies for AHPs do not see a good awareness of the capability, the capacity or the evidence base on prevention from an AHP perspective. My colleagues on the panel, who sit on many more groups than AHPs do and have decision-making positions, might have a better idea.

Rachel Cackett: The RCN is doing some work across the United Kingdom, including in Scotland, with the Office of Public Management. In Scotland, because there is not enough evidence to do the modelling, we have been trying our best to start to find a way to quantify how innovation results in efficiency, which will not always be a cash efficiency. One of our difficulties is that, when cash efficiencies arise, they might not arise in the body in which the person is employed. How do we take

account of efficiencies throughout the whole system? That is Annie Gunner-Logan's point again.

For example, we have been considering a very interesting project that has been trying to reduce acute in-patient stays in child and adolescent mental health services in Fife. The programme has been rolling out for some time and can demonstrate the efficiencies that it has created and the improvements in service and outcomes for the people involved. However, our current budget framework at the local and national levels means that we might not be able to account for whether all those efficiencies will arise in the NHS because it has chosen to invest in that project. That is a flaw in the system that we have created.

All those around the table, including members of the committee, probably have local examples of fantastic work that is going on. How do we extrapolate that work up so that NHS boards that come to speak to you about how they intend to spend their money can take that work into their part of the spend—which will not be everything—and how can we then extrapolate that up into the decisions that are made on levers for prevention in the Scottish budget?

We do not have that line through the system at the moment, nor do we have the line that runs across agencies. That makes the question difficult.

Annie Gunner Logan: I do not know what the health boards are doing about the issue but, again, I come back to Audit Scotland's work on reshaping care, in which there will be some interesting information for the committee with respect to Mark McDonald's question.

In our experience, third sector organisations can demonstrate their cost benefits and outcomes until they are blue in the face but it does not always make a lot of difference to purchasing decisions. There are two parts to the issue: demonstrating that we can deliver results, outcomes and efficiencies into the future; and still making the case that that is worth investing in.

That is where many third sector organisations still really struggle because, despite providing endless evidence—up to and including peer-reviewed articles that have been published in journals—about the outcomes that they can achieve, they still get huge pressure on costs or the application of the dead hand of public procurement to what they do, with the contract going to somebody else who can do the activity for less money but cannot demonstrate the outcomes.

The convener will know that I bang on about this endlessly, but the connection between what we invest in and the demonstrable results that it will achieve is really not there. That needs to be strengthened. Going back to joint strategic commissioning, I hope that evidence is a strong point that people will consider when looking at what they are going to invest in under that agenda.

Mark McDonald: That is helpful. It widens the discussion on who makes the spend and who then derives the benefit. I worry that the silo mentality that we have spoken about exists not only in the health service but between different agencies and bodies, with people thinking, "Well, we're going to be the ones spending the money up front but we're not the ones who will see the benefit." We must consider whether there can be a whole-Scotland approach to the preventative spend agenda, rather than only within individual services.

Annie Gunner Logan: That is what the revisions to the community planning processes are supposed to be achieving, because there you are not talking about just health and social care but bringing in all the other things that people have mentioned—housing, education, early years services, leisure and recreation, police and the whole lot. That is the kind of forum where some of those decisions can be made, but I return to my point about it not being just the money that needs to shrug off its label, but some of the people around the table too.

Rachel Cackett: I would like to pick up on a point that Annie Gunner Logan made about joint strategic commissioning being where some of the discussions should take place. I certainly hope that that happens, but it is a new way of working in Scotland and we have a lot of development to do to get to the stage at which the people around the table feel confident in handling the evidence and making evidence-based decisions on how to invest.

We need to think about whether we have enough investment going into the development of the front-line staff, the community groups, the third sector or whoever it is who needs to be around the table to get that right over the next couple of years. The responsibility for investment decisions that we are going to put on those groups will be enormous, and we will be doing them a disservice if we do not ensure that sufficient investment is made now.

Nanette Milne: There has been some interesting discussion on health inequalities and the issue of keeping an ageing population out of acute services and crisis care. It strikes me that the key to that is promoting and supporting self-responsibility, both in avoiding long-term conditions and in managing them when they arise. To do that, as we have already heard, health visitors, specialist nurses, GPs and AHPs are important, and all of them seem to be in increasingly short supply in terms of coping with what is required. Has any estimate been done of how many people need to be trained up in those

areas of expertise, and is there any estimate of what that might cost?

Rachel Cackett: At the moment, one of the difficulties in coming up with firm figures on, for example, health visiting—members will be aware of the discussions that have been held about that in relation to the named person provisions in the Children and Young People (Scotland) Bill—is the quality of the data that we are already working with. The Government has been open about the fact that the data that we have on the community nursing workforce is not wholly accurate at this stage. Finding the baseline from which to start projecting therefore becomes difficult, and work is continuing to clean that data so that we are absolutely clear what the workforce is.

Another important issue takes us back to the discussions around prioritisation. I do not know that we are always 100 per cent sure about what we are aiming at, so, as Kim Hartley has been saying, how do we staff it in the right way? We need to be absolutely sure what we are training for. If we know that we are going to have an older population with multiple morbidities and complex needs, how are we going to bring the relevant groups around the table to plan for that? What do we want that service to look like? I think that we can give great examples of where things are working well, so how do we extrapolate those up into a national vision of what we want? The risk is that, without that vision, we will keep making decisions that are based on cost rather than on aspiration.

11:30

Donald Harley: One of the strange things, I suppose, is that while the number of GPs has increased in the past 20 years, in the same timeframe the public's expectation has outpaced that and the things that we are asking GPs to do have grown like Topsy. GPs are doing a huge amount of preventative care under the quality and outcomes framework, which was not anticipated before the 2004 contract. All of that is a good thing but it has a knock-on, constraining effect on the acute care side.

Again, this is about deciding priorities. We can do only so much with a fixed pot of money, and we have to make some hard choices. Ultimately, that buck comes back to rest with the politicians.

Nanette Milne asked about what more GPs or a bigger workforce in an area would look like. It is really difficult to say because the modelling is pretty poor and some perverse incentives are built into the system. The starting point has to be what you want and how you are going to resource it.

The Convener: It might be fewer GPs and more carers at home.

Donald Harley: It might be—it is your choice.

The Convener: I am not being facetious. I do not know whether it is our choice. I thought that we were all agreed about creating a new workforce. Sometimes it is not a GP that people need but a friend or a sense of wellbeing. We have definitely bought into a system that would shift the nature of the workforce. That does not necessarily mean having more GPs, who might have a smaller workload. It might mean shifting to a more professionalised group, or even just shifting to more people dealing with individuals in the community.

I look at the focus that we have on the GP and the people who deliver the service. The 15-minute care visit is all over the news down south this week. Where is the continuity and quality around the GP if the people who actually deliver the service are sometimes on a zero-hour contract or the minimum wage, and have no time to take their coat off to provide a meal or have a conversation? Is that not the contradiction that we have here when we are dealing with budgets?

Annie Gunner Logan: Absolutely.

Donald Harley: There were quite a few questions in there.

The Convener: It was a bit of a rant.

Donald Harley: To a certain extent, it is motherhood and apple pie. We all want a more effective and efficient service, whatever that looks like, if it delivers better care all round.

Nanette Milne mentioned GPs in her question so my answer was on GPs. It is true that the solution will involve a mix of staff and resources; nevertheless—I go back to a point that I made earlier—much more is being asked and expected of GPs. There is clearly a demand there from the public and from politicians, and you have to decide what you want.

Annie Gunner Logan: Convener, I agree with your rant. You are right that this is not about more and more professionalisation; it is about less and less. Nanette Milne's question was how we maximise self-management, resilience and community support. The question for this committee is how the budget drives some of that behaviour.

I go back to a point that my colleague Martin Sime made when he was before the committee about how the third sector is pivotal to that approach. If anything is going to keep people out of hospital, it will be the neighbourhood network, the garden angels project and the lunch clubs. Such localised self-help and community supports do not cost much, but investment in them will reap the savings that Mark McDonald was talking about

for the more acute services down the line. That is an absolutely key point.

We would like a guarantee that the third sector will have a voice and representation when some of these decisions are made because, notwithstanding the discussion we had about bums on seats and power struggles, if the same people are around the table, we cannot expect the decisions that they make to be any different from those that they made before. I suggest that we need a rogue element of people who have an agenda to be put into some of the decision-making processes.

Kim Hartley: I could not agree more. It is down to the modelling that Mark McDonald talked about. We absolutely need that. I agree with the convener's rant as well. It is down to evidence-based modelling of what will deliver self-management.

I represent a group of people and, like others, I obviously want to say what we bring to the piece. The panel mirrors what we hope would go on round the modelling table, not with anyone thinking that they are more or less important but with everyone being part of the mix to deliver the outcome.

Third sector organisations are crucial. They receive a lot of training from the statutory sector, not least AHPs, who do a lot of training for our third sector colleagues. We cannot have one or the other; it is not a competition. It is a matter of the modelling. We might come out with a workforce that looks very different. The point should not be what is important to that particular workforce but whether it delivers the outcome.

That takes us back to Malcolm Chisholm's point about the link to targets and indicators and what makes the difference. Getting the modelling and the intelligence around it right is crucial to making the shift.

Rachel Cackett: The executive director of the RCN in Scotland has been out a lot talking to newly qualified nurses and students. One of the key messages that she is giving them is that they should not expect their careers to look like hers because they just will not. Nursing careers will look really different in the future. Nurses will work in different ways and for different people.

I absolutely agree with Annie Gunner Logan. If we want to prevent people from becoming socially isolated in older age and falling into the need for public sector care, we need community transport to get them to an appointment or to the shops so that they have people to speak to every single day.

This almost takes us back to the round table that we had a couple of weeks ago on integration at which I kept making the point that we need to understand why people are round the table and have a seat. This is no different. There should be a panoply of available resources as people's needs change, ebb and flow. Nurses bring a specific contribution to that, just as doctors or volunteer community transport drivers in the local community do.

We need to have that range so that people can pick up on what they need, when they need it. We absolutely support that approach in relation to self-management. The availability of information technology support is crucial to that if we are to allow people to live the most independent life that they possibly can, whatever their condition. They need to know that they have the support of an expert on the end of the phone if they need it, but they do not need to have that expert crowding their every moment. We must move down that line, otherwise the system will creak.

Matt McLaughlin: Convener, I suppose that your rant—as you described it—shines a light on the elephant in the room. It is the big issue.

In some sense, it is a credit to successive Scottish Governments, which have not said, "Let's do something different. Stop the bus. Scrap everything we've ever done before and start with a clean sheet of paper." We know that we cannot do that. We need to get there through an incremental, staged progression. I suppose that the frustration that we all share is that that staged journey is ponderously slow and there seem to be some real taboos around the issues that people want to tackle.

One of the fundamental issues lies with the notion—thankfully, it is not necessarily a Scottish notion—that we can just create a big society, it will happen and it will be free. We are bit smarter than that in Scotland, but we need to recognise that, if we design a service based on cost, we will get a service delivered on cost, which will not necessarily drive a quality service. If we are dead keen on tackling health inequalities and giving proper resources to public sector bodies and colleagues in the voluntary sector—and, indeed, potentially, colleagues in the private sector—who might be able to provide particular services, we need to base that on quality and real cost.

We need to start by recognising that 15-minute care visits are not acceptable in Scotland and that, as a consequence, paying somebody the minimum wage to do a 15-minute visit but not paying them between visits is not acceptable. If we start from that premise as we devise the new services, we will start to tackle the health inequalities agenda in totality. We cannot ask organisations or the front-line workforce to deliver a service with their hands financially tied behind their backs. We need to be fair, open, reasonable

and honest if we want fair, open, reasonable and honest services for the people for whom we provide them.

Nanette Milne: That has been a further interesting discussion.

The Convener: As there are no further questions from committee members, I say once again to the witnesses that we appreciate all the time that they have given and their written evidence. We will take their evidence on board and will probably find ourselves round a similar table in the near future.

11:42

Meeting continued in private until 12:37.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice to SPICe.

Available in e-format only. Printed Scottish Parliament documentation is published in Edinburgh by APS Group Scotland.

All documents are available on
the Scottish Parliament website at:

www.scottish.parliament.uk

For details of documents available to
order in hard copy format, please contact:
APS Scottish Parliament Publications on 0131 629 9941.

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@scottish.parliament.uk

e-format first available
ISBN 978-1-78351-864-7

Revised e-format available
ISBN 978-1-78351-889-0

Printed in Scotland by APS Group Scotland