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Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 28 October 2014

Session 4

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HEALTH AND SPORT COMMITTEE
27th Meeting 2014, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor David Bell (University of Stirling)
Rachel Cackett (Royal College of Nursing Scotland)
Annie Gunner Logan (Coalition of Care and Support Providers in Scotland)
Kim Hartley (Allied Health Professions Federation Scotland)
Lilian Macer (Unison)
Jill Vickerman (British Medical Association Scotland)
Dr Andrew Walker (University of Glasgow)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 28 October 2014

[The Convener opened the meeting at 10:39]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning, and welcome to the 27th meeting in 2014 of the Health and Sport Committee. I ask everyone to switch off mobile phones because they can interfere with the sound system. That said, people will notice that committee members and clerks are using tablets instead of hard copies of our papers.

Our first agenda item is a decision on whether to take in private at future meetings consideration of a draft report on the Scottish Government's draft budget 2015-16. Does the committee agree to do that?

Members *indicated agreement.*

Subordinate Legislation

Scotland Act 1998 (Agency Arrangements) (Specification) Order 2014 (SI 2014/1892)

10:39

The Convener: Agenda item 2 is subordinate legislation. We have two instruments that are subject to negative procedure before us this morning, the first of which is statutory instrument 2014/1892. There has been no motion lodged to annul the instrument, and the Delegated Powers and Law Reform Committee has made no comments on it. Do members have any comments? No. Does the committee agree to make no recommendations?

Members *indicated agreement.*

Food Hygiene and Official Feed and Food Controls (Scotland) Amendment Regulations 2014 (SSI 2014/213)

The Convener: The second instrument is Scottish statutory instrument 2014/213. There has been no motion lodged to annul the instrument and the Delegated Powers and Law Reform Committee has made no comments on it. Do members have any comments? No. Does the committee agree to make no recommendations?

Members *indicated agreement.*

Draft Budget Scrutiny 2015-16

10:41

The Convener: Agenda item 3 is our first draft budget scrutiny evidence session. I welcome our witnesses, who are Dr Andrew Walker from the University of Glasgow, and Professor David Bell from the University of Stirling.

Professor Bell, do you wish to make some points?

Professor David Bell (University of Stirling): I will make a few introductory points, if I may.

I will start with the share of the budget: how much health spending accounts for as a share of the Scottish budget, which is an issue of some interest. The share appears to drop from 33.8 per cent in 2014-15 to 32.5 per cent in 2015-16, but that is somewhat misleading. In fact, the share stays pretty much the same if we discount the annually managed expenditure on Scottish pensions provisions. There has been a huge increase in the AME budget for pensions, which apparently results in a reduction in the share of health spending, but that is to do with something that is not really under the Scottish Government's control.

I will talk a little bit about spend per head in Scotland. Between 2008-09 and 2012-13, health spending in Scotland, compared with that in England, has gone from a higher spend, with a margin of 14.3 per cent, down to a margin of 11.7 per cent, so there has been something of a fall in the spend of Scotland relative to that of England. At the same time, there has not been a huge amount of change in Scotland's overall extra spending. In 2008-09, in Scotland's overall public expenditure per head, the margin over England's overall public expenditure per head was 18 per cent, which was considerably more than the margin in health spending. In 2012-13 it was 19 per cent, so it has not changed much. However, there has been a bit of a change in respect of health spending. I am happy to take questions on that.

10:45

I will say a little about targets. Andrew Walker comments on the issue in his submission, so I will be brief. I consider that targets are a snapshot of experience and that people are interested in the broader perspective of the health service, their experience in it and the quality and availability of the care that they get. I would like there to be broader public involvement in how we come to decisions on what we want from the health service. The Scottish universities innovation institute is doing an interesting project on wellbeing, in which we are considering how we might engage the public in the national performance framework to a greater extent than has been the case up to now.

As an economist, when I think about things such as the level of productivity in the Scottish health service, I look at the Information Services Division statistics, but it is difficult to figure out what is really happening. For example, how are costs changing and is the gross domestic product deflator—which is used in Scottish Parliament information centre publications and other publications to get to what is described as real spending in the health service—the appropriate measure of costs in the health service? It is not entirely clear to me that there is sufficient evidence to back that up in Scotland.

On the mix, or interaction, between social care and health, it seems to me that we are in for an extended period in which local government budgets will come under increasing pressure. Health budgets are likely to be protected to a greater extent than local government budgets, which will put more and more pressure on the interface between social care and healthcare. Therefore, it is important to make as efficient, and as well-evidenced, as possible the use of resources that go to that interface.

My final point is perhaps a little bit from left field. The See Me campaign has today produced a document asking for an end to the stigma around mental health issues. It seems to me that Scotland is perhaps a little behind the curve in its focus on mental health, in relation not just to stigma and to wellbeing—the evidence is absolutely clear that mental health is one of the most significant predictors of low levels of wellbeing—but to the economic case for investment in mental health services, which has been made strongly south of the border, where the National Institute for Health and Care Excellence has recommended a number of policies that relate to a switch towards mental health services. Now that the Scottish Government has control over at least a proportion of its income tax revenues, and that proportion will perhaps increase, there is a case for considering whether investment in more mental health services capacity in Scotland would lead to a larger increase in income tax revenues than would, say, increased investment in childcare, which is one proposal that seems to be out there.

I will end on that slightly controversial point.

The Convener: Thank you.

Dr Walker, we have your written evidence but do you want to make some opening remarks?

Dr Andrew Walker (University of Glasgow): I will do so very briefly, convener.

Thank you for inviting me. Having been an adviser and witness, I think that the only role left to me is to get elected and become a committee member—

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Good luck with that.

Dr Walker: I have no ambitions in that direction, and lack so many of the skills and talents that the committee exhibits. You are very brave people to listen to two economists for an hour.

Having read draft budget documents since 2001 as part of my previous role with the committee, I see a lot of continuity in the style and presentation of the document, which continues to frustrate me. That is not specific to this document; it is common to all documents. The draft budget is essentially an allocation statement in which we take a top-level line in the budget—roughly £12 billion—and say into which lines in level 2 and level 3 of the budget it will go.

There is some accompanying text that is loosely linked to the budget, but it is not always clear what line it feeds in to. Having seen the SPICe briefing that became available yesterday afternoon, I can see some more of those links, but it is still frustrating that the text in the document does not really tie in with the tables terribly well.

The questions that the committee sent out this year about the national performance framework were helpful in reminding us that it is there, but that highlights the fact that it does not really link in to the draft budget document. Certainly, national outcomes are mentioned at the start, but in terms of specific indicators there is not much analysis of what is going well, what is going less well, and where the budget spending should be allocated in line with that. That is an issue to which we might come back.

As I looked across the different indicators, I saw that some are improving, some are staying the same and some are going in the wrong direction. The two that caught my eye were public health indicators that are static: the committee might like to pursue the question why there has apparently been no progress on improving levels of physical exercise and smoking cessation in Scotland. We would like to see those figures improving, but according to the indicators they are currently stalled. Is there a case for more Government spending to be put into moving those in the right direction?

The main other line that I comment on, given my role in the area, is the new medicines fund. I remind the committee that I have conflicts of interest here as I work with pharmaceutical companies. The new medicines fund clearly responded to the parliamentary debate and the cross-party consensus last year on better access to medicines. We can see the historical context of about £10 million extra going into prescribing costs, so the fact that the fund stands at £40 million shows what a difference that decision made and will make, but there are still questions about whether that is the right sum of money. How does the Scottish Government plan to stop medicines accumulating in that fund and it building up so that next year we need £80 million to go into it and £120 million the year after that? We also need to come back to the issue of health gain and how much we are getting for the money.

I hope that I have gone into those points in a bit more detail in my submission. As I read through it, I noticed that I had a section 1 and two section 3s, so having exhibited my inability to count to three, I would be happy to leave at this point should the committee wish me to, convener. Otherwise, I am happy to take questions.

The Convener: Thank you both for those introductory remarks.

Richard Simpson has the first question.

Dr Simpson: I have a general question to open with. Since 2001, before the Christie commission—Dr Walker was involved with us and I was on the committee at that time—we have talked about a shift in the balance of care from the acute sector to preventative care, and how that is fundamental to ensuring that we have a sustainable health service. Do you see anything in the budget that evidences a coherent attempt to make that shift, given the additional impetus of the Christie commission, which was absolutely clear that we would fail if we did not get this right? I know that some of this is down to level 4 spending by the health boards, but unless there is a drive from the centre—from Parliament, the Government and this committee—we are just playing at it, I think. Would you like to broaden that out a little bit?

Dr Walker: Absolutely. Anyone who knew Dr Simpson before 2001 will know that we were talking about the subject during the decade before that, as well, so it is an extremely long-running theme.

The best answer to the question that I can see in the document is probably the integration fund and the assumption that, because it will be linked to local government spending, it will involve community-based services and will therefore place the emphasis on getting people out of hospital. That is the clearest thing that I see.

However, as Dr Simpson suggests with his question, some of that activity has to be implied. I am glad that the committee will come back and ask more questions in April when it sees health boards' delivery plans. I agree that there needs to be a central commitment. In the Scottish

Government's defence, I say that £70 million to put in the integration fund is quite a big chunk of what was available. I guess that we would all feel a little bit more comfortable if there was a firmer commitment to what we will see in 12 and 24 months as a result, in terms of something measurable. However, that is the best that we can do with the draft budget at the moment.

Professor Bell: I looked at some data on activity measures that I managed to find on the ISD website. It is quite surprising how rapidly acute specialty throughput has been increasing over the past six years. Over 2008 to 2014, the numbers of in-patient and day-case discharges have been growing annually at 2.1 per cent and 1.9 per cent. Accident and emergency numbers have been increasing at 0.7 per cent, and consultations with general practitioners have been increasing at 0.3 per cent. It looks to me, therefore, as though acute throughput has been increasing faster than GP consultations and so on. In fact, the case might be made that the reverse of where the Government has been trying to go should be what to follow. I am not saying that I agree with that, but somehow the system does seem to be focusing on the acute side rather than on other activity.

Dr Simpson: I have a supplementary question. If we take the section of the budget headed "Improving Health and Better Public Health", it has an increase of 1.3 per cent this year. However, what happens if we strip out the family nurse partnership programme? It is a programme that we all support and is very interesting, but it is hugely and inordinately expensive. If I had said to one of my nursing colleagues when I was a GP "We're going to give you a workload of 20 patients and if they drop out you won't have to replace them", they would have bitten my hand off for that job. The work with the families in the family nurse partnership is not intense work, and a case load of 20 is just extraordinary. If we strip out the family nurse partnership programme, we can see that everything else is going down.

We have a huge problem with obesity, but the food and health budget is down by 48 per cent. The grants to voluntary bodies, which are critical for delivery in many public health issues, are down by 13 per cent. The healthy working lives budget is static. Is the section of the budget on health improvement and health inequalities appropriate? I know that some of it is shifting and that we must tease that out; for example, the keep well programme has been put under the authority of health boards and they are being told just to get on with it now. However, there is no evidence that the keep well programme is working.

Would you like to comment on that section of the budget? That is the only identified preventative spend that we have.

Dr Walker: You are right.

Dr Simpson: There is the spend on tackling tobacco and alcohol issues, but the spend on alcohol is down for another year, despite it being a major problem; and the spend on smoking cessation has been flat for four years now. Those are the big public health issues, as well as obesity.

Dr Walker: Absolutely. I said in my written evidence that there is a question around putting £70 million into an integration fund or a public health fund. I can see that there is a case for both of them, but my instinct would have been to put it in the public health fund to tackle inequalities directly. I do not know what that would have done to health board finances, though.

I guess that that presents us with a choice about whether we talk about moving money from acute into primary care or from curative into preventative care. The public health approach would push us more towards the latter, which is about the prevention of ill health before it happens, whereas the integration fund pushes us more towards the former, which is about where we care for people when they are sick. I would make a distinction between those two approaches.

I would certainly like to hear those cases argued more clearly, so that we can understand on what basis the Scottish Government decided to bet the budget on the integration fund. That is the key issue in this draft budget.

11:00

Professor Bell: I agree, in that what is missing is the information that we need if we are to make the kind of decision to which Richard Simpson implicitly referred.

There is quite a lot of evidence that public sector costs and tax revenues are very skewed towards the problem parts of society, so a family nurse partnership case load of 20 might be value for money in the long run, if everything is taken into account. It might not necessarily be best value for money, because there might be alternatives that would give a better rate of return. However, we do not yet seem to have made the case that helps us to make that kind of decision.

Dr Simpson: I make it clear that I am not against the family nurse partnership programme: we are all committed to it. It is valuable and in America it has been proved to be functional. However, budgets involve making choices, and it is difficult to know whether we should be expanding the programme as rapidly as we are doing, given the costs that are involved.

Bob Doris (Glasgow) (SNP): Dr Simpson has started an important line of questioning. Every year at the start of the budget process we wonder whether we should scrutinise lines in the draft budget or wait until health boards set their budgets—is that the real scrutiny job?

My reading of the budget is that there is a political commitment to pass on the Barnett consequentials to territorial health boards for direct patient services. SPICe has shown that that has resulted in a 1.1 per cent real-terms increase. However, rather than look at the numbers, which take the politics out of everything, the committee is trying to consider how we spend the moneys, which is more important.

Is this a transition budget? We are moving towards health and social care integration, but when I see allocation of £9.474 billion in the budget line for health boards and special health boards, I have no idea what chunk of that money will find its way into the first health and social care local delivery plans and priorities across the 32 local authorities. Is this budget scrutiny really a bit of shadow boxing before the scrutiny that must happen in years to come? Will the robust scrutiny job be about looking at local health and social care plans? Scrutiny of the draft budget is still important, but what can we do other than debate the headline figures?

Richard Simpson made an excellent point about the family nurse partnership. However, Governments are often accused of not thinking long term. The family nurse partnership is costly up front and we will not see the benefits for a generation. It is an initiative that will not bear fruit for years. Politicians find themselves in a bind in that regard.

I apologise for drifting off my line of questioning, convener. I suppose that I am looking for a steer. It is for politicians to scrutinise the budget, but we have an economist and a health economist with us. Where is the real, detailed scrutiny that the committee must do? Should we look at the headline numbers and how they relate to outcomes, targets, the national performance framework and all that, or should we be turning towards health and social care integration, which is the real biggie at the moment?

Professor Bell: I think that the health and social care issue is critical because of the demographic change that we are going to see over the next couple of decades.

As I mentioned earlier, we have budgets that are probably going to go in different directions. The health budget is most likely to remain stable in real terms, although we know that, if the current age profile of spending does not change, the health budget needs to increase in real terms just to stand still if we are to give the same level of care to, for example, older people as they are currently receiving.

On the other hand, the local government budget, which has already come under a lot of pressure, is likely to continue to come under pressure because it is unlikely that we will see a situation in which there will be any substantial increase in overall spending. Indeed, it is likely that overall public spending will continue to contract for the next three or four years, or possibly longer.

Health and local government are therefore two organisations whose funding profiles look a bit different but who are being asked to integrate and to produce some new, joined-up provision. That integration will be critical to the success of Scottish Government policy, because it covers the two areas—it is a cross-cutting issue. What matters is not the success of the health budget or the success of local government but the success of the two together. There is an argument for looking at those two budgets in particular detail. I think that that would be a more useful exercise than the kind of exercise that we are going through now.

Going back to what Dr Simpson said, the issue of preventative spend is also very important. It may be over a shorter time period, but we need to consider how we will deal with older people to ensure that they do not end up needing acute care for prolonged periods of time. That should be an issue of great importance for the committee.

Dr Walker: I echo what you said, deputy convener, about 80 per cent of the funds going to the health boards and how we cannot see how they will be used. I am glad that the committee does its scrutiny in April, because it is the only effective scrutiny that the health board budgets receive.

On top of that issue, we know that about 98 per cent of the health budget is to be spent on the same things that we spent it on last year, so we end up talking about quite small changes around the margin. That is in the context of a portfolio that controls one third of the Scottish Government's budget and which covers organisations, such as NHS Greater Glasgow and Clyde, that have budgets bigger than other portfolios that will see parliamentary scrutiny. The whole thing does get a bit skewed.

Some of the budget lines are very important and interesting, and it certainly merits some of the committee's time to look at them. The key debate is the one that Richard Simpson started on the balancing of integration, public health and new medicines. Where is the balance to be among those aspects, given that all three are things that

we would like to spend money on? That is a really important issue to examine at this stage.

The amount of time that the committee devotes to looking at the health boards and—presumably this year—at the health and social care partnerships is appropriate. However, if you cut back a little of the time that you spend scrutinising the national budget at this stage, you could devote more time to looking at the performance framework and the number of targets and indicators that there are.

As I did my background work for the committee meeting, I found the national performance framework and various iterations of the data; I found a website called Scotland performs, which may or may not be the same thing; I found the HEAT—health improvement, efficiency and governance, access and treatment—targets, which we know about from the NHS; and, reading the SPICe briefing, I found something called the quality monitoring framework.

I am not sure whether those measures are all overlapping or whether they are intended to overlap or integrate. If the committee were to spend a meeting or two getting to the bottom of that and encouraging the Scottish Government to demonstrate to those outside of Government how they link together to make things more transparent, that would be time well spent.

Bob Doris: That takes us somewhere with our scrutiny.

You mentioned the integration fund and the new medicines fund. In the coming year, those funds added together amount to about £111 million. That is a significant amount of cash, but I suppose that, in the greater scheme of things, it is a relatively small chunk of the headline figure that territorial health boards get. I take on board the point that you made about a lot of those costs being fixed, so there is little room for manoeuvre there. Is it the case that, as Dr Simpson suggested, one of the main areas in which there is room for manoeuvre is in reviewing the targets that the territorial health boards have to meet, whether for surgical procedures or for in-patient and out-patient waiting times?

Surely any review would have to be twofold. It would have to consider what NHS outcomes patients are looking for—to give an example off the top of my head, whether waiting 18 weeks rather than 16 weeks for a hip replacement makes a significant difference—and it would have to consider whether, if it did not make a significant difference, it was possible to monetise the cash saving from that extended time, so that cash could be released and put somewhere else. That could be done only with patient support, because it is a national health service for the people we all represent.

The committee could consult patients' groups, the NHS, our communities and constituents, and the Government, but what we need the health economists to do is to monetise what the cash release savings would be for any decisions that the Scottish Government might take—which we would, of course, scrutinise—to get cash out of that suite of targets and outcomes if we rearranged them and slimmed them down, as we could perhaps get public support if people knew how we planned to redirect that cash. Can you point us to any work on that? Is it work that you would be itching to do?

Dr Walker: I was about to agree with everything that you said until the last statement. It would be a PhD-length piece of work.

I completely support that suggestion. I welcome the fact that, in the past three or four years, the committee has stepped out of the annual scrutiny at this stage and has looked at what the health boards do. That has been a terrific advance. The things that you are proposing—looking at whether targets are set at the right level, cover the right range of things, and appropriately drive decision making at local level, which is something that the British Medical Association representatives might raise later in the meeting—would be excellent areas for the committee to scrutinise as an annual item. Maybe you could give up some of the time that you spend looking at fairly arid level 2 and 3 documents.

You asked specifically whether I was aware of things that would monetise those targets, and the answer is that I am not. It speaks to the fact that both Professor Bell and I have alluded to in our evidence—that we really do not have a lot of the data that we need to help us make decisions. We would like to know what the cost difference is if the time-to-treatment target is set at 18 weeks rather than 16 weeks or 24 weeks. The Scottish Government might have that information, so we might be talking about structuring some questions for the Scottish Government to provide the evidence that the committee could then consider and scrutinise. I am not aware of any independent economists working on that, unless Professor Bell is about to surprise me.

Professor Bell: No, I am not. To make a nerdy point and following up on Andrew Walker's remark, it may well be the case that not all weeks are equal in terms of cost. Going from 12 weeks to 18 weeks may cost X per week, but going from 12 to 24 might cost quite a bit less, because health boards would not have to put people out to private providers for the care that is required just to meet the target. We are interested not in the average

but in how much has to be spent right at the margin to hit a target.

11:15

The Convener: We have had a bit of a debate about the boards, and that scrutiny is still to come. However, when we look at the recent debate that became public following the leaked papers from the people who are running the health service, it is not simply about allocation, is it? They complain bitterly that the introduction of new legislation is placing binding financial resources and obligations on NHS boards. They complain about policy decisions being made that require boards to prioritise additional investment in acute care—we have seen that that is increasing—in conflict with the 2020 vision.

Where are the big messages in the draft budget? Of course, boards, politicians and Governments come in all guises. You make the point in your submission, Dr Walker, about the drugs bill—an issue that we got caught up in—but there has not been any real evaluation of whether that money is well spent. Indeed, there is the provocative point that Professor Bell made about whether we should be investing in childcare and early years or in mental health—there is no real evaluation of that.

The papers come to the conclusion that £400 million to £450 million in additional savings are required to meet some of the challenges that are being faced by boards, which all have an impact. It is not just about budget allocation; it comes with all sorts of catches, clauses and demands, and the process is not very open at all. Indeed, the discussions between the Government and health board managers are taking place in secret.

Professor Bell: It is a question of governance: how do we run the system as a whole in a consensual way that everyone understands and accepts? It is a really difficult problem because politicians often want to interfere. Then there is the question: how democratic are the boards themselves? How do they come to make decisions? What would the public accept—how far would they like to see politicians interfere with the processes? Given what Dr Walker said about the different sets of targets that are out there, it must be a very difficult space to live in as a health board manager.

Dr Walker: I echo that. I think that, when the committee looks at the health board plans for next year, there will be a chance to quantify some of those targets. I know that you tried to quantify the prescribing uplift and so on. There may be scope for a broader question, asking health boards to tell you about other cost pressures, because we want to see the evidence base for them.

I am aware of that £400 million figure, but I do not know the detail of it and how it was arrived at. It would be interesting to know that. Whether the committee wants to wait until April next year, when the health board scrutiny is planned, to find that out is another issue. However, it is important to know that and to find out about the pressure on spending—which brings us to one of the seven questions that the committee asked. Is the 3 per cent savings target that is imposed across the public sector going to be enough, and does the £400 million figure imply that perhaps there should be a 4 or 5 per cent savings target within the health portfolio? It is important to find out what the Scottish Government's reaction is to that figure and whether it accepts and agrees with it—yes or no.

Those are very important points, but my frustration with the budget document—I think that I agree with you on this—is that it does not give us any of that information, and neither has any previous version of it, going back to 2001. It is a frustrating business.

The Convener: The leaked papers were released to us by the Government when we asked for them. In relation to that £400 million figure, pensions costs of £100 million are expected and changing access to drugs is projected to cost £50 million in 2016-17, so the Government has supplied some additional figures.

We have a political consensus, of course, on progress or lack of progress on the 2020 vision, but we do not see that political consensus across the Parliament, the parties and the Government being reflected in the draft budget in relation to the priorities that are needed to push it through. In fact, there is a contradiction in that we are still investing in beds, staff, buildings and hospitals.

Dr Walker: As I look at the Parliament as a voter and as somebody who comes here to advise and so on, one of the terrific advantages that I see is the cross-party consensus that we have within the Parliament on so many aspects of health policy. Things are not usually controversial—we agree about most of the fundamentals.

What there is not a consensus on is on priorities. Everyone agrees that integration is a good thing. Everyone agrees that public health and prevention are good things. Everyone agrees that more access to new medicines is a good thing. However, what do you do when you cannot have all those three things? Which one of those is the most important across parties? That is the part of the debate that is still missing. Everybody quite likes hospitals, but everybody quite likes primary care as well. When you cannot have both, which do you choose? I am still waiting for that debate to happen in Scotland.

Richard Lyle (Central Scotland) (SNP): I have listened intently to Professor Bell and Dr Walker. In your written submission, Dr Walker, you say that you have been reading the draft budgets since 2001. You state:

"Another decade long problem is the lack of any link between planned spending and planned outputs or outcomes and this stifles debate about the allocation ... the debate falls back on sharing the cake out roughly as in line with last year, a little more for some, a little less for others ... the debate does not get beyond 'how great are the pressures?' and 'is anything likely to go seriously wrong before we do this again in 12 months' time?' ... However, we end up with a pattern of spending that is (probably) different to the one where we achieve the maximum health gain."

I really like the last paragraph of the submission, which I want to ask you about. You say:

"To repeat, this is not a criticism of the present Cabinet Secretary or Government, but rather frustration with the way Scottish Government and Scottish Parliament are settling into a pattern of accepting this as the norm. I invite MSPs to reflect on whether we should aspire to a fuller debate."

Further to the questions that Richard Simpson, Bob Doris and the convener have asked, do you feel that we should have a fuller debate on health across all the parties on projections for the next 10 years and how we will spend, or should we do what a lot of people have done previously and just tinker about at the edges?

Dr Walker: I welcome your question. A case can be made for the incremental approach. You will be dealing with some massive issues. Bob Doris asked me about spending on various levels of waiting time targets. We could have a guess at the spending, but detailed work on that might take months, frankly, to come up with the answers and we would need to ask some really fundamental questions.

The alternatives are the incremental approach—maintaining public confidence in services, but leaving a lot of the decision making to local people—or Parliament trying to become a little bit more interventionist and looking for links between spending and outcomes, as I said in my submission. Parliament could ask what the health of the population is going to look like, and what the health service is going to look like, in five years and in 10 years as a result of what we are doing today.

We have the 2020 vision, but it does not quite link in with the budget document, which stands alone, and the budget document does not quite link in with the national performance framework, which also stands alone. I would be very happy to know that there are some people in the Scottish Government who have an overview of all those things. Of course, we would expect the cabinet secretary and the chief executive to be in that position, but it would be good to have that overview for outside consumption, so that we know that there is an integrated plan. The different parts seem to stand alone.

The last paragraph of my submission came from the heart. It is why I am not a committee adviser again this year. It has been frustrating to deal with fairly arid documents that do not really give us the information that we need if we are to have the discussions that we want to have, which lead to the issues that the convener led me to a minute ago. We are not really choosing between different priorities—integration versus public health versus new medicines—because we can do just enough for each of them to keep them going. I come back to the point that there is a political case for doing that—it might be a perfectly respectable thing to do—but is it the option that will give us the best long-term outcomes?

Richard Lyle: Professor Bell made comments earlier about various figures going up and down. I respect the comments that Dr Simpson made but, all too often, political parties tell each other, "We spent more than you last year," "Your targets have gone down," and so on. Are we so focused on targets that we forget that we have one of the best health services in the world?

We have to rationalise in such a way that we go along with the staff in order to help them and to help with the changing demographic situation. We are all getting older—none of us is getting any younger—and, in 10 years' time, I might need to use the health service. I am very seldom in a hospital, and I take pride in the fact that my doctor sees me only once every seven years. Nationally, should we all—including people such as you—be looking at the whole national health service in order to make it better for the people of Scotland?

Professor Bell: I agree with your first point: the batting about of what are sometimes relatively small numbers is not a terribly useful exercise. A very large resource is being put into the health service, and a small change at the margin probably matters less than how efficient the system is as a whole. As this debate has exemplified, we are not in a terribly good position to know how efficient the system is as a whole.

We have a reasonably efficient system, but we also have some very bad health outcomes. We still have levels of life expectancy that compare very poorly with those in other parts of the developed world. We are good at interventions, and we do a lot of them, both in health and in social care. Overall, however, we have not had that much impact, in a relative sense, on those outcomes since 2001, when we started debating budgets.

Dr Simpson: This might be a silly question, but what if we had said in 2001 that 3 per cent savings a year would have to be made—which we have been doing almost continuously—and that 1 per cent would have to be applied to public health, instead of the money always going back to the Government or back into the health service to be used for acute services? Would it be worth our directing funding centrally to that extent? That would be on top of the integration fund, which would be separate. We would not direct precisely where resources should be used—the health service must proceed in the most effective, evidence-based way. What if we said now that the money could not just be put back into acute services, and that at least 1 per cent had to be used as I have described?

Dr Walker: As you have illustrated yourself, not everything done under the banner of prevention is cost effective or particularly effective. Nevertheless, I welcome the point that you are making. If we assume that the NHS budget over the intervening period has been roughly £10 billion, on average, a 1 per cent saving would be £100 million per year, which I think would make a substantial difference to some public health indicators. I personally would very much like to explore that option—while being careful about what the money was actually spent on.

Professor Bell: I agree with Andrew Walker about that. We need to educate people and the press about the importance of public health measures, emphasising that the beneficial outcomes may emerge over decades. That is often quite a difficult sell.

Dr Walker: Journalists sometimes draw a distinction between the "deserving" sick and the "undeserving" sick, who have "brought it on themselves"—I put the quotes round those terms with my eyebrows. Most of the spending will be devoted to people who have fallen into what the press would regard as the latter category. We have to bear that in mind.

I understand that it is hard when you have a child with a genetically inherited condition who is in no way to blame for their condition and who needs a particular medicine but the money is being put into drug misuse prevention programmes, for example. These are difficult issues; I do not think that anyone pretends that they are not.

11:30

Nanette Milne (North East Scotland) (Con): We are all committed to the basic principles of the NHS: patients should have healthcare as they need it, and it should be free at the point of delivery. How sustainable do you think the current system is? Can it be sustained into the future?

Dr Walker: I am optimistic on that point. My history of studying the health service goes back to about 1990 or so, and I would say that for at least 20 of those 25 years, the NHS has been in some form of crisis, with people saying that it might not be sustainable, that it is underfunded, that gaps are building up and so on. Today we hear almost exactly the same speeches that were being made in the 1990s about how the NHS will not last much longer unless something dramatic is done.

I am not saying that there is no problem, or that there are no pressures; I am saying that there have always been pressures. In fairness, the only gap that I can think of was around 2002 to 2007, when the Labour Government put resources into the health service at a rate that we had not seen before and possibly never will again, given how the UK economy is looking at the moment. The Labour Government gave a level of resourcing to the health service that, arguably, the service could not absorb very well, but it took those pressures away.

I think that the NHS is sustainable. It is weird: the system has lots of fixed costs and other fixed elements, but it is also flexible. People adjust and adapt. We rely on the likes of Richard Lyle to go to his GP once every seven years to leave enough space for the rest of us in the GP system. The system is flexible and adaptable. At the end of the day, the principle of the system is that it pays the bills and provides the services within the public sector largely through funding from the taxpayer. That is quite an adaptable idea and it has stood the test of time. Personally, therefore, I am optimistic.

Professor Bell: It has been interesting to see how the past five or six years compares with the period 2002 to 2007 when money was being thrown at the health service. It is not that money has been withdrawn, but it is much more difficult to see new resources coming into the health service. In a sense, that is evidence that the NHS is quite adaptable.

On the issue of costs and why the health service has managed during the past five or six years, wages and salaries have been much more restrained than they were over the period 2002 to 2007. I recently saw an article that suggested that, over that whole period of time, wage costs in the NHS have not increased more rapidly than those in the economy as a whole. However, an important factor that affects costs is that, unlike in a standard manufacturing enterprise that uses new machinery to replace people, in the health service, as new and more sophisticated technology is introduced, there is a switch from needing people with relatively low qualifications to needing people with

higher qualifications. By itself, that changing mix drives up wage costs, rather than wages per person being driven up.

Social care and its costs are, however, the one area where I am not necessarily optimistic. We have free personal care in Scotland, but that does not mean free care. That is an important distinction to make.

No country has set up a long-term care insurance system all that effectively. There is an issue, which we will encounter increasingly as the population ages, whereby people with dementia have a quite different outcome, in financial terms, from the outcome for people with cancer. We must think about that. What does equity mean in those circumstances?

Nanette Milne: I presume that that is where adaptability has to come in. We may have to look at different ways of providing services for the increasing number of people who will need increasingly complex services.

Professor Bell: We should think about doing some work on comparisons between England and Scotland in respect of social care. It is not obvious to me that Scotland is necessarily more expensive, because the free personal care policy is effective in keeping people at home. However, we have to do the work on that.

The Convener: I suppose that the contradiction there is that as things get more technical or highly skilled in the acute sector, which costs more, we push out that other level of care to nurse assistants or into the community and to carers, where the opposite is the case. Driving down costs becomes a driver for pushing care out of the acute sector into the community because it is cheaper, with everything that goes with that—sometimes there is an impact on quality, and sometimes, although not always, there is an impact on the patient experience and on the people who are delivering that care. It accelerates inequalities and the problems associated with wages and so on.

Professor Bell: Yes. These figures are not necessarily absolutely accurate, but they are of the right order. The average for a week in an acute ward or a geriatric ward might be £4,000. A week in a care home is £600 or £700. Somebody might be paid £7 to £10 an hour for 40 hours a week to look after someone in their own home. Those are not complete substitutes, but, if possible, working at the margin to move to lower-cost outcomes can make a huge difference.

Dr Walker: One of the big barriers is that it is hard to take the £4,000 out of the hospital, because the £4,000 covers the fabric of the building and the staff who work there, and we are not planning to take any of that out. To return to Richard Simpson's first question, it is very hard to take money out of a hospital structure.

The Convener: You had some criticisms around the recording of information and comparing outcomes, performance levels and so on. In focusing on the 2020 vision, does there need to be a review of the whole system to make sure that the information that we collect is useful in describing outcomes, whether things are getting better or worse, how we can improve and the financial planning for that? Should we be doing that just in the health service or should we look at health, social care and wellbeing services together? We are just looking at health here, but we know from our previous work that although health services deal with a lot of the outcomes, the issue is much more complex and relates to people's life chances and getting them to services earlier or later. Even if we just look at this in a box, do we need to do so in a more simplified way? Do we have too many targets? Do we need to understand performance and financial planning much better than we do now? Is that something that the committee could usefully do?

Professor Bell: I think that it is. Andrew Walker talked about the incremental budgeting that we have done since the Parliament's inception. Maybe the approach is appropriate, but if we thought that it was not appropriate and we moved to a zero-based budgeting approach, would we have in place the information that would inform us on the best way to go about doing that? It is not clear to me that that kind of information is available. The committee could do an important job by looking at the kind of information that would be needed by people who might plan the system somewhat differently.

On the health and social care interface, I am doing work with the Scottish Government on the first joint data set that has been made available, which integrates social care information with health information. People from all over the world think that what we are doing is really innovative, because other health and social care systems do not have data that are as good as Scotland's data. However, currently we are only scratching the surface of the issue. There is huge potential to position Scotland as a leader in understanding the integration of health and social care.

Dr Walker: I would not necessarily advocate a bonfire of the indicators, convener. I do not think that I was suggesting that. It could be tempting to say, "We have 120 indicators, which is too many; we want only 20." However, part of the fascination of health for all of us who are involved in scrutinising it is its multifactoral nature, which covers everything from simple public health interventions to complex, hospital-based

interventions for very sick people, so we need a range of indicators to catch everything.

My current frustration is that indicators are all put under one heading. A way forward would be to think of them in groups—the public health group, the healthcare experience group and so on. From the performance indicators for last year, it looks as though a lot of the public health initiatives have stalled, but if we look at the trend, we see that it is in the right direction. However, there is not much change from year to year, and we should probably put those indicators to one side and look at them only once every five years or so, and focus on a different set each year.

It is about having sets of indicators that are clearly grouped for different purposes, with the clue to what they do being in the title. General titles such as "quality monitoring framework", "HEAT" and so on do not tell us what is in there. I would probably keep the range of indicators, but I would group them more clearly by purpose.

I would also definitely think about the integration of data systems across the health and social care divide, because one thing that we know, as we are demonstrating with the draft budget document, is that attention tends to go where the numbers are. We are focusing on the 20 per cent of the budget for which we have the numbers, because we do not have the numbers for the other 80 per cent. If we get an equivalent situation in health and social care, with all the information on the health side—despite Professor Bell's misgivings about ISD's contribution—and very little on the social care side, we will end up having a skewed debate about what is going on. It is really important that we get integrated data systems from the start.

The Convener: We talked about what will happen in a decade's time and the importance of understanding that we are on a journey. Bob Doris raised the problem of politicians who need to deliver on a five-year timescale—and a hospital manager or chief executive is judged annually on the indicators that we are talking about.

Dr Walker: I think that that approach is open to challenge, which is why I talked about grouping indicators. If something is going wrong in the system this year that leads to a waiting time problem, that should set a red light flashing. The fact that indicators on physical activity in a particular health board's population did not improve in 2011-12 is a warning for the longer run, and if things did not improve in 2012-13 and 2013-14—or over five years—we would be worried, but I guess that the issue is how quickly that triggers a response. It is about making everyone in the system aware which indicators will lead to questions being asked within weeks of things going wrong and which are, frankly, about a five-year timescale. That is the essential difference between different types of indicator.

The Convener: If there are no more questions for Professor Bell and Dr Walker, I thank them both on behalf of the committee for their submissions and attendance today.

11:45

Meeting suspended.

11:52

On resuming—

The Convener: We now continue our draft budget scrutiny with a round table of stakeholders. As usual, I ask everyone to introduce themselves. My name is Duncan McNeil and I am the committee's convener.

Bob Doris: I am deputy convener of the committee.

Jill Vickerman (British Medical Association Scotland): I am the Scottish secretary of the British Medical Association.

Dr Simpson: I am an MSP for Mid Scotland and Fife.

Annie Gunner Logan (Coalition of Care and Support Providers in Scotland): Hello. I am director of the Coalition of Care and Support Providers in Scotland. I state for the record that I am also a Scottish Government non-executive director, but I am not acting in that capacity today.

Richard Lyle: I am an MSP for Central Scotland.

Lilian Macer (Unison): Good morning. I am the convener at Unison Scotland.

Colin Keir (Edinburgh Western) (SNP): I am the MSP for Edinburgh Western.

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

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

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

The Convener: Thank you all for that.

I hope that members will understand that, before I give them the opportunity to ask questions, I always give our witnesses precedence. I will kick off with a general question. Is the allocation of resources in line with the Scottish Government's stated priorities as set out by the draft budget?

Rachel Cackett: I feel that I should justify the welcome invitation to give evidence by saying something new. However, I sat through the previous panel's evidence and I have engaged in such conversations before, and it is hard to find the thing to say that differs from what has been said before.

My simple answer to your question is, "I don't know," and that is probably what you got from the previous witnesses. However, I welcome where I heard your conversation with them going. The set of documents that we have in front of us has probably set up a number of parallel conversations that should be joined up, and it is that joining up that I welcomed in the earlier conversation.

The documents give us allocations within an envelope of money that is available, and on that basis we have to acknowledge that the NHS budget—the health budget—is in a fairly privileged position in the context of fairly straitened public sector spending. It is also worth noting that there is not much change between the 2015-16 draft budget and what was proposed for 2015-16 in last year's budget.

That can easily push us towards the discussion around allocations at the margin and whether the budget lines are right. The information that we have does not allow us to have an easy conversation about the bigger issue—the second of the parallel conversations that should be joined up—which is how we create a sustainable and quality future for health and social care in Scotland. That conversation cannot be at the margins, which is why I welcome the committee's earlier discussion.

We need to have the discussions, which are not about small changes in individual budget lines, with the public, staff working across all organisations and the various political parties. We need to discuss how we take into account not just where the allocations are but how they are reflected and how we meet demand, expectations of our services and the cost of the welcome developments in technology that Andrew Walker talked about extensively.

We have discussed how to have that robust and transparent debate before, but I guess that we are in a different position now. In the past few months, we have seen civic Scotland engage in discussions about the future of Scotland in a way that we might never have seen before, so I suppose that my question is: if we cannot get that discussion on the table now, then when? We cannot quite answer the question from the documents that we have.

Annie Gunner Logan: I agree with Rachel Cackett that there is a groundhog day element to this. I looked back at the evidence sessions from the past two years and I struggled to think what I might say that would be new or different, because a lot of the issues are still with us and are intractable. That came out in the committee's discussion with the previous panel.

From my point of view, the social care element is of most immediate concern, because my members deliver social care rather than healthcare. I am again drawn to the budget document talking about health and social care in chapter 4 but then talking only about the health budget in that chapter, whereas chapter 15 is on the local government budget, which is where social care has always come from and probably will continue to come from. Professor Bell was absolutely right to say that it is at the local level that the situation will or will not be resolved, so scrutiny of the health and social care integration authority will be extremely important in relation to the targets that we have.

Another thing that I said last year and will say again—it echoes what you heard from the previous panel—is about the plethora of targets and outcomes. The earlier witnesses mentioned the national performance framework outcomes and indicators and the HEAT targets, but we now also have national outcomes for health and social care integration, which may or may not link to the other two. We have single outcome agreements at the community planning partnership level, and we have care standards, which are under review. There are not just the targets and outcomes that were mentioned before; there are all the other ones, and it is difficult to figure out which are the priorities, which are national and which are local and how we can marry up the budgets.

There is also a series of policy initiatives, such as reshaping care for older people and shifting the balance of care. If we are asking whether the budget is allocated appropriately to priorities, we first have to figure out what the priorities are. They might be different at different levels and for different organisations. In effect, that is the challenge of integration.

12:00

Kim Hartley: Thank you for the opportunity to talk to you again about allied health professionals' view on the budget. Even though this is only the second year that we have spoken to you on the subject, it seems a bit like groundhog day.

To pick up on points that others have made, the federation cannot tell how the budget will play out for service users, but the trends are definitely not encouraging. The impact that it will have on the targets, the aspirations and the experience of patients will depend on the awareness and buy-in

to the value of AHPs on the part of local authorities and the NHS at a local level.

From an AHP perspective, the money is definitely not shifting at the moment. As I said, the figures show that things do not look good for us. Table 5 in the SPICe briefing shows how the spending aligns with the various commitments in the budget. AHPs are mentioned in the "Nursing, Midwifery and Allied Health Professionals" line, which is being cut. That part of the budget covers that workforce, which is fantastic, but those people are part of a much larger workforce. The money also has to cover all the health visitors, so the increase in them is not getting a look-in there, either. In the other budgets that are important to us, such as e-health, tiny amounts of money are going into the value that AHPs deliver. The figures do not look good, and the trends in the funding from health boards and local authorities over recent years do not look good either.

A lot of the previous witnesses talked about information. It is important to state that, in terms of the level of data that we have on productivity, experience, performance and the difference that AHPs make to waiting times, waiting lists and anything like that, we do not have a clue about that at a national level. We do not have the information that would allow us to say what impact the budget will have on the care groups that we work for and into whose care we have a major input. No one at a central Government level or a local government level has the information that they need to use the money effectively for AHP services.

The short answer is that we cannot tell for sure, but the situation does not look good.

Jill Vickerman: I appreciate that the BMA has been invited to speak to the committee before, but this is my first opportunity to do that, so at least I will not repeat myself. I agree with a lot of what has been said and I will try not to repeat too much of that; instead, I will build on it.

On the specific question, as others said, it is difficult to tell whether the allocation is in line with the Scottish Government's aspirations. The conversation that took place about whether the high-level budget lines can be changed to drive change in how health services are delivered was slightly worrying. The BMA's perspective is that we really are in different times. There are significant and worrying pressures across the health system. I do not have the same level of optimism that, if we carry on doing what we have always done, we will be able to manage to do that within the current approach to budget allocation.

The point that Annie Gunner Logan made is absolutely correct. This requires a stand back and an assessment of how services need to be delivered in the future before a decision is made about how budget lines are applied to them. At that point, we might be in a better position to say whether we are applying budget lines in a way that reflects the Scottish Government's aspirations.

Like many stakeholders and the committee, the BMA entirely supports the high-level aspirations of the 2020 vision, but we do not yet see how that vision is being played out in the approach to delivering services or the way in which health boards make decisions locally. As others have said, it is important to free up the ability to make the decisions locally about how to pursue that vision. The pressures that central Government is putting on health boards through targets and so on are diverting some of the ability to do that.

On the specific question, it is not possible to tell at the moment, but there is a serious concern that the range of pressures that exist and the lack of flexibility do not allow, below the high-level budget lines, resources to be applied in such a way that they will achieve the aspirations.

Lilian Macer: Thank you for the opportunity to discuss the budget and the proposals related to it.

Among the staff-side organisations, Unison Scotland is probably in a unique position, because we not only organise in health but have a significant membership in local authorities. We see the integration of health and social care as not a challenge but primarily an opportunity to bring those workforces together to deliver better outcomes for the population of Scotland.

I do not disagree with what my colleagues said. There are significant challenges for health boards in Scotland. I declare an interest in that I am not only the convener of Unison Scotland but a health service worker and a board member as employee director in NHS Lanarkshire. I therefore have practical knowledge of how budgets are allocated in the health system and how they are delivered for health workers and the population.

On the desire to move the budgets from acute care provision, we heard the earlier discussion about the continued investment in acute care—not only in beds but in facilities and staff—and I suggest that the investment in staff is crucial to the delivery not only of health and social care integration but of health services in Scotland. The one thing that can be absolutely guaranteed is that an investment in staff is not a wasted investment, as those staff have transferable skills and can move from an acute setting to a community setting. That is an excellent investment.

In Unison's submission, we laid out some areas that we think that the committee should look at in more detail. I would very much welcome debate and discussion on those areas today.

The Convener: We heard in evidence earlier that the current crisis in the health service has been around since we have been around. Even when lots of money was going in, there was a crisis, and it has not brought the health service down yet. What is different now?

Jill Vickerman: There have been peaks and troughs over the past 20 years—and, no doubt, longer than that—in the sense of crisis, morale levels and the concerns among all the different staff groups involved in delivering and planning healthcare. However, we are seeing among doctors at the moment specific and new problems that are hugely concerning.

In two health board areas, we have over 20 per cent vacancy rates for consultants, and we have never seen anything like that level of vacancies before. We have a weekly crisis to deal with in seeing whether GP out-of-hours services and accident and emergency units will be properly staffed. We also have significant problems in filling partner posts in general practice, and there are issues with trainees choosing not to train in Scotland and fill our training posts.

We have not seen such levels before. Andrew Walker and David Bell talked at some length about the range of factors that are contributing to the pressures on the health services. Those have come together in a perfect storm and in the way that we predicted, but we have not had the economic pressures, the level of population change, the increased life expectancy with increased levels of multimorbidity and the pressures of the expectations and behaviours of the public all coming together in the way in which they are right now.

We are genuinely seeing on the ground through our members a significant difference from what has been experienced before. We also have levels of planned early retirement that we have not seen before, so we can see the situation continuing to get worse unless we have an honest debate about how we change how services are delivered if we are to continue to deliver high-quality services in Scotland.

Kim Hartley: To reiterate what Jill Vickerman has said, demography demands that we do things differently and that we have a different model of not letting people get ill or, if they are ill, providing care in a much more efficient way that is further from expensive acute care. The agenda is about shifting the balance of care. Patient expectations and the population's needs have changed, but political needs and expectations have also changed and become a lot smarter. As the convener said, there is a consensus about how we need to deliver care but, although we have that impetus, we do not have the change on the ground, because we are not changing who is making decisions and how. That is why the crisis is getting more and more acute.

Rachel Cackett: We have to bear it in mind that one reason why we are facing this crisis—I will not repeat what Jill Vickerman said, which was a fantastic summary of why we are here—is down to the success of what we did in the past. We now have much longer life expectancy, although that is not always good and healthy life expectancy. Some of the figures that were in the report on the five-year plan down south, such as cancer survival rates, are significantly better, but that places an additional strain on the NHS, which relates to healthy life expectancy, how long people live and the fact that people who are frail into very old age require complex services. Those things cause an additional strain.

However, we have an opportunity, because we could look at creative ways of dealing with some of the issues. Jill Vickerman talked about some of the recruitment issues, which apply to many parts of the service. The Auditor General for Scotland reported on such issues in Orkney—we sometimes have issues in our remote and rural areas that are particular to staff recruitment. An issue is how we deal with the specialist input that is needed more as things become more complex, which the earlier witnesses talked about.

There are creative ways of thinking about what the workforce of the future will look like. Who has to do what? Do we always have to rely on the traditional models that we have had in the past, or are our skills spread through the professional workforce? How do we take into account people's ability and desire to manage their own care? What is the role of carers?

We need to do all this differently rather than simply throw money at what we have known. That is the big discussion about sustainability and quality that we need to be having rather than simply looking at where the gaps are and asking how we fill them in the same way as we always have.

Bob Doris: We are scrutinising a budget document. The BMA has previously made a powerful case on recruitment and retention and filling vacancies across a range of specialties. It has spoken about distinction awards and the 9:1 rota system. Those issues are on the record, and I have met Kim Hartley and other colleagues to talk about how the allied health professionals can help to support a seven-day service, stop delayed discharges and do a variety of other things.

Those issues are to do with workforce, management, planning and skills development; I get all that. I know that a number of workstreams are under way that the committee could look at in a stand-alone inquiry, but what we have in front of

us is a budget document. I suppose that the question is how we tie in a high-end budget document with the concerns and comments that we have heard this morning. We might look at a budget document and see that it means a 1.1 per cent real-terms increase in territorial health boards' budgets, but that in itself is meaningless—it all depends on how that money feeds into the system and what it is spent on.

12:15

I totally respect the witnesses' position, and I take on board all the pressures, tensions and stresses and strains in the system that they raise. My question is how we tie those to the headline budget document. That is the obvious question that we ask every year, so it will be a case of déjà vu for those who have been members of the committee over the years. We cannot spend the same pound twice. That is why the conversation headed on to what the health boards might not do and how they might reprofile some of that expenditure. That is why we are talking about targets and outcomes and whether the savings from that could be redirected.

I ask the question that we always ask at this time of the year: how can we relate the headline budget document to the specific concerns that you have? Do we need to wait until later on, when the NHS boards set their budgets, and ask what they would do differently? I apologise to all those who have heard the question again and again, but it has to be asked. I suppose that the fact that it has been asked so often might mean that you have pretty slick answers to it.

Annie Gunner Logan: I think that that is the right question to ask. My answer is always that we should look at what is in the budget that will make a change.

We heard from the previous witnesses about the integrated care fund and the resource in the budget to support integration but, as they said and as we see from chapter 15 of the budget, the local government settlement is going down, so social care will be under much more pressure than NHS services. I do not think that a £100 million integrated care fund will make up for that. I am always interested in looking at what it is in the budget that will push forward change. There is something in the budget, but it is not quite enough. In my view, it is scrutiny of what the health and social care integration authorities do next and what stimulus is given to them to do things differently that will provide the answer to your question.

I will go back to my point about targets. If a health board is seriously performance managed on things such as treatment time and waiting time guarantees, it will probably prioritise its resource to meet those targets. It will then look at the national outcomes for integrated health and social care and it will see a number of aspirational outcomes, such as people who are frail being able to live—as far as is reasonably practical—independently and at home. It will look at those outcomes next to the treatment time and HEAT objectives and decide which to prioritise.

There is a bit of confusion about exactly what the objectives are and how far they are shared across the different agencies that are expected to come together to deliver some of them. I am not convinced that the levers that are in the budget are sufficient to drive that work.

What we will see is joint strategic commissioning locally. In the earlier session, there was a bit of discussion about the relative merits of incremental budgeting, zero-based budgeting and outcome budgeting. It seems to me that what health and social care integration authorities are being expected to do locally is what the Government is not doing in this budget. This is an incremental budget, but joint strategic commissioning is supposed to be about not quite zero-based but certainly outcome budgeting. That is where the focus is, but this budget does not do that itself, if you see what I mean.

Jill Vickerman: I return to the answer that I gave to the first question. A piece of work needs to be done—the size of which we do not underestimate—that will involve revisiting how we deliver healthcare services. That goes back to what Rachel Cackett said earlier.

As the leaked paper that was discussed by chief executives and the Scottish Government said, it is not possible to continue to do what we are doing every year: to have marginal increases in the health budget and to sustain the delivery of healthcare services. If we carry on doing what we have been doing year on year, with that marginal level of increase in the health budget, we will not be able to deliver healthcare services by 2020.

What is missing is a message about what is going to change if we are going to make the healthcare system sustainable. That is the point that Annie Gunner Logan is making, too. There is not any evidence about what the levers for change are; there is very much a continuation of the same things as last year and the year before.

We want to see a signal, even in the high-level budget, of a recognition that there needs to be a shift in how budgets are spent. That will largely happen when we reach the stage of looking below the health board budget lines. There is nothing, even at the high level, that gives a sense of a commitment to make such a change.

Rachel Cackett: I will pick up on and support something that Annie Gunner Logan said. At the Royal College of Nursing, we have been examining health board spending for some time now. We are having to rethink what that might look like once health and social care integration kicks off in April 2015. The level of detail that we are getting at the moment will not necessarily transfer into that new world.

I agree with Annie Gunner Logan that the levers that should be included should come through joint strategic commissioning. There should be something about the fact that the expectations that joint strategic commissioning will do some of the things that we have not yet managed to do nationally in relation to choices about investment and disinvestment represent a tall order for brand-new organisations that are due to come together and have never done those things before. My concern is that we will be placing expectations on our new integration authorities to make really difficult decisions and to consult on them appropriately with people—carers, staff and the general public—using services that are going to be very new.

We do not yet know how that scrutiny is going to play out. There is obviously a lot of work going on with the scrutiny bodies but, as regards what future budgets look like, I do not yet know how, in 12 months' time, the decisions that will have been made locally will impact on the issues that have been raised around outcome and impact. We will have to grapple with that fact, because the big decisions will not be taken at that high level within the budget; they will be taken at a very different place.

Our college has started examining the first iterations of commissioning plans that were put together in relation to older people, and we considered the impacts on our constituent bodies and on nursing. What are the things that will make a difference? What do the plans tell us about what the nursing workforce will need to look like in the future? My hope is that the strategic commissioning plans will help all of us in that regard. ISD is doing a lot of work at the moment to support the needs assessments that will go into those plans, which will, we hope, ensure that services are designed in such a way as to meet and improve outcomes.

I go back to the Auditor General's reports on Highland. Although they were specifically about acute spend and Raigmore hospital, there was a comment among those reports about the speed of the shift of balance through integration—about how long that is likely to take, given that Highland is ahead of everywhere else by a couple of years.

I would guess that the first joint strategic commissioning plans are unlikely to be radically different from what we already see, because the organisations are new and are finding their feet. It might take us three to six years to reach the point where we have had the evidence, the consultation and the decisions to do something radically different. The difficulty is that we have an issue with pressures now, whether through social care—and I refer to Annie Gunner Logan's points about the local government budget—or in relation to the discrepancy between the welcome increase in the health budget and the impact of other cost pressures within the health service.

There is a timing issue at play, and we have to be careful about our expectations of integration authorities come April 2015. They have a massive job ahead of them.

Lilian Macer: I understand Bob Doris's question, and if there were a straightforward answer he would have had it all those years ago when he started to ask that question.

It is worth discussing some of the pressures that colleagues have described in relation to our population living longer. It gives us an opportunity to celebrate some of the successes, but we also need to understand and recognise that that population is not necessarily a healthier population. That is another issue for health boards and local authorities to deal with. We need to put provisions in place to support Scotland's elderly population, which may not be a healthier population.

One of the opportunities that Unison sees in strategic commissioning relates to some of the procurement elements. The public sector organisations with the biggest spend in Scotland can procure goods and services that enhance and support health board and local authority aims and objectives to make the population healthier. There is a real opportunity for us to ensure that the spend that health boards and local authorities have in relation to the day-to-day running of those services is spent on the local populations, and we have said in our submission that we need to look at the community benefits realisation that that opportunity will afford us.

Some pressures on the workforce have been identified—Bob Doris acknowledged that in his question—but it is absolutely crucial to discuss those pressures. Jill Vickerman was right to mention the consultant vacancies in Scottish health boards. It is right that we have the senior decision makers in the boards making those decisions, but it is also absolutely right that we have staff in those boards who can support all that work, whether that is in minor injury units or in major accident and emergency units, where there are some fantastic initiatives such as minor/major injury/illness nurse treatment services—MINTS

minors and MINTS majors—that the nursing workforce and AHP workforce are delivering.

We need to look at the support staff in those areas as well. We are a healthcare team and we need to be a health and social care integrated team, and Unison is best placed to support that work with our cross-sector membership.

Over the past two years, we have looked at the 2020 workforce vision. We have some fantastic information and evidence on the pan-Scotland workforce planning and there is further information and evidence that we need to produce. However, health boards currently do not have the capacity to undertake the scenario planning that was identified as an absolute must or to look at those areas where there may be cliff-edge staff who are about to retire as we move to new pension provision in 2015. People are concerned about the increase in pension contributions—something that has not been mentioned already—and they are considering how best to use their own pension provision after 2015. We have an ageing population, which means that we have an ageing workforce. As Jill Vickerman said, that workforce will be looking at some retirement provision for themselves as individuals.

There is a huge amount of work that we need to do on workforce planning. There is a lot that we have done, but we need to join up what has been done for the workforces in local authorities and in healthcare and look at an integrated workforce. We are not there yet—health boards are not very good at workforce planning—but we have some tools in our systems that will afford us the opportunity to do the planning. We should be looking at the information from the pan-Scotland work that was done over a two-year period. We should be looking at the 2020 workforce vision—we have staff representatives dealing with that at health board level and at Scottish level. We are also doing some work with an engaged workforce in relation to the "I matter" survey.

There are some fantastic initiatives out there. We need to allow them the opportunity to develop, but we also need to look beyond the health service workforce and into the integrated workforce. Sadly, we have not had the opportunity to contribute to legislation on the staff governance agenda, which is a significant issue for Unison. If we had a staff governance framework across the public sector, and indeed the private sector, we would have the opportunity to bring in the community workforce. We have the opportunity to bring in the public and private sectors, and a staff governance framework would give people support and reassurance in making that integrated workforce a reality.

12:30

Annie Gunner Logan: I have been sitting here pondering, and I thought that I would have a go at answering Bob Doris's question in a different way. I will focus not on what is not in the budget but on what it would have been nice to see in the budget, in order to back some of the policy initiatives and outcomes that we have all been talking about since the year dot.

It would be nice to see a budget that said that we are now going to make a massive investment in social care and in the community support—a lot of which is in the voluntary sector—that will keep people well and out of hospital.

If we had that money coming in, we might be able to look at some of the savings that the previous witnesses mentioned in relation to the health service. There are any number of voluntary organisations out there that can say, "What we do will save someone being in a hospital bed for £4,000 a week", but that is a notional saving—they are not going to save that money if the lights still have to be kept on and the staff still have to be employed. The savings will come from stopping doing things completely rather than making differences at the margins.

A huge investment in social care and in community capacity through the voluntary sector would change that. Instead, the local government budget is shrinking, and the social care sector is in many respects being pauperised. A lot of social and home care for older people is being delivered by workers who are on the minimum wage with minimalist pensions. The committee will have heard me say this many times, but the budget is not doing anything about that.

We are expecting to see work to address the issues at joint strategic commissioning level but, as Rachel Cackett said, it is early days in that respect. Some of the same discussions will play out at local level because the drivers are just not there. That is one way of answering Bob Doris's question—that is what I would have liked to see in the budget, but it is not there.

Jill Vickerman: Like Annie Gunner Logan, I was having a think about how to answer Bob Doris's question more directly. Unlike Annie, though, I was going to look at things that were in the budget at level 3. That takes us to the conclusion that we have reached: the budget document does not have a joined-up narrative with regard to how the various different lines of investment that it describes will come together to deliver on the Scottish Government's aspirations.

That dips back into the earlier conversation and the evidence that the committee received from Andrew Walker and David Bell. We do not have a clear evidence base for why we should invest £55

million in health and health improvement and £41 million in tackling alcohol misuse. Those issues are clearly very important, but there is currently no clarity on how we make decisions on how much to invest and how we prioritise different areas, not only in the category of health and better public health but alongside the themes that have come up in our discussions this afternoon.

Those themes include the costs that we incur by not being able to fill posts, ranging from consultant posts to the whole spectrum of health service provider posts. We are having to fill vacancies with very expensive locums, spending massive amounts of money that could be saved by taking a different approach to workforce planning and by looking at the way in which we make those posts more attractive to bring the workforce to Scotland.

Which of the decisions that we should make to achieve our aspirations for Scotland are the most sensible ones? How do we prioritise expenditure in areas where we still do not have a clear evidence base for what works and what will make a change, given that we still have gaps elsewhere? That is a question that I would raise and a request for a more joined-up approach to thinking about how we plan across all the different budget lines in a way that maximises the impact of the investment that we make in each line on the ultimate ambitions that Government has set out for us.

Kim Hartley: In answer to Bob Doris's question, which I would paraphrase as, "Do we have to look at the budgets later on?", my very short answer is absolutely yes.

I say that because, if we just look at the budget as set out and the briefing that was provided, we see, as we said in our submission, that the budget simply reiterates more and more of the same way of doing things. It does not shift anything.

I agree whole-heartedly with many of the speakers but particularly with what Rachel Cackett said. This is a massively tall order for the integrated health and social care board, the joint boards or the joint committees, particularly in light of the fact that they have poor data on which to decide how they are going to spend their money. Where is the difference made? Several speakers have referred to that. What makes the difference, where and when?

The boards have no direct input of expertise or information, certainly from an AHP perspective, at the moment. As has also been demonstrated at a national and local level, they have a poor habit of integrated workforce planning. We do not have that habit nationally, and we certainly are not going to have it at a local level. Some think that that is a good idea, but that is silly. It is silly to increase the number of staff who are delivering part of a care pathway without looking at all of it. All you will do is create a backlog in another part of the pathway.

It is really important that we look at how money is being spent at the local level. At this stage, it would be helpful to highlight in the committee's budget report that the trend in the national budget is not promising in relation to the national patterns of behaviour in the workforce and the information and intelligence that we have to make good plans.

Rachel Cackett: You can see how hard we are all trying to answer your question as directly as we can. I am listening to what is being said around the table, and I am thinking about previous meetings with the committee and about recent reports from Audit Scotland.

For me, the thing that is missing is how we get the understanding. We keep sitting around tables saying that we do not know which things make the biggest difference. Where is the additional funding to support more of that understanding so that, in a few years, when we are sitting around this table or the table of an integration authority, we are clearer about what is starting to make a difference?

I agree with Annie Gunner Logan that there are far too many indicators and targets and we still do not understand how they are all meant to link in. Work is being done on the health and wellbeing outcomes that are currently in draft regulation and the indicators that go behind them, but how will we understand?

Earlier, Dr Simpson was talking about the family nurse partnership; a lot of resource is going into looking at its impact. Resources have been going into looking at its incarnation in the United States for some time. There are other pieces of work as well, such as the deep-end practices. Those initiatives might not be cheap, but at least we are trying to understand what the impact of a significant level of investment is. That seems to be an important piece of work.

For a couple of years now, the Royal College of Nursing has been doing a piece of work with the Office of Public Management to help nurses to quantify the impact of particular nurse-led services. We have previously given some information to the committee about that activity in Scotland, and it has been rolling out in Northern Ireland and Wales as well.

One thing that I note from doing that work is that, although the health service—and I suspect that it is also the case for social care—can be awash with data, all the right data is not always collected to allow the level of impact to be assessed so that we know whether we are putting money into the right things. We had brilliant examples of projects that we thought sounded as if they would be fantastic pieces of work, but one

of our difficulties in doing a robust piece of work on economic assessment with the OPM was that it simply did not have the right data to allow it to go into the programme and do that full economic assessment. We could invest in that aspect, and it would make a big difference to how decisions are made in future.

Bob Doris: I have to say that I asked the question because it would have been remiss of me not to ask it. I did not expect anyone to say that this is the silver bullet and if we do this it will all work. I was trying to tease that out.

We are scrutinising the headline budget figures and, ever since we began doing that, there has always been a feeling of disconnect between the headline policies and practice at local level, and I hope that health and social care integration may tease some of that out. I also accept that we cannot expect an all-singing, all-dancing health and social care integration in April 2015, and that the system has to bed in. I understand that.

The other tension that I want to ask about is something that is mentioned in the SPICe briefing. Budget lines go up and down across the health portfolio, and the briefing shows that the family nurse partnership is a cash-intensive programme, although it has cross-party support. According to the SPICe briefing, there is a 69.8 per cent cash increase for family nurse partnerships, which is huge and significant. I mention that because we can tie it directly into the headline national budget that has been set, whereas the vast majority of moneys that will be spent as part of the £9.6 billion going to territorial health boards is not broken down.

I suppose that my question is about localism. Would you rather have a smaller figure than that £9.6 billion and have other figures in the rest of the budget where there are national policies and budget lines, so that health and social care partnerships and health boards just have to do what is expected of them? From what I can see, how the figures are presented affects our scrutiny at this stage, but it gives more freedom and flexibility to territorial health boards, and hopefully also to local authorities when health and social care integration comes in, and that might be a good thing. However, the consequence of Annie Gunner Logan saying that she does not see the big picture here is that we would have to filter away some of that revenue allocation to health boards and put it elsewhere in the health budget. I hope that it is clear what I am trying to ask. People need not feel obliged to answer, but that is the only way that I can see of redirecting spend from within the budget to do some of the things that have been suggested around the table.

Annie Gunner Logan: That will be the biggest challenge with health and social care integration, because we are dealing with a centrally managed NHS having to negotiate on targets, outcomes and delivery with a non-centrally managed system of local government. I hate to say, "I told you so," but we did point out that that was one of the fundamental tensions with that agenda.

Rachel Cackett talked about knowing what works. In some respects, we know what works. We know that, if there is good care available at home, people will not be delayed in hospital beds and will be discharged. We know that if there is good, low-level support available for people, they are unlikely to end up as emergency admissions in hospital. We know all that, but we still find it difficult to make that shift, because there is a discrepancy between a protected NHS budget and an unprotected local government budget. I seem to say the same thing every time I come to the committee, but I think that that is what is at the heart of the matter.

Jill Vickerman: I shall try not to say the same thing as I have said before, but there is a danger of that. To answer Bob Doris's question, I do not think that there should be a shift in the direction of travel. As we have said, we need clear evidence of why the investment in the things that are outside the allocation to health boards will have a significant impact on driving us in the direction of travel of the Scottish Government's aspirations.

All of us have commented on the fact that we need local bodies to be able to make decisions about how best to spend the money and to have the freedom to do what is right for their local populations. However, we have not seen clarity on how that expectation, freedom and authority to make decisions will be applied to the integrated joint boards and health boards. I am going to enter into the conversation about targets, because we have evidence that things happen at a national and Scottish Government political level that stop some flexibility in local decision making and create pressures that cost money and redirect resources away from where they can have the maximum impact.

We have all been talking about the need to look at the effectiveness and appropriateness of our targets, particularly given our experience in the health service, where we have real examples of how the current set of HEAT targets has directed resources away from people who would do better if they were prioritised.

12:45

Rachel Cackett: The Public Bodies (Joint Working) (Scotland) Act 2014, which was passed with cross-party support, devolves a lot of decision making about priorities and the spending of money at a very local level, and that is what we are going

to see and what we are going to have to learn to live with. I agree with Annie Gunner Logan that tensions are going to arise at the beginning of that process, given the tradition of having a very centrally managed organisation and the fact that it is going to have to find out how to work in a very new sphere in which the new integration authority will have a locus in some—though not all—of its services. I am with the previous speakers in that I am not sure that the issue is necessarily about how much is ring fenced centrally, how much goes out to health boards and, beyond that, how much will be allocated by health boards to integration authorities.

I remember how, at the NHS conference a couple of years ago, the clinical director of the NHS said that the service is not always good at upscaling. We have a lot of initiatives, projects and new ways of doing things that can be very good at a local level, but they do not get the necessary traction or leverage to be expanded in a way that makes sense in other parts of the country. That is where central funding for things such as family nurse partnerships and that kind of Government support for trialling and evaluating new ways of working and making that available to partnerships can be very helpful.

Kim Hartley: As far as the allocation of funding is concerned, our concern is not about the distinction that Bob Doris drew between retaining more money centrally and giving less to the boards and local authorities. Instead, we are concerned that, wherever the money has gone, it does not seem to be working to bring about integrated and fully multidisciplinary planning at either central or local level. I think that, centrally, we could start to demonstrate the integrated behaviour that we would like but which we are not getting at the moment and to enable local agencies to make some smart decisions on the basis of real evidence and real data. That kind of evidence base, certainly with regard to the impact on AHPs, is not available either.

The Convener: I am tempted to go back, but all I will say is that, over the past couple of years, we have tried to focus on what is changing. We all agreed that there needed to be a shift from the acute sector to the community, and there have been bits and pieces of legislation in that respect. However, the draft budget does not show that shift and whether that money is going in that direction. Indeed, we are seeing contradictory demands on health boards and the health service, with, for example, trauma staff working 24/7. We played a part in highlighting that issue, and we have also noted increased spending on prescriptions when we expected savings that could have been channelled towards these issues. Moreover, treatment targets are distorting the whole service and preventing things from happening.

As a result, a massive contradiction is emerging. The draft budget does not show any significant shift in the change fund budget. When the older people's change fund was in place, we asked how it was being spent and whether it was just providing residential places, and we are not seeing any significant shifts in the health service budget in that direction. There is a contradiction in that respect, and politicians and the Government as well as increasing demand are putting more pressure on the health service.

When is this shift going to take place? We all supposedly agree that the 2020 vision is a priority, but I have taken the opportunity in this discussion on the draft budget to find out whether anyone is serious about it. Depending on where you come from—apart from Unison, which straddles both health and social care—one of you might say, "It's a good idea to get more money locally, because community services will benefit from that," while someone else might say, "No, no. We can't take money away from the acute sector, because we need to deal with demand."

Wherever we come from, the issue is about where the chances are best. There is nothing filling the hole in the middle. That is perhaps a bit of a rambling description—I am getting frustrated with this, too. Everybody is talking about what we need to do and the need to do it quicker, but it is not happening, and the draft budget does not provide the boost or acceleration that is needed.

Jill Vickerman: I do not think that the draft budget is the place to provide that boost or acceleration—it will follow what happens. We do not have a plan for how we are going to change the profile of demand, which is what a number of us around this table are talking about. We must have an open and honest discussion with the public, politicians, professionals and service providers about how we are going to shift the way in which demand currently falls.

At the moment, the budget can only respond to where the demand is coming from. As you have rightly said, that is from the public's expectations about how they use health services, the demands that are being placed on those services by politicians and the promises that are being made.

We need to shift from that culture which, despite our rhetoric about needing to shift the balance, is where we have remained, to having a serious conversation about how we change people's expectations for how they use health and social care services and about people taking personal responsibility for how they use those services, how they manage things and how they self-care. We need to listen to the range of stakeholders represented around this table and to people more widely regarding how that shift needs to happen. We should stop making promises about new

things in healthcare until we have clarity about the plan to shift the balance. Then, we would expect to start seeing evidence in the budget of those things beginning to take effect.

Without a plan—without something that we all stick to, are agreed on and are moving towards—there will not be anything apart from a repetition, year on year, of the same kinds of budget demands at the levels where they have always sat.

The Convener: I share this frustration, if not stress, with the committee—it is like group therapy. We are great at, and enjoy, doing new things, but we do not like giving up the old things. We spend all our money doing what we have always done. In earlier evidence, we heard a view that was expressed not just by the two economists concerned, which was that we are changing things only at the margins.

The draft budget does not come alone; it comes with conditions. The Government is retaining a bit of money for some of its initiatives, and it is placing requirements on health boards for 24/7 working trauma staff, for instance. It is imposing significant targets on health boards, and some people would say that that is distorting the service. That perhaps prevents money from shifting out.

All those actions and the things that we have been doing prevent new thinking about evaluation. We contributed with our recent work on access to new medicines, particularly rare and end-of-life medicines. There is a political £40 million or so in the budget—it might cost more, and the figure could turn out to be treble that amount—but, as David Bell said earlier, there has been no evaluation of the benefits of investing in mental health, childcare, family nurse partnerships or anything else against that investment. No quality assessment has been applied to anything that we are doing in the way that it applies to new medicines, with people being asked to justify the spend and the outcome against the investment that is put in. For most of what we do, none of that takes place.

How can we have that debate with the public about what is important when we are all basically defending the status quo?

Rachel Cackett: I am not sure that we are all defending the status quo.

The Convener: There will be good, nice wee examples—they are all over the place—but does that shift things away from it?

Rachel Cackett: I would urge, from conversations that I have had outside this room, that a lot of us are willing to have the difficult conversations, because we cannot keep doing what we are doing. In a recent RCN survey of nurses, about two thirds felt that they did not have enough time to deliver the care that they felt they should be delivering. The status quo is not going to be possible. It is important to acknowledge that there are difficult decisions to be made. Some of those will be decisions about disinvestment. People working in the service are not going to be averse to having those discussions as long as they are done openly and transparently. There is a good rationale for having those discussions, but they need to be done well.

We are placing a lot of faith in integration authorities to make those decisions about investment—and about disinvestment in particular—that simply have not been made recently. We have to have the conversation about what the hospital sector is going to look like in the future.

I hear lots of conversations when I sit in conferences about the freeing up of money from the acute sector to shift the balance of care to the community. We have two issues in relation to that. One issue is that when we were awash with money, we did not use it in a way that allowed a level of double funding. We are now in a situation where double funding, such as the £100 million to boards for integration, which is actually in their uplift, is not going to be a sufficient lever. Therefore, how do we make that shift without impacting negatively on the care of people who need the acute sector at the moment because we have not dealt with the long-term implications of reducing obesity, drug or alcohol misuse or any of the things that will impact on that need?

The other issue is, if our hospital system starts to look different, with the people going into hospital being the frailest, the most complex cases and the most acutely ill, the costs of that acute sector are also going to change. How do we do it? I think that engaging the public, staff and people who are using services in a debate about what this is going to look like is probably the only way that we will be able to start making some of the radical decisions that will free up the integration authorities to genuinely redesign services, without there being an immediate outcry because people have not been brought along in a debate about what that means. We have seen that happen repeatedly in the past and that situation cannot happen in the future because, if it does, the quality of our health and social care services will decline in a way that none of us wants to see for any of us.

Kim Hartley: AHPs have absolutely no investment in the status quo at all. It is not working for our service users. We need a change in culture and hierarchy. I think that Jill Vickerman made the point that we do not have a plan for change or a plan to change the pattern of demand. We do—we have lots of different plans. Specifically, AHPs

have a national delivery plan—there is zero funding for that. Nothing has changed. AHPs are demonstrating all the time how they prevent spending and how they increase self-management. The early years collaborative is a huge example of tests of change and the difference and the savings that people are making. However, the early years change fund is stopping, more or less. Contrast that with the investment that is being made in one part of the early years funding.

What we need to do to shift the balance is to start demonstrating and celebrating an awful lot more loudly the evidence that we have on what is making a difference. We need to have different people talking about success rather than to keep focusing on the same model of provision, which is about waiting for people to get ill and then dealing with them.

Lilian Macer: I have a couple of points to make. There were questions about what we can do within the budget that would make a difference in terms of shifting the balance of care, and what would make a difference to health inequalities. Recently, I attended a conference, looking at the idea of a just Scotland, that was organised by the Scottish Trades Union Congress. The people who gave evidence earlier were also at the conference and gave some really useful and helpful information not just around health inequalities but around income inequalities. For us, one of the biggest issues—one of the biggest constraints on the public sector—is public sector pay restraint. I say that and make no apologies for saying it because one of the biggest issues for us, in the workforce that we represent across the whole of Scotland—a public sector workforce that delivers quality services—is around the ability to generate spend and influence the local economy.

13:00

We talk about localisation and how we can build from the bottom up locally in order to support public and private sector organisations within local economies. One of the biggest and, perhaps, easiest ways to do that is to generate and encourage spend. Public sector workers in Scotland, especially the public sector workers whom I represent, do not have huge bank books and they do not go to the stock market; they spend in their local economies. However, people's ability to spend in their local economies is significantly reduced when they have been under pay restraint, have had no pay rise for two years then get a 1 per cent pay rise in the past year while their pensions contributions have been increased by 3.4 per cent. We need to talk seriously about public sector pay restraint and how to regenerate and refocus on local economies.

Again, the issue around the link between the health service and local authority is that there is a huge demarcation between one and the other. We need to get some serious and focused discussion around how we can make sure that one workforce does not stop at one point so that we then have to engage another workforce. That discussion should be around care pathways and how they need to interlink and engage with each other.

Unison recently undertook a survey of its members and service users about the 15-minute care visits, which we had highlighted as being inappropriate. Again, that is a local authority issue, but it should not be. It should be our issue; it should be an issue for the health service and the local authority. The integration agenda is our issue and that is part of it.

We are also looking at the ethical care charter, which means that people who are employed to deliver care should be given the training and the ability to care, the right to the time to care, and the time for training so that we have a trained workforce.

On health services in isolation, we heard earlier about how boards had been asked to implement the keep well project with no additional funding. Some people are saying that the project might not be realising the health inequalities benefits that it was badged to do. We need to look at where it has worked and allow the local systems and health economies to consider where keep well has made an impact on and a difference within a particular area. We cannot continually look across the whole of Scotland and say that one size fits all. The keep well project has made a significant difference in some deprived areas. Should we stop that? I do not think that we should. Should we support it through investment? Absolutely, we should, but if we say to the policymakers in the Scottish Government and across Scotland that it is not working in every area across Scotland so it needs to be stopped, that will have a significant impact on local democracy and how the integration boards generate localism and deliver health services and care services.

There are things that we can do and learn, but there are also areas in which we need to join up and link. We need to link policy makers with the health service. Working in the service, I hear all too often that there is an initiative coming out, that the policy makers have decided on X and that it is up to us to implement and deliver it but without any additional resources and without thinking on what it will mean for local communities. That needs to stop. I am not saying that it happens all the time, but when such things happen once, it is once too often.

There are things that we can do and things that we should do. It is absolutely right to say that we

need to have a mature discussion about disinvestment. The first thing that happens locally when we talk about disinvestment—about how beds are old currency and how we want to disinvest from provision of acute services—is that the politicians tell us that their local communities and constituents do not want that to happen, so it does not happen. We all need to have a serious conversation with the health service, with the policy makers and with the politicians.

The Convener: Absolutely. We know about the cost of arguing for change in the health service in my party, but I will say no more about that.

Annie Gunner Logan: I am going to say some things that Lilian Macer is not going to like, so I will declare an interest as a member of Unison. I will preface it by saying that there is an extraordinary amount of good stuff happening, although it is maybe not at scale and not measurable nationally. I am a great champion of self-directed support. Right now, it is transforming people's lives. It is getting a bit hidebound with bureaucracy, but let us not forget it.

However, I want to come back to Rachel Cackett's point about disinvestment. If we are going to do new and different things, we need to stop doing some of the old things. This is where Lilian Macer is going to get upset, because the budget contains commitments on pay and no compulsory redundancies for the public sector that do not apply to the rest of the social care market. Worse than that, pay and conditions in the voluntary and private sectors have been driven down by public sector commissioners. Those commitments in the budget make it more difficult to disinvest in public sector services. We need to face up to that. It is easy for a public sector commissioner to export pain to the private and voluntary sectors, because they do not then have to manage that. There are no commitments in our sector, from commissioners or anybody else, to there being no redundancies, to maintenance of pay and conditions and all the rest of it.

The quality of care at home provision in the voluntary sector for adults and older people is absolutely streets ahead of that in the private or public sector. The private sector is cheaper, so we might think that it would be worse, but the public sector is enormously more expensive and yet still does not attain the quality of the voluntary sector. Even on a best-value basis, why are we not investing more in the voluntary sector and, if you like, disinvesting in public sector care at home, if it is expensive and its quality is not as good?

Lilian Macer might not like that but, if we are going to have hard conversations about what to invest in and what not to invest in, we have to go to some of those places.

The Convener: I see that Lilian Macer and Rachel Cackett want to come in. After that, we really need to wind up, because it is after 1 o'clock.

Lilian Macer: I do not necessarily agree with all of what Annie Gunner Logan has said. However, we can agree that there needs to be a level of investment that means that whoever delivers services for the population of Scotland gets the living wage. That is a significant issue for us. There are fantastic achievements in the voluntary sector, where our members deliver high-quality services, where they can.

The significant issue for us is that—as Annie Gunner Logan rightly said—when public sector organisations commission or procure services, they pass on the pain. That absolutely needs to stop, and it needs to be absolutely clear. Unison has certainly said that it needs to stop. Organisations cannot pass on the pain—they cannot pass on the ability to deliver the services and think that they have washed their hands of the matter. All that happens is that they lose control. When they start to lose control, they lose quality and the recipients of the care suffer the consequences. When it comes down to it, public sector organisations then have to pick up the pieces when it is no longer deemed to be an appropriate or viable option to deliver that care, and care providers walk away.

We need a level playing field, through the living wage. Irrespective of whether the care is in the public, private or third sector, the living wage should be the benchmark for pay in Scotland. If the committee takes time to look at "Working Together: Progressive Workplace Policies In Scotland", which was commissioned by the Scottish Government and in which the STUC was a significant player, you will see that it has fantastic recommendations on the workforce across Scotland—not just in the private sector or in health and social care, but across Scotland. The recommendations are about a democratised workforce that gives workers a voice, and part of that is about ensuring that people get appropriate pay. The living wage would offer that security. Therefore, we do not necessarily disagree with all of Annie Gunner Logan's comments.

The Convener: We have worked our way back to agreement. I recommend the committee's "Report on Inquiry into the Regulation of Care for Older People" from 2011. It is all in there.

Rachel Cackett: A quality service requires a quality workforce. Delivering care is about the dynamic between the people who deliver services and the people who receive them. For me, it does not matter where the service is delivered. The Royal College of Nursing has members across the independent, third and NHS sectors, and we want

fair terms and conditions for every single one of them. Like Lilian Macer, we support the living wage. I was delighted that the principles for integration that were put through Parliament eventually contained a quality principle. I hope that when integration joint boards or lead agents are commissioning and procuring services, the thought that quality services require quality staff will translate exactly into their procurement practices, including assuming that the third or independent sector will be able to pay fair and decent wages to their staff.

The Convener: I am sure that we all agree that we do not foresee a sustainable solution that is based on sweated labour and poor quality, but it all comes at a cost. I suppose that that is the challenge for all politicians in relation to delivering care. That takes us back to the draft budget, which we have drifted away from considerably. We are also way over our allotted time. I thank our witnesses for being with us today and for staying beyond the allotted time. We look forward to seeing again our regulars and, especially, our newcomers.

I propose that agenda item 4, which is our private discussion on health inequalities, be postponed until next week. Do members agree?

Members *indicated agreement.*

Meeting closed at 13:12.

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