OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 20 December 2016

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 20 December 2016

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HEALTH AND SPORT COMMITTEE
16th Meeting 2016, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
*Donald Cameron (Highlands and Islands) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Alison Johnstone (Lothian) (Green)
*Richard Lyle (Uddingston and Bellshill) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Christine McLaughlin (Scottish Government)
Shona Robison (Cabinet Secretary for Health and Sport)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 20 December 2016

[The Convener opened the meeting at 10:06]

Subordinate Legislation

National Health Service (Dietitian Supplementary Prescribers and Therapeutic Radiographer Independent Prescribers) (Miscellaneous Amendments) (Scotland) Regulations 2016 (SSI 2016/393)

The Convener (Neil Findlay): Good morning and welcome to the Health and Sport Committee's 16th meeting in session 5. I ask everyone in the room to ensure that their mobile phones are on silent. It is acceptable to use mobile devices for social media within the room, but I ask people not to take photographs or to film proceedings.

Agenda item 1 is subordinate legislation. We have two instruments that are subject to negative procedure to consider, the first of which is the National Health Service (Dietitian Supplementary Prescribers and Therapeutic Radiographer Independent Prescribers) (Miscellaneous Amendments) (Scotland) Regulations 2016 (SSI 2016/393). No motion to annul the regulations has been lodged. However, the Delegated Powers and Law Reform Committee drew them to the attention of the Parliament under reporting ground (h) on the basis that they could be made clearer in the following respects.

In regulation 3(b)(ii), the word "or" could be used instead of "and" at the end of subparagraph (f) of the definition of "prescriber" in regulation 2(1) of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004. That would put it beyond doubt that the subcategories that are listed in that definition are alternatives and not cumulative. On the same basis, in regulation 6(b)(ii), the word "or" could be used instead of "and" at the end of subparagraph (f) of the definition of "prescriber" in regulation 2(1) of the National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004.

The Delegated Powers and Law Reform Committee has confirmed that the Scottish Government will make no changes. If there are no comments from members, does the committee agree to make no recommendation on the regulations?

Members *indicated agreement.*

Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Amendment Regulations 2016 (SSI 2016/401)

The Convener: No motion to annul the regulations has been lodged and the Delegated Powers and Law Reform Committee has not made any comments on them. If there are no comments from members, does the committee agree to make no recommendation on the regulations?

Members *indicated agreement.*

Draft Budget Scrutiny 2017-18

10:08

The Convener: Agenda item 2 is an evidence-taking session on the draft budget 2017-18. I welcome to the committee Shona Robison, the Cabinet Secretary for Health and Sport, as well as Christine McLaughlin, who is the Scottish Government director of health finance, and Paul Gray, who is the Scottish Government director general of health and social care and the chief executive of NHS Scotland.

I invite the cabinet secretary to make an opening statement. As agreed with her office, the cabinet secretary will make some reference to climate change issues in her statement.

The Cabinet Secretary for Health and Sport (Shona Robison): Thank you for the invitation to discuss the draft budget for 2017-18. I welcome the opportunity to give evidence on the important subject of ensuring that there is fair and appropriate funding for the national health service, an asset that is precious to us all.

Over the next few years, the demand for health and social care, and the circumstances in which such care is delivered, will be radically different. NHS Scotland must work with its partners throughout the public and voluntary sectors to ensure that it continues to provide the high-quality health and care services that the people of Scotland expect and deserve, and to secure the best possible outcomes for people through the care and support that they receive.

As I have highlighted before, the NHS simply cannot stand still—it must continually evolve to deliver the best medicine and best care, while always ensuring that public money is spent as effectively as possible. It is with that in mind that we published yesterday our delivery plan for health and social care. The plan brings together the key programmes of change for ensuring that our health and social care system can meet new challenges, particularly the national clinical strategy, health and social care integration, and public health improvement. The delivery plan sets out high-level actions and we look forward to working closely and intensively with the Convention of Scottish Local Authorities, employers and staff-side partners in NHS Scotland and a range of others to deliver our aspirations.

At the core of the delivery plan and our overall approach are the twin themes of investment and reform. Those themes are also at the heart of this budget. In addition to providing extra financial resources, we will continue to drive forward our significant programme of reform. The budget sets the framework for our next steps.

We have consistently prioritised investment in the NHS and have increased front-line health spending between 2010-11 and 2017-18 by 9.3 per cent in real terms. In 2017-18, funding for our core NHS budgets will increase by more than £320 million—more than the Barnett consequential for health, which was £304 million. As a result of an additional £50 million to be directed to national resource allocation committee parity, no board will be further than 1 per cent from parity in 2017-18.

That reflects the priority that this Government places on protecting front-line services and ensuring an equitable distribution of resources. We will continue to demonstrate that central priority moving forward. The NHS revenue budget will be almost £2 billion higher at the end of this session of Parliament than at the outset.

Our commitment to integrating health and social care services is demonstrated in this budget, with additional investment of more than £100 million to be allocated to health and social care partnerships. That will bring the additional NHS investment in health and social care integration up to almost £0.5 billion in 2017-18. It will allow key services to be delivered differently, with greater emphasis on supporting people in their own homes and communities.

As well as progress with integration, the budget sets out further measures to shift the balance of care by increasing, in every year of this session of Parliament, the share of the NHS budget dedicated to mental health and to primary, community and social care. The budget represents an important step to ensuring that, by 2021-22, more than half of front-line NHS spending will be in community health services.

We will invest £72 million in improvements to primary care and general practitioner services, going towards an additional £500 million being invested in this area each year by the end of this session of Parliament. By 2021-22, we will increase spending on primary care to 11 per cent of the front-line NHS budget. In 2017-18, investment in mental health will exceed £1 billion for the first time and mental health investment will exceed £5 billion over this session of Parliament. That will help to underpin our new 10-year mental health strategy, which will be firmly based on the principle of ask once, get help fast.

Our capital investment programme will ensure that the NHS estate is equipped for the challenges ahead. We will invest more than £200 million in the NHS estate and focus on improving primary care facilities, maintaining and updating medical equipment, and replacing key vehicles such as ambulances.

Furthermore, we will prioritise investment in the new Dumfries and Galloway royal infirmary, the

new sick children's hospital and department of clinical neurosciences in Edinburgh, and the Baird family hospital and Aberdeen and north centre for haematology, oncology and radiotherapy in Aberdeen.

The draft budget commits to progression on our £200 million commitment to expand the Golden Jubilee hospital and create five elective care centres in Aberdeen, Dundee, Edinburgh, Inverness and Livingston. That will, for example, allow us to meet the increasing demand for hip and knee replacements and cataract operations. Dedicated elective capacity will help to tackle the knock-on effect that peaks in demand from unscheduled emergency patients can have on planned elective care.

In this global and interconnected world, it is more important than ever that we all consider the impact of our work on wider issues, in particular that of climate change. The NHS, the Scottish Futures Trust and the Scottish Government have been working closely in partnership to develop and procure a Scottish energy efficiency framework, which will permit vital energy efficiency work to be carried out using both capital and revenue funding.

10:15

Recent capital funding has been directed to a number of NHS capital projects, such as the replacement of boilers in the Glasgow royal infirmary and in St John's hospital in Livingston to improve energy efficiency. In 2017-18, we plan to provide capital investment of £1.8 million to energy efficiency projects in NHS Tayside and NHS Ayrshire and Arran to help lower our carbon emissions.

I conclude with what I said in my opening comments about investment and reform. It is through an approach of continued investment and reform that we will set the basis for delivering the 2020 visions and our longer-term strategy up to 2030 through the delivery plan that we have published. That will ensure a safe, sustainable and person-centred NHS for the people of Scotland. The draft budget for 2017-18 puts in place the framework to enable us to achieve that vision, and I commend it to you.

The Convener: Thank you for your statement, cabinet secretary. The budget document shows a 0.6 per cent increase in real terms in the allocation. Audit Scotland said that the rate for health inflation is 3.1 per cent, so are we in effect seeing a cut?

Shona Robison: First, the NHS territorial board budgets will increase by 2.8 per cent in 2017-18. That includes the baseline uplift, NRAC parity and baseline transfers. If you look at the health service inflation figure, you will find that it is 2.3 per cent, so the allocation to territorial boards is higher than the inflation for 2017-18. Of course, what is required through the reform process, which I have laid out clearly in the delivery plan that we published yesterday, is for us to continue to drive efficiency to ensure that we can invest in the transformation that requires investment. That is why in 2017-18 there is £128 million going into a change fund to help us shift the balance of care from the acute sector and hospital-based services into the community. Although there is an above-inflation increase for boards, we recognise that the services that are delivered need to change in order that the quality of service is maintained.

The Convener: Across the health and sport budget, the total allocation is £13.2 billion, which represents a 2 per cent increase or a 0.6 per cent real-terms increase. At the same time, Audit Scotland's figure is that health inflation is 3.1 per cent.

Shona Robison: That was for 2016-17. It decreases to 2.3 per cent in 2017-18.

The Convener: There is still a gap between 0.6 per cent and 2.3 per cent.

Shona Robison: No, because the territorial budgets are receiving 2.8 per cent, which is higher than 2.3 per cent.

The Convener: I am talking about across the piece. The total allocation is £13.2 billion across the whole area of your responsibility, and that increase is 0.6 per cent.

Christine McLaughlin (Scottish Government): Allow me to clarify that. You are right that there is a distinction between the board uplifts and some transfers into their baselines next year. The point that we have tried to make in the budget document is that there is a contribution towards inflationary pressures and there is also investment in reform next year. We could have put all the money into board uplifts for inflationary pressures, but we have tried to target some of it for investment in primary care and mental health, so we thought that it was appropriate to recognise both of them. That is why we are talking about an investment of £128 million in year. If you take that into account, it is more than an inflationary increase.

Shona Robison: That is money that the boards will get in year, but it is directed by a change fund in order to ensure that the direction of travel is towards investment in community health services. It is money that the boards will still receive.

The Convener: When you talk about efficiencies, that would suggest that money is being used more effectively. If we take NHS Lothian as an example, we see that 70 per cent of its targets are being missed, as reported in its

recent board papers. Do you think that the efficiencies that are being made there are effective?

Shona Robison: I certainly understand that efficiency savings can be challenging for boards to deliver, but if we are to shift the balance of care and to make sure that services are funded in the community, we must ensure that services are delivered in the most efficient way. If we look at NHS Lothian's NRAC uplift for 2017-18, we can see that it is getting the lion's share of the £50 million—it is getting £19.2 million—so NHS Lothian will get a 3 per cent uplift. Although the situation is still tough for boards, I think that the budget that we have put forward is a fair settlement for the NHS. Reform will be required alongside the significant investment that we are providing.

We have delivered what we committed to delivering in our manifesto—£500 million above inflation. That was by far the highest commitment of any of the manifestos. We will deliver that, but boards will have to make efficiency savings.

The Convener: If, as you say, the boards are getting more money and becoming more efficient, yet they are missing more and more of their performance targets and criteria, what do you say to patients and staff in, for example, Lothian? They are told that more money is being put into the service and that the measures that are being taken are efficiencies, but the services appear to be getting worse.

Shona Robison: We laid out our funding commitments to the NHS in our manifesto and we were elected on the basis of that manifesto. We committed to provide £30 million more than those parties that committed to provide inflation-only increases committed to provide. If we had gone down that line, there would have been less money in the NHS.

The NHS's performance targets are tough. There is more demand on our services, which is why we must make sure that every penny in every pound that goes to our health and social care services is spent as efficiently as possible. Yesterday, I laid out a clear delivery plan for how we would ensure that as much of that resource as possible goes to the front line. We must make sure that the patient outcomes that we measure are the right ones to measure. That is why the work that Harry Burns is undertaking is so important.

Despite all that, as you said, some of the targets have been missed, but the performance of the NHS is still very good. It has delivered some of the lowest waiting times that we have seen in a long time. I would say to the public and patients that the NHS is still delivering an extremely good service, but to ensure that it continues to do so, given the increasing demands of an ageing population, we need to reform the way in which services are delivered. That is what the delivery plan that I published yesterday lays out.

Alex Cole-Hamilton (Edinburgh Western) (LD): I would like to pick up on an issue that I have discussed with you previously, which is funding for drug and alcohol partnerships. We know that those services received cuts of up to 22 per cent in last year's Scottish budget. In Edinburgh city in my region of Lothian, that equates to a £1.3 million year-on-year cut. I understand that the Scottish Government has asked health boards to deliver services to the same standard as before and to find money to make that happen but, as I have just said, that is not happening in Lothian, nor is it happening in Glasgow, where, since those cuts were made, we have seen an HIV outbreak among intravenous drug users.

Can you walk us through any aspects of the budget that mitigate that and put money back into drug and alcohol partnerships? What is the prognosis for those services?

Shona Robison: As I have said to the committee before, what is most important is what outcomes are delivered for those who require access to alcohol and drug services. The performance on the waiting-time standards for access to alcohol and drug treatment is extremely good, and it is important that boards maintain that level.

I know that Alex Cole-Hamilton has been consistent in raising the issue of the situation in Lothian. As I said in my previous answer, NHS Lothian's 2017 allocation contains £19.2 million of NRAC uplift. That is by far the highest level within the NRAC allocation of £50 million. We are intending to discuss with boards what that resource should be spent on, particularly those boards that will gain a significant investment from NRAC that they did not necessarily expect.

Our intention with NHS Lothian is to include a discussion about alcohol and drug partnership funding, to make sure that it is adequate to deliver the outcomes required at a level that we can come to some agreement on; I am happy to keep you informed about that. There will be other elements within the agreement on the local delivery plan that we will want to see NHS Lothian improve upon as well, particularly some of the performance measures that the convener mentioned earlier. It is a significant additional fund that is available to NHS Lothian, part of which we would like to discuss with them in relation to alcohol and drug funding.

Alex Cole-Hamilton: Thank you for that. My contention is that, while outcomes still look pretty good, we are measuring them only for what we

were spending before that cut properly took hold. As I mentioned, with an HIV outbreak in Glasgow and other things happening in other parts of the country where ADP funding has been reduced, we may see that that cut is problematic. I am grateful to the cabinet secretary for those assurances, however, and I look forward to hearing more about those discussions.

Obviously, everybody around this table will welcome the increase in funding for mental health. I want to ask specifically about two areas. What percentage of the spend will be directed at child and adolescent mental health services, particularly for reducing waiting times and providing access to tier 4 beds? Also, I have recently been quoted in the media talking about the need for mental health first aid and upskilling our workforce in mental health first aid. Can you cover those two issues?

Shona Robison: A lot of the detail about the priorities for mental health spend will, of course, be part of the strategy. There has been engagement around that by Maureen Watt, the Minister for Mental Health. We are always open to suggestions as to how we could deliver and develop new services within the community. You will have seen at the weekend that Maureen Watt was talking about the £10 million for mental health services within primary care.

Importantly, the delivery plan that I announced yesterday focused very much on the shift in spend to community health services, including primary care, mental health and social care. Within all that there is scope to develop many innovative services for mental health, whether within schools, primary care or to improve some aspects within our emergency services that are responding to people who are in crisis.

This is a draft budget; there is further scope to discuss some of the detail. We have set out a number of priority areas for mental health spend. It is quite a substantial additional spend over the course of this Parliament, but if there are specific issues, detail and suggestions concerning that spend, discussions on those can be had in further detail.

Alison Johnstone (Lothian) (Green): I think that your Government had anticipated that by 2016-17 no board would be below NRAC parity level. I appreciate your comments regarding the increase, particularly in Lothian, but it is still below parity, as are seven other health boards. Is the Government still committed to NRAC parity and, if you are, what is the timescale for achieving that?

Shona Robison: As I said in my opening remarks, by 2017-18 all boards will be within 1 per cent of parity. That funding will mean that since 2012-13 an additional £884 million will have been committed over a six year period to those boards below the NRAC parity levels. That is a significant investment and it will continue, to ensure that boards are kept within at least 1 per cent parity. The £50 million investment in 2017 will make a big difference, particularly to boards such as NHS Lothian, which have faced a number of challenges.

10:30

Christine McLaughlin: We are really keen to see that additional funding used for investment. For example, over the last few years, NHS Grampian has taken the additional NRAC funding and treated it not just as money going towards the pressures on their bottom line, but as investment in services. We would like to see that happen across all boards. We want to see the funding helping to make services more sustainable.

In deciding to go for a lower level of uplift for all boards, you really start to see the impact of that on a cumulative basis. We give out the in-year funding—the £128 million that goes to boards—in a way that fits with NRAC parity. In other words, rather than giving it out on funding, we are giving out on shares, so we start to make bigger inroads into a shift towards parity. With every element of additional funding that goes to boards, we look to see whether we can continue to help to move towards parity.

Finally, we have also said to boards that we will give them a three-year forecast to give them more certainty about what the NRAC position would look like for the next few years. As part of finalising the budget we will give all boards the forecast position of their shares for the next three years, based on current population trends. If you look at that, you will see that in Lothian, population trends are predicted to grow by 0.5 per cent every year, so we would expect to continue to put more money in over the next few years. That approach to getting to within 1 per cent parity for all boards means that this is the closest that we have been since that commitment was made.

Alison Johnstone: There has been a significant cut to the sports budget—7 per cent in cash terms and 8.3 per cent in real terms. That is of great concern to many of the governing bodies and to the people delivering sports in our communities. We are aware that all the international research suggests that a major global games is no guarantee that we will see a significant increase in people participating, but cuts of such a scale will certainly not help. Has the cabinet secretary been in discussion with the governing bodies and others about the impact that such cuts will have?

Shona Robison: Aileen Campbell, the Minister for Public Health and Sport, has had discussions.

It is a tough settlement. We would expect sportscotland to focus on and prioritise the delivery of grassroots and community sport. The commitment to increase the community sport hubs is important. We also need to see some of the other investments in early years and public health measures as being important. We would want to see the new diet and obesity strategy, the investment in physical education and the active schools network being prioritised.

Other parts of government contribute to sport, through Event Scotland in relation to major sporting events. There was a significant announcement of £15 million of tennis investment next year—a partnership between the Lawn Tennis Association and sportscotland.

It is a tough settlement. We will continue to talk to sportscotland and the governing bodies. I am aware that there are also lottery pressures. I am happy to have further discussions, but within that tough settlement we would expect bodies to prioritise grass-roots and community sport.

Alison Johnstone: You mentioned other investments and other parts of government contributing. I think it is fair to say that groups that lobby for greater investment in active travel infrastructure are disappointed—to say the least—that there is an increase in the trunk roads budget that is four times the size of the entire active travel budget. In our evidence-taking session on obesity, we heard from Ian Findlay from Paths for All that physical inactivity is costing the NHS and the country £94 million a year. If climate change and health are cross-cutting Government priorities, is there an opportunity for you to speak to the Minister for Transport and the Islands and suggest that the active travel budget be revised in an upward direction before we come to vote on the budget?

Shona Robison: I have had discussions with the current and previous transport ministers and other ministers across Government about how we can better co-ordinate our work to be more cohesive and coherent around trying to tackle some of the big issues of the day, such as obesity. Government is always about balance and we need to ensure that we also invest in some of our infrastructure that needs investment. These things are always about striking the right balance, but I am happy to continue those discussions around active travel. There will perhaps be opportunities as we revise our obesity strategy next year to look at that in more detail and consider how we can encourage people to use public transport, to walk and to cycle. Of course, there has been investment in our cycling infrastructure. We have investment of, I think, £39.2 million per year in active travel, which is not insignificant. Again, however, it is a draft budget, and I am happy to continue to have those discussions.

Alison Johnstone: I emphasise that while that £39.2 million has not increased at all, the trunk roads budget has increased by four times the entire active travel budget. I would be grateful for any conversations that you might have on that.

The Convener: What is the thought process behind sport getting such a significant cut? What is the logic of that?

Shona Robison: It is a tough budget in that we need to make sure that we are able to prioritise the areas of investment, which I have made clear are around community health services. However, we have prioritised investment around early years, making sure that some of the preventative work that we do within our health services is prioritised, and in sport we have said that we want priority given to grass roots and the active schools element. This is about having to set a tough set of priorities.

The Convener: It is to do with prioritisation. Okay. Donald Cameron is next.

Donald Cameron (Highlands and Islands) (Con): I would like to ask about the £500 million of additional funding for primary care. Just to be clear at the start, is it your commitment that you will invest £500 million additionally each year by 2021? Have I got that right?

Shona Robison: No. It is investment of £500 million in primary care over the current session of Parliament. That will deliver an 11 per cent share of the budget. Next year, the primary care budget increases by £72 million. The breakdown of that includes the GP contractual uplift and population growth but also, importantly, investment in the new models of primary care. That is about delivering the new vision of primary care that we want to see, with multidisciplinary team working.

Donald Cameron: So it is £500 million over the course of the parliamentary session.

Shona Robison: Yes.

Donald Cameron: Are you able at this stage to break down the £72 million that you have just referred to into primary care, general practice and so on?

Shona Robison: I will ask Christine McLaughlin to take that question.

Christine McLaughlin: The team has been working on the prioritisation of that investment. The work has not yet been finalised, but I think that we will be happy to share what is in it.

The investment is made up of quite a lot of different components. For example, there are certain areas in relation to GP investment, but

there is also some investment for digital technologies and implementing the out-of-hours review. There is also some funding for resources on the ground to allow partnerships to try out some of the new models of care. A whole raft of things accounts for the £72 million, and we will be able to share the work with you once we have reached a slightly more advanced stage, which will not be that near into the new year.

We are also happy to share with you where we are with the shift in what we are looking at for next year. It is important to distinguish between the funding that goes in and the expenditure on the ground, and we are doing quite a lot of work on understanding the flows and what kind of reporting we will have in that respect. If you would like to see anything like that, we would be happy to give you more information about it.

Donald Cameron: I would very much like that information, and I am sure that the committee would, too.

I believe that, last week, the Cabinet Secretary for Finance and the Constitution, Derek Mackay, used the phrase "improvement plan". Does that describe just a general ambition to improve general practice and primary care, or is there actually some concrete improvement plan?

Shona Robison: The changes to primary care are a critical part of the delivery plan that we published yesterday. For quite a few months now, we have been talking to the profession and the British Medical Association with regard to not only the negotiation of the new contract and what that will deliver, but wider investment in primary care to ensure that we build up the workforce around the multidisciplinary team. Of course, there will be more about that in the workforce plan in the spring.

We have to make sure that we deliver not just a funding plan but a reform plan, which is why the new model of primary care is so important. There are also short-term funding measures to address recruitment and retention and to provide support for clusters. Certain elements of funding are very much about the here and now, I guess, and other elements are more about transformation.

Richard Lyle (Uddingston and Bellshill) (SNP): I could ask you many questions about the budget, but I want to focus on two items that I have always been interested in.

As you know, cabinet secretary, I have continually pressed the case of patients who have been given contaminated blood products. I note that the budget in that respect has not changed any. At the end of the last parliamentary session, you answered a question of mine about the payment programme for patients with contaminated blood; where are we in that respect? Are things still being held back by the United Kingdom Government?

Shona Robison: The latest is that there has been progress to ensure that we have some interim arrangements for making additional payments to those who have been affected, and my officials are at quite an advanced stage in discussions with the funds down south and Department of Health officials, basically to try to get that money into the hands of people as quickly as possible. Obviously the second strand of this is the setting up of the Scottish scheme, and I am confident that we will have that up and running in 2017-18 to deliver the more comprehensive package of support to those who have been affected. I believe that the package totals about £20 million.

Christine McLaughlin: That is right.

Shona Robison: It is a significant investment, but it is important that the money gets into the hands of those affected, and a lot of work is therefore being done to try to do that as quickly as possible. We have been working with stakeholders on what the new Scottish scheme will look like and ensuring that there is patient involvement. I am happy to keep the member posted as we take those measures forward.

10:45

Richard Lyle: Basically, again, the sooner that money is paid out the better—I will constantly press you about that. Will there be any effect on local NHS budgets?

Shona Robison: No. The payments are being funded centrally.

Richard Lyle: We have gone through having integration joint boards and we identified that there would be savings of, if memory serves me right, £100 million or £140 million, although I do not think that we are going to see them.

My concern is that by October or November this year, some integration joint boards had still not made up their budgets. They are now predicting that they will be able to finalise budgets next year. Do we have total confidence that integration joint boards will do that? What monitoring will you do of their budgets? Is someone checking on integration joint boards to make sure that they are meeting their responsibilities?

Shona Robison: Christine McLaughlin will answer in a bit more detail in a minute. However, we have tried to improve the budget-setting process. You are right that there were certainly some challenges with that. The statutory guidance requires three-year budgets, with a review of years 2 and 3 carried out on an annual basis. Boards and councils are adjusting their budget-setting

processes to fit with that cycle. That entails a greater adjustment by health boards in estimating medium-term assumptions and associated risks. A lot of work is going on with directors of finance. Christine McLaughlin has more of the detail on that.

Christine McLaughlin: Largely, we expect those timing issues to have been year 1 transitional issues. As a result of conversations that I have had with the integration authority chief finance officers, I am certainly reassured that they feel that they are in a clearer position in terms of their plans for next year. On getting agreement on the draft budgets, I think that we are much more joined up through the discussions that we have had between health, local government and the integration authorities. On people being unclear about the settlement, I think that we are starting to see improvements. Clearly, there will still be work with integration authorities on how they deliver their plans, but I expect that, as with all other public bodies, at the beginning of the year, the integration authorities should have much greater clarity about their overall funding levels and the plans that they need to operate within that.

Richard Lyle: Finally, on the same subject, will we ensure that integration joint boards give value for money?

Shona Robison: I will chair a meeting of the ministerial strategic group tomorrow. The group's remit has changed to give a bit of a sharper focus to how we oversee performance, how we support partnerships to develop and share best practice, and how we support their improvement teams to make the changes that need to be made if they are not delivering what, collectively, we, local government and third sector partners think they should be delivering. Everybody who sits around the table is jointly responsible for ensuring that we and they deliver what needs to be delivered. For example, as I have said before, if all partnerships were delivering at the same rate as the top 25 per cent, which is made up of a mix of urban and rural partnerships, we would be able to halve the delayed discharge numbers.

We know that there are things that work, and we are keen to help partnerships make changes in that regard. I hope that the oversight and support role of the ministerial strategic group will make a difference.

Christine McLaughlin: Just over £8 billion comes within the remit of the integration authorities. That is integral to the NHS's sustainability and value programme. Savings programmes and efficiencies in areas such as prescribing are wholly dependent on the integration authorities being part of the solution.

We are seeing much more that the lines between bodies are fluid, as we are all working together on the overall programme. We are looking at how we get the best value for the £8 billion rather than looking at one subset within that. Some differences and some really good examples of changes in ways of working are starting to come through the integration authorities—particularly in the way in which people are being treated in their own homes. That progress needs to accelerate through next year, and our focus will be on that.

The Convener: In our committee report, we said that we wanted to see some action to align budgets, but your response was that there was no need to issue any new guidance on that. Are you confident that we will not see those issues this time around?

Christine McLaughlin: I would say that the budgets are now entirely aligned. That is why, in the funding letters that went out with the budget last week, we were completely consistent in our message to all bodies. Those reasons are not there any more. The only reason that I can see for why we would not have a signed-off budget at the start of the year would be if there was still some work to do on understanding some of the savings programmes that need to be put in place. There should be no process reason for not getting information about budgets at the same time, if that answers your question.

The Convener: We will watch that with interest.

Miles Briggs (Lothian) (Con): Good morning. Last year, NHS Scotland spent £248 million on locum doctors and nurses, which represented a £41 million increase on the previous year. What does the cabinet secretary believe that the figure will be in 2018-19? Will it increase?

Shona Robison: Our aim is to reduce that spend. Part of the national programme in which Christine McLaughlin and her team are involved with boards is very much about driving down those agency costs. One of the boards that has been delivering a significant reduction in agency spend, because it had one of the highest figures, is NHS Tayside. We would expect best practice in how to address that to be shared across boards.

The chief nursing officer, Fiona McQueen, has been working with boards to look at getting the balance right in filling some of the substantive posts. She has been working with the boards' directors of nursing to look at how that can be done in a helpful and meaningful way. Christine McLaughlin can say a bit more about the national programme. Driving down those costs is a really important priority.

Christine McLaughlin: This year, alongside the draft budget, we have given boards some direction on looking at how the money will be used next

year and the areas in which we expect to see improvements. Spend on agency staff and locums is one of those areas. Overall, we expect to see a minimum 25 per cent reduction next year.

There are two aspects to the issue. One is that, where agencies need to be used, that should be done in the most effective way. Ultimately, the benefit comes from managing the need for staffing provision and looking at alternative methods. Changes such as introducing a regional bank for medical staff are critical, because we will not get a reduction in locum spend until such substitutes are in place.

We are much further on in that area, and I expect to see some reductions. The picture will probably vary across the country depending on local circumstances in individual boards, but we expect a 25 per cent reduction to be a realistic target for next year.

Miles Briggs: My second point is on the use of the private and independent sector. How much has been spent this year on patients who have had to be treated in that sector, and what are the projections for future years? Will that figure also increase?

Shona Robison: It has actually reduced this year, and it is reducing overall.

When we launched the £200 million plan for elective centre development, which runs over the current session of Parliament, we stated explicitly that one of the reasons for that was to further reduce spend in the private and independent sector by having in place elective capacity to meet the needs of the population, and in particular our growing elderly population, which requires issues with hips, knees, cataracts and so on to be addressed.

Some boards have used the private and independent sector more than others have done, but we expect the sector to be used only at the margins and never as a replacement for capacity in the NHS. That said, we recognise the need for additional elective capacity, which is why there will be an additional five centres as well as the Golden Jubilee national hospital. I anticipate that there will be less spend on the private and independent sector.

Christine McLaughlin: I will not have the detail until we see the plans from the boards. We have just given them the settlement, and we will start to see the plans in January and February.

A theatre improvement programme is considering how to increase the number of procedures in theatre over a day. Such things can have an impact on a board's need to use additional capacity. Through the national clinical strategy, work is starting to make inroads into the issue. There are good improvements—in NHS Lothian, for example. A lot of consideration has been given to practice in, for example, the NHS national waiting times centre, where the number of operations in a session is higher in some specialties. Such work will lead to an overall reduction in use of the independent sector.

Colin Smyth (South Scotland) (Lab): Cabinet secretary, in your opening remarks, you included the £107 million for social care in the overall figure for health spending. Will you confirm that the £107 million is for the health budget and not for the local government budget?

Shona Robison: The £107 million is being transferred through the health budget to the integration authorities, which is what we have done with the £250 million. The £107 million is being transferred on the same basis, given that we now have an integrated system. That is about moving out of silos.

Colin Smyth: In the budget document and in your earlier comments, you included the £107 million in the overall figure for the health budget. Will you explain why page 101 of the Government's budget document includes funding for health and social care in the local government budget, under the heading "Other Sources of Support", which is included for the first time? That did not happen last year, so why is it happening this year? Surely such an approach leads to accusations of double counting.

Shona Robison: I do not think that there is double counting. We have been clear in saying that the £107 million, like the £250 million, is being allocated to the health budget and is then transferring to the new integration authorities. I do not think that that could be clearer.

Christine McLaughlin: We were trying to make the position as transparent as possible, and the language is very clear. I think that the issue is that integration authorities do not get a budget as part of the budget settlement; their budget comes through health and local government. We felt that the approach was not really about whether the money sits in the health portfolio or the local government portfolio. We were trying to make it clear that funds are transferring to the integration authorities.

What is reflected in the local government table is not added to the value of the settlement. The table shows another source of funding, because the money flows through from health. I might be being a bit pedantic, but the figure is included only once in the overall numbers, in the health settlement. It is not included in local government as part of the settlement; it is shown below the line as a source of additional income that flows through from health. The money absolutely is

counted only once in the overall financial settlement in the budget.

Colin Smyth: You have confirmed that the money is in the health budget, so it cannot also be in the local government budget—

Shona Robison: But it is, in the world of integration. It is surely a good thing that we are seeing health and social care as one system instead of two systems.

Colin Smyth: The money cannot be spent twice, so the impression should not be given—

Shona Robison: I do not think that anyone is claiming that it is being spent twice.

Colin Smyth: I beg to differ.

The £107 million is largely ring fenced for specific purposes—in particular, the payment of the living wage. Can you confirm that you are happy that the funding that has been provided this year in all IJB areas will be sufficient to cover the full costs of paying the living wage?

I welcome the fact that the previous bizarre assumption that 25 per cent of the costs would be met by the providers is no longer being made. Can you confirm that the funding will fully cover the cost of the living wage? Will you also explain what exactly the £10 million for sleepover shifts will cover? Obviously, it will not fully cover the living wage for a sleepover shift, so what will it actually cover?

11:00

Shona Robison: The £80 million to support the continued delivery of the living wage is important. It enables the increased rate of £8.45 per hour to be paid to care workers who support adults in care homes and in care at home and housing support settings. That should also now include—where it does not already—adult day care workers and personal assistants through arrangements that are made where care is provided.

The figure of £80 million—and the £10 million that has been identified for sleepovers—is based on negotiation and looking at the cost with local government and third sector providers. A huge amount of work has gone into estimating that cost as accurately as possible.

We will continue to work with COSLA and third sector providers as we go through the year to make sure that the living wage can be delivered. There is a substantial investment in making sure that 40,000 workers will continue to receive the living wage and in dealing with the issue of sleepovers, which I know that Colin Smyth and others on the committee have raised.

Colin Smyth: I am not clear about exactly what the £10 million will cover. Given the number of sleepover shifts, it will not cover the full cost of paying somebody the living wage for a sleepover shift, so I am not sure what it will specifically cover.

Shona Robison: It was agreed that all waking hours would be paid at the national living wage and that sleepover hours would be paid at an average for all hours of the living wage over the week. It has been agreed that that position will remain as part of the offer for 2017-18. That will allow time for reform to take place and for more work to be done by us, COSLA and the third sector to make sure that we can continue to deliver that.

There have been concerns about ensuring that those who are vulnerable and receiving sleepover support continue to get that support. That is the most important thing as we take forward the discussions. This is a work in progress.

The Convener: I am sorry—could you explain the part about the wage again? I missed it; you skated over it quite quickly. What does that mean in practical terms for staff who do sleepovers? You say that the living wage covers only waking hours. What does that mean?

Shona Robison: It is part of the negotiation that is still going forward—

The Convener: What is the position at the moment?

Shona Robison: It has been agreed that, on an interim basis as we take forward the discussions, all waking hours will be paid at the living wage, with sleepover hours being paid at an average for all hours over the week, so that is basically averaging out the hours over the week.

It has been agreed that that position will remain part of the offer for 2017-18 to allow time for further discussions to take place with providers and with COSLA. I am happy to provide more detail on that, because it is work in progress.

The Convener: That would be helpful, because I am no clearer. It may just be me—it would not surprise me if it was.

Shona Robison: The arrangement is complex and detailed and you will appreciate that there are on-going discussions with the sector and with local government to make sure that we give a fair position to those who work in a sleepover setting.

The Convener: It would be helpful if you could provide that information and perhaps provide an example of a Mr or Mrs Smith, their hours and how it would work for them.

Shona Robison: I would be happy to do that.

Colin Smyth: That would certainly be helpful. What you describe is the current situation in relation to Her Majesty's Revenue and Customs rules, but we need to know how we will move forward.

Most of the £107 million that you described—£87 million of it—is ring fenced, as £80 million is for the living wage and £7 million is for changes in care charges. Why then did the Cabinet Secretary for Finance and the Constitution write to local government leaders last week to sanction what is in effect an £80 million cut in the contribution from local government to IJBs, which will more than cancel out any additional funding that has been provided in the £107 million, given that most of that is ring fenced?

Shona Robison: It is important to look at the global amount that has gone into integration. The £250 million in 2016-17 continues to be provided to integration authorities. In 2017-18, there is another £107 million, albeit that the focus of that is—rightly—on delivering the living wage. Integration authorities will need to ensure efficiency savings and reforms in how work is done so that all the resource that they get is delivering at the front line. Although more money is going into integration authorities, they will—like health boards—be required to change some of how they operate.

On the delivery plan that we published yesterday, it is important to recognise that, as well as investment, there is reform. That is the other side of the coin, and we will work with integration authorities to deliver it.

The Convener: We are short of time. Are you finished, Colin?

Colin Smyth: Yes.

Ivan McKee (Glasgow Provan) (SNP): I want to touch on a couple of things. At the start, we spoke about the overall picture and the numbers. Just to be clear, if I am reading this correctly, in cash terms the overall budget is up by £267 million, which is 2.1 per cent, and in real terms—over and above inflation—it is up 0.6 per cent, which is £79 million. If I am reading it correctly, the 0.6 per cent increase is after inflation has been taken into account and the £79 million is the first step in the manifesto commitment of increasing the health budget by £500 million over the session of Parliament. Is that correct?

Shona Robison: Yes.

Ivan McKee: Earlier on, there was some confusion about the 0.6 per cent, with people trying to say that it was a cash terms, not a real terms, increase, but it is clear that it is a real terms increase

The Convener: I am sorry, Ivan, but I say—just to clarify the point that I was making—that it is at general inflation rates and not health inflation rates.

Ivan McKee: Yes—health inflation is 2.3 per cent, versus 2.1 per cent.

As you correctly said, cabinet secretary, at the end of the day, it is all about outcomes. It does not really matter how much money we put in or do not put in; the issue is what is delivered by the health service and from the process as a result.

I want to drill down a wee bit in a couple of areas. One is how we measure what boards are delivering. We have a target review, the national performance framework, outcome measures and a number of frameworks for measuring things. How are we drilling down to measure boards, and taking best practice across boards? How do you deal with boards that are not delivering as they should? What is the efficiency process? By that, I mean how do you identify best practice and transfer it across the piece? I again make it clear that in my mind "efficiency" means delivering more for the same or less, which is different from cuts. I am talking about how we can identify areas where we can deliver more for the same or less money across the piece.

Shona Robison: There are clear performance management arrangements for the NHS. Christine McLaughlin and others in the Scottish Government support boards to ensure that they deliver on their financial performance and patient-facing performance targets. Each board develops its own local delivery plan, which sets out what it will deliver for the resources that it gets. That gives visibility of priorities. We expect plans to reflect what was published yesterday in the delivery plan for the NHS and care services. Boards need to demonstrate a shift in the balance of care and ensure that they invest in preventive measures and all the things that we know will make a difference in community health services.

As we laid out yesterday, there are opportunities to examine support functions and to consider how, through regionalisation and ensuring that boards work together across regions—whether on clinical networks and providing more sustainability to rotas and so on, or on functions that support our NHS—we can deliver them more efficiently.

Christine McLaughlin and her team are working with the boards on the detail around that to make sure that we know what works. I have a list of examples of what boards are doing well around the country; that information needs to be shared. We need to adopt a "once for Scotland" approach, which means that we expect that something that is working well in one place—driving efficiency and

ensuring that money can be invested in patient care—will be done by boards everywhere.

Ivan McKee: To follow up on Alison Johnstone's comments, I say that health is interconnected in a big way—stuff that happens in other cabinet secretaries' portfolio areas impacts on health. Active travel is an obvious example, but others, including housing, also improve health outcomes. Are you having conversations about health with those portfolios? Are you looking at spend that is outside your remit? Are you having conversations along the lines of, "If we spend more on that, it's going to save money on the health budget in the medium to long term." It is important that we have those conversations—with data behind them—if we are serious about moving the preventative agenda forward.

Shona Robison: Yes, we are doing that. In the attainment challenge, for example, the spend is about ensuring that children get the best start in life through education and childcare support. Our aim is to avoid people ending up having to use NHS services through, for example, early years intervention, the family nurse partnership and health visitor investment. All those things try to prevent ill health in later life.

Clare Haughey (Rutherglen) (SNP): I will be brief, cabinet secretary, because I am mindful of the time. A few weeks ago, we were fortunate enough to hear evidence from Sir Harry Burns about the targets review that he is doing. He mentioned concerns about targets skewing performance and being a tick-box exercise. How do you anticipate the draft budget will shift the focus on to the improvement agenda? Is there any specific funding for programmes such as the Scottish patient safety programme?

Shona Robison: The work of the Scottish patient safety programme continues. It plays an important role in making sure that our services are as safe as they can be. The focus has moved: it is looking not only at acute care, but at other parts of the system, including community health services. Work and investment in that area continues.

The targets review is on-going. Harry Burns is talking to a number of important stakeholders, including patients and staff. The consensus is that we should focus more on outcomes. He is getting on with his work; I await his report in the spring. I am sure that he will help to ensure that we measure the right things that better reflect the integrated system in which we work, and that our resources deliver in the best way possible. That work is an important part of the changes that we need to make.

The Convener: I know that time is short, cabinet secretary, so when you are responding to our request for written information, it would be helpful if you could also address the non-profit distributing situation, in which money has gone from off balance sheet to on balance sheet, and what the implications of that are for capital spending in the NHS.

Shona Robison: Okay.

The Convener: That is the end of today's meeting. In closing the meeting, I wish everyone a healthy and sporting new year. Have a good festive season.

Meeting closed at 11:14.

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