AUDIT COMMITTEE

Tuesday 25 January 2005

Session 2

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AUDIT COMMITTEE
2nd Meeting 2005, Session 2

CONVENER

*Mr Brian Monteith (Mid Scotland and Fife) (Con)

DEPUTY CONVENER

*Mr Andrew Welsh (Angus) (SNP)

COMMITTEE MEMBERS

*Susan Deacon (Edinburgh East and Musselburgh) (Lab)
*Robin Harper (Lothians) (Green)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*George Lyon (Argyll and Bute) (LD)
*Mrs Mary Mulligan (Linlithgow) (Lab)

COMMITTEE SUBSTITUTES

Chris Ballance (South of Scotland) (Green)
Mr Ted Brocklebank (Mid Scotland and Fife) (Con)
Marlyn Glen (North East Scotland) (Lab)
Mr John Swinney (North Tayside) (SNP)

*attended

THE FOLLOWING GAVE EVIDENCE:

Mrs Jill Alexander (Scottish Executive Health Department)
Dr Peter Collings (Scottish Executive Health Department)
Mrs Julie McKinney (Scottish Executive Health Department)
Mr Mike Palmer (Scottish Executive Health Department)
Ms Carmel Sheriff (Scottish Executive Health Department)
Dr Kevin Woods (Scottish Executive Health Department and NHS Scotland)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

David McLaren

ASSISTANT CLERK

Clare O'Neill

LOCATION

Committee Room 4

Scottish Parliament

Audit Committee

Tuesday 25 January 2005

[THE CONVENER *opened the meeting in private at 09:32*]

09:54

Meeting continued in public.

Items in Private

The Convener (Mr Brian Monteith): I call the meeting to order for agenda item 2 of the second meeting in 2005 of the Scottish Parliament Audit Committee. I welcome members of the public and press and remind everyone that mobile phones and pagers should be switched off.

Item 2 is to seek the agreement of the committee to take items 5, 6, 7 and 8 in private. I will run through those items for the benefit of everyone while our witnesses are taking their seats for item 3.

Item 5 is to enable the committee to consider the evidence taken at item 3 on the report of the Auditor General for Scotland entitled "Overview of the financial performance of the NHS in Scotland 2003/04". Item 6 is to enable the committee to consider the evidence taken at item 4 on the section 22 report by the Auditor General entitled "The 2003/04 Audit of Argyll and Clyde Health Board". Item 7 is to enable the committee to consider arrangements for its inquiry into the section 22 report entitled "The 2003/04 Audit of the National Galleries of Scotland" and item 8 is to enable the committee to consider an issues paper on its inquiry into the reports by the Auditor General entitled "Commissioning community care services for older people" and "Adapting to the future: Management of community equipment and adaptations". Those are all items that we would normally discuss in private.

Are we agreed to take agenda items 5, 6, 7 and 8 in private?

Members *indicated agreement*.

"Overview of the financial performance of the NHS in Scotland 2003/04"

09:56

The Convener: We move on to agenda item 3, which is consideration of the national health service financial performance overview. We are pleased to have with us for our evidence session today Dr Kevin Woods, who is the head of the Scottish Executive Health Department and chief executive of NHS Scotland; Dr Peter Collings, who is head of performance management and finance; Mrs Jill Alexander, who is head of the analytical services division; and Mr Mike Palmer, who is assistant director of the workforce and policy division. We are grateful to you all for coming today.

Before we move on to questions, I invite Dr Woods to make an opening statement.

Dr Kevin Woods (Scottish Executive Health Department and NHS Scotland): As members of the committee know, I was appointed very recently. I will do my best to answer your questions today, but I am pleased that my colleagues are with me because they will probably know more about some of the detail than I do.

It is my hope on this, my first appearance before the committee, that we will be able to develop a dialogue over the coming months and years. In that respect, I will do whatever I can to provide briefings and insights around the issues if the committee would value that.

I have read the overview report and have one or two observations. First, I found it very clear and helpful, and I thank Audit Scotland for that clarity. As I am new to the job, the report has given me a good picture of some of the issues.

When I read the report, I was pleased to see that Audit Scotland is of the view that the stewardship of financial resources is of a high standard and that there were no qualifications of accounts. Throughout NHS Scotland, sound governance standards are being maintained. I was also very pleased that the overall deficit was as low as 0.2 per cent of the NHS boards' budgets of £5.8 billion—we need to remember the size of those budgets—and that 19 of the 23 NHS boards that were covered in the audit were in balance or better.

However, on reading the report, I was concerned to discover the seriousness of some of the boards' financial problems, particularly those of Argyll and Clyde NHS Board, and I am sure that we will discuss that later. We take that matter extremely seriously and, with the convener's

permission, I will make some further comments on it when we get to that item on the agenda.

The Convener: Indeed.

Dr Woods: I was also concerned that there appear to be some differences in the costing of pay modernisation, which is a major policy theme at the moment. However, I believe that those apparent differences have narrowed following further work after the publication of the report.

Finally, perhaps I can share with the committee my sense of my role as accountable officer. First, I want to build on the good things that the report says about governance and stewardship and ensure that those standards are maintained. Secondly, I want to work with the accountable bodies that currently have financial difficulties and return them to better financial health. Thirdly, I want to ensure that those bodies fulfil ministerial objectives in a way that uses resources economically, efficiently and effectively.

I will stop there, convener.

10:00

The Convener: Thank you very much. I invite Andrew Welsh to open the committee's questioning.

Mr Andrew Welsh (Angus) (SNP): The financial overview report identifies that the department and boards have different estimates for pay modernisation. How did you work with the boards to calculate the estimated costs of pay modernisation agreements?

Dr Woods: I understand that, in general, the department develops a model that it shares with boards. The boards then work with the model and, through dialogue, agreement is reached on the estimated cost.

I invite Mike Palmer to say a little bit more about that.

Mr Mike Palmer (Scottish Executive Health Department): Reinforcing Dr Woods's comments, I should point out that our overall approach commences with a macroeconomic model of the all-Scotland costs. The model also takes in the United Kingdom context, because the major strands of pay modernisation are UK-wide.

We started with national costings for each strand and tested them out with boards. For example, with the agenda for change strand, we took an integrated health system in west Lothian that gave us a comprehensive range of staff cohorts and allowed us to test potential costs. After putting those staff through dry-run agenda for change job evaluations, we had quite firm costings that we extrapolated across to the Glasgow payroll, which is the largest staff cohort in NHS Scotland. That provided a 20 per cent sample of all staff across Scotland. In fact, when we took the costing model down to Leeds and showed it to Department of Health colleagues, they thought that it was probably the best one in the UK. They felt that, because we were able to model the costing on individual payroll data from Glasgow, it gave a very robust projection.

That is one example of how we have taken national costs and worked with boards on developing a software package to enable us to sample and test out costings on actual board systems. For each board, we have developed user-friendly software packages for each pay modernisation strand, to allow the boards to calculate the exact costs according to their staff profile.

Mr Welsh: You have said that the process involved introducing a model, having a dialogue and reaching an agreement. However, was there any joint agreement on how the estimates would be built up?

Mr Palmer: Yes. For example, with agenda for change, we tested out the data from the Glasgow costing exercise in a series of workshops that we held with NHS Scotland finance directors, to ensure that what we were doing with our sampling was sense-checked with them and that they were comfortable with it. We feel that we and NHS Scotland have reached a good consensus on how the costs come together.

Mr Welsh: You might have reached consensus, but you certainly did not have agreement. After all, there are different estimates for pay modernisation. What were the major points of disagreement?

Mr Palmer: I do not know whether you are referring to the new figures for the general medical services contract, but I am aware that, in that respect, there have been some discrepancies between some of the figures that Audit Scotland collected from boards and the figures that we collected from boards. The first thing that I would say about that is that the figures that we built up for our general medical services cost estimates were directly collated from boards. They come from the monitoring returns that we get from boards, so that information is absolutely anchored in what boards are telling us the costs are for them on the ground. We have had a look at the Audit Scotland figures and shared our figures with Audit Scotland. We hope and expect that we will be able to reconcile those two sets of figures once we have bottomed out the methodologies and assumptions that lie behind them. Clearly, we need to do that to get to the bottom of the discrepancy.

Mr Welsh: You will accept that there have been differences and subsequent reductions of some £79 million, so there remain differences between the figures.

Mr Palmer: I am not sure what the £79 million figure refers to.

Mr Welsh: The GMS contract increased by £18 million, from £64 million in August 2004 to £82 million in December 2004. The latter figure was subsequently reduced to £79 million in the department's response to the Auditor General's letter. There still seems to be a fundamental disagreement over the figures, but you say that there is now agreement and consensus. Is that true?

Mr Palmer: In terms of the costings that we are doing and whether they line up with what the boards are telling us the contract is costing them on the ground, we are confident that our figures are anchored in exactly what they are telling us and that we are reflecting as fairly as the data allow us to—and the data come in on a daily basis—what the situation is for them on the ground. I know that there are a number of different figures on the table. They refer to different aspects of the contract and they vary subject to the assumptions that are made around them and what exactly they cover. Often, we are not comparing apples with apples, but comparing apples with pears, so it is difficult for us to take one figure in a particular form and at a particular time and be able to reconcile it back to another without having a look at the methodology and assumptions behind the figures.

Mr Welsh: How much confidence do you have in the robustness of the figures? You have talked about extrapolations from samples to produce what you call the best costing model in the UK, but you seem to be referring to extrapolations of samples. How much confidence do you have in the pay modernisation figures that you provided to Audit Scotland for the overview report?

Mr Palmer: Clearly, that depends on the stage that we are at in the implementation of each of the pay modernisation strands. For example, we will not know what the precise costs of agenda for change are until we have done more than 130,000 job evaluations over the course of the next year or so. Clearly, therefore, we must work on sampling, on pilot sites, on projections and on the software package feedback that the boards give us about the dry-run exercises that they do, until we have actually implemented the new contract across all 130,000 staff.

The new consultant contracts and the new GMS contracts are already being implemented. For the 2004-05 figures, we are now getting to a stage where we are really seeing the actual cost on the ground. The information is coming through and we can put that together, so I think that the figures now reflect quite precisely the exact cost. There are clearly still some aspects of those contracts that have yet to be absolutely measured. For example, the quality and outcomes framework of the new GMS contract and the amount of reward that general practices receive will not be known until around next June, because they have to go through a full year up to this April before we can do the wash-up on exactly how many points they earned and what the expenditure was. That information will not be available for another few months.

Mr Welsh: You sound as if you are still dealing with quite a number of unknowns. Have you carried out any sensitivity analysis for variations in the estimates? For example, there was a significant rise in the cost of the consultant contract from the original estimates.

Mr Palmer: Yes. For example, with the consultant contract costs, we have broken down the various elements and examined what the variation would be, subject to changes in those elements. To give an example, some of the costs on the consultant contract are driven by the amount of on-call activity that consultants do. If they are in a high on-call band, the costs are driven up materially by quite a few percentage points. If they are in a middle band the costs are less, and if they are in a low band the costs are even less.

We performed quite a lot of sensitivity analysis around what the on-call activity would be. In the returns from boards we found that on-call activity largely takes place in the lowest band, so we were overcautious with some of our estimates, because we assumed that more of the activity would be in the middle band. We actually saved a bit on our projected figures.

Mr Welsh: What impact will the cost of pay modernisation have on other areas of national health service spend and service delivery? From the information that you now have, will the increases in NHS boards' funding be sufficient to meet the costs of pay modernisation?

Mr Palmer: The overall annual uplift to boards more than covers the total additional costs of the pay modernisation strands. We do not see the pay modernisation strands as solely costs, as we see a cost benefit coming back from those strands. Although it is clear that there will be financial pressure from pay modernisation—particularly in the initial stages—that is accounted for first by the record increase in the overall allocation.

We expect to see benefits from the way in which the pay modernisation strands are managed through the use of the levers for change and

reform in the health service that pay modernisation brings. For example, in the job evaluation system for agenda for change, there is a ready-made series of building blocks for creating new roles within the health service that can, for example, take work from doctors and give it to extended scope practitioners, such as extended scope physiotherapists, who can do some of the work that orthopaedic surgeons do. That is already starting to happen in Glasgow. The job evaluation system gives us the ability to create new posts that the Whitley system did not. That saves a lot of money and provides a more responsive service for patients. We see savings coming in over the medium and longer term, as well as costs.

Mr Welsh: You are leading on to the answer to my next question. Have the new contracts been sufficiently tailored to reflect the needs and practices of the NHS in Scotland?

Mr Palmer: Yes. None of the contracts that we have agreed—although they are all either within a UK framework or are UK contracts—is absolutely unvaried from the contracts that are being delivered in England, for example. That is because we were clear that we needed responsiveness to Scottish circumstances.

For example, in the new general medical services contract, we requested that a separate funding allocation formula be created just for Scotland to reflect Scotland's remote and rural needs, because we did not feel that the English funding system sufficiently reflected them. The consultant contract in Scotland is a separate contract, and we put in a number of elements, for example on timetabling, to reflect Scottish circumstances. On agenda for change, we in Scotland demanded—and England accepted—to be allowed to negotiate separately distant islands allowances for non-medical staff in the islands, to ensure that we can respond to their needs. In all the different strands, we are being as sensitive as we can, within a UK framework, to Scottish circumstances.

The Convener: On pay modernisation we have one or two supplementaries.

10:15

Susan Deacon (Edinburgh East and Musselburgh) (Lab): Good morning. Dr Woods, I feel duty bound to welcome you back to NHS Scotland and I wish you well in the challenges that lie ahead.

My first question follows on from Andrew Welsh's question. On page 24 of the financial overview report, a table gives Scottish Executive Health Department estimates for the three strands of pay modernisation. In the light of the answer that we have just heard, can Mr Palmer give us any updates on those figures, either now or in writing subsequent to the meeting?

Mr Palmer: Yes. I can give you updates for those figures. For the consultant contract, the latest figure that we have is £31 million. That is the total additional cost, including pay inflation. For agenda for change, the latest figure that we have is still within the £130 million to £160 million range that is given in the table. However, as I explained before, because we have to evaluate the jobs of 130,000 staff, that is still a projection and finalisation of the figure is some way off.

Susan Deacon: A range of £30 million is a considerable margin. Are you able to give us any indication of where, within that range, you think that the final figure will be?

Mr Palmer: Yes. It will come in at the upper end of that range.

Susan Deacon: And the figure for the GMS contract?

Mr Palmer: The figure for the GMS contract is now £85 million.

Susan Deacon: Some of those revisions represent substantial increases on the estimates that are given in the financial overview report. What are the implications of those increases for what were already considerable cost pressures on the service? Do you anticipate further significant increases in the figures as the work that you have described progresses?

Mr Palmer: I will address each revision in turn. The latest figure for the consultant contract, which I have just given you, is pretty much going to be the final figure. The figure of £22 million, which we gave you last year, was based on work in progress on job plans that have been signed off with consultants. It has taken longer than we would have hoped or expected to get all the job plans signed off. We are now much further down that track, and the higher figure reflects the impact of the further job plans that have been signed off since then.

There is still quite a lot of potential for change, either up or down, to the figure for agenda for change. It is not unknown for health boards to be quite cautious in the financial provisions for years ahead that they put in for. That is understandable. It may be that some of those costs will come in, but we cannot give a more precise projection of where that figure will end up. All that we can say is that the software modelling is as precise as it can be, in terms of giving health boards the opportunity to model the costing on all their staff.

The GMS contract figure has risen slightly because the cost of the out-of-hours reprovision has gone up since we last gave you that figure. Out-of-hours reprovision is being delivered across

all health boards and it is now live, which was not the case when we gave you the figure of £82 million. I do not expect that figure to change any more, as we have now completed that exercise.

There is no denying the fact that the extra costs will have an impact on the service. Extra money, over and above the estimates that we gave you, needs to be invested in pay modernisation. I do not know the degree to which each board will have made financial provision in its forward planning for the total amount that it will eventually incur. That money may have been put by, so to speak.

Susan Deacon: Thank you. We may return to wider questions on financial pressures later. However, I have a question about the impact of the costs of pay modernisation on the service. The question specifically relates to two additional releases of resource to boards last year. First, £30 million was released last March to aid cost pressures in the area; then a further £70 million was released last June. Where did those resources come from? When the minister announced the £70 million on 15 June, he specifically indicated that it had come from savings that had been identified in central budgets. What were those savings? What has been the impact of those extra resources going out to aid the cost of pay modernisation and no longer being available to the department?

Dr Woods: I think that Dr Collings is best placed to answer that one.

Dr Peter Collings (Scottish Executive Health Department): The £30 million arose from a review of how we were doing on a range of budgets as the year end approached. Partly through budgets that were undershooting without action and partly through budgets on which we felt that we could reduce expenditure towards the year end, we were able to release £30 million. We thought that it was important to do that, given the financial pressures on health boards at that time. The £70 million was found from budgets right across the department, but the biggest single element was £30 million that we had deliberately left uncommitted, given the likely pressures. The remainder was spread across a range of budgets.

Susan Deacon: I am grateful for that information.

Audit Scotland's financial overview report shows that, of the total NHS budget, only £500 million is identified as being departmental expenditure. On further examination, it seems that some of that amount is a technical accounting adjustment. Therefore, from the additional information that the department has provided, I calculate that the real level of resource that is available to the department at the centre is anywhere from £100 million to £300 million. Even allowing for your point about £30 million of the £70 million allocation being uncommitted resource, that still leaves £40 million to be found from efficiency savings within a departmental budget of, say, £150 million to £300 million. With the greatest of respect, that level of resource is not found by, for example, reducing the amount of paper-clips that are purchased. Therefore, I would like further information, if not today then in writing subsequent to the meeting, about where that money came from and what the impact has been.

Dr Collings: I am happy to provide that in writing, because a lot of small amounts add up to the total, rather than a few big ones that I could tell you about today.

The Convener: That would be fine—thank you.

George Lyon (Argyll and Bute) (LD): I have just a couple of points of clarification. First, Neil Campbell informed us at an evidence session that the impact of the consultant contract would result in a change from the initial 2003-04 budget figure that your department allocated to boards of about a 7 per cent uplift. However, by the time that the process was completed, the figure ended up being 25 per cent, which was a huge cost to boards right across the country. Indeed, if I remember correctly, NHS Lothian said in evidence that it represented a £4 million hit in one year. How did you get your estimate of the cost of that deal so wrong?

Mr Palmer: The original cost model that was used for the consultant contract made some assumptions around consultant activity and how that activity would be played out in the job-planning exercise that was done for the contract. It made an assumption that consultants would end up working an average of around 11 programmed activities a week and that savings would be recycled back from on-call activity and various other elements, such as payment of fees. With hindsight, we realise that the costing was low. Certainly, the estimate undershot what the eventual costs were.

We released the price contract and all the information necessary to do costings on the consultant contract when the framework document for the contract across the UK was published in the summer of 2002. At that point, we engaged boards in the negotiation process for the contract, which stayed within the envelope of the prices that were given for the various elements of the contract through 2003. There was therefore a long period during which boards were able to plan financially for the impact of the consultant contract, knowing what the prices and the costs would be.

It was not as if we went out and said, "We know that it will cost you X per cent." As with the other strands of pay modernisation, the approach has

been to state that a contract must be costed on the basis of the local consultant population, the kind of activity that is undertaken and how that activity is organised—those elements must be factored into the overall allocation. It is difficult to project exactly what the costs will be from one board to the next, given that, with the consultant contract, we are moving from a situation in which there was an absence of a baseline. Before the new consultant contracts, it was not possible to have a coherent and comprehensive picture of each consultant's activity because five of the 11 sessions that consultants were doing a week were unfixed and were not managed in the way in which we would expect an employee's activity to be managed. There was no management information. We were working on the best data that we had at the time, which were patchy.

George Lyon: Are you saying that you did not know how many hours each consultant was working for the NHS in Scotland?

Mr Palmer: No. We knew how many hours each consultant was working for the NHS in Scotland, but the way in which consultants' activities were managed was not the way in which they are managed under the new contract, which schedules in each element of activity, from the clinical care duties that they perform to the clinical audit or continuing professional development that they need to do. That activity was not as highly managed previously, when there were six fixed sessions of clinical activity that was to be done by the consultant and agreed with the manager and five unfixed sessions, which were less proactively managed because they did not directly involve clinical activity. The new consultant contract has introduced a system that allows the whole of the activity to be managed across all the various elements of the consultant's job each week. We have moved from an incomplete database of activity to one that will be absolutely comprehensive and that we can use as a management tool to increase efficiency and effectiveness.

10:30

George Lyon: Will you detail the benefits of the contract in terms of activity and efficiency?

Mr Palmer: Okay. I see the benefits going in three areas: staff—the consultants—patients and service. On the benefit for consultants, there was recognition from the outset that consultants had traditionally worked more hours than they were paid for. Many consultants have worked over the European working time directive limits and those additional hours were not recognised in their contracts. The general consensus was that it was important to recognise the contribution of consultants; some of the extra investment was made in order to do that. A benefit is gained because consultants' hours are being managed more effectively, which means that consultants are not being overworked and their alertness and quality are increased. In turn, the benefit for consultants increases the quality of care that patients receive. We should not lose sight of that.

On the benefit to the service, we now have a situation in which a manager can schedule with his or her consultant all of that consultant's activity in a way that is linked directly to the corporate objectives of the organisation. The consultant's pay is linked in such a way that, if they do not hit the agreed targets, they do not get their pay increase. In terms of medical workforce pay, terms and conditions, the link that has been created is pretty revolutionary.

We now have a clear picture of the amount of clinical activity that is required. The figure has risen from 21 contracted hours a week, under the old fixed sessions about which I spoke earlier, to 30 hours a week now. I am aware that there has been a lot of feedback that says, "We are losing activity from our consultants in clinical care," but that reflects the fact that consultants were being worked at levels that were not being recognised in their sessions.

If one wants to be an exemplar employer, one has to make a judgment about whether one thinks that it is fair and right to allow that kind of working practice to continue. We need to pay people fairly for the work that they do and to ensure that the whole system is organised in a way that ensures that people are being worked for the right number of hours and for the right pay. We also need to maintain our agreed level of activity. We are doing that by creating tools that allow managers to organise consultants' time more efficiently and more in line with the aims and objectives of the organisation.

George Lyon: You have cut to the heart of the contract, which is the increase in committed time to the NHS from 21 to 30 hours a week. Why could your department not tell us how many consultants worked fewer than 30 hours a week before the new contract was introduced? Indeed, Neil Campbell said that, in the Argyll and Clyde NHS Board area, it was fewer than a handful.

Mr Palmer: As I said earlier, the department does not collect—or we have not collected—individual consultant activity data. That would be something that—

George Lyon: But surely that is the sort of basic building block that you need if you are going to assess the impact of the contract and evaluate the costs and the impact on the service in terms of performance and productivity. Why on earth did your department not gather that information?

Mr Palmer: What I am saying is that we would expect employers to have that kind of management information. At the outset of the talks on the consultant contract, sampling work was undertaken on consultant activity. Those samples were used.

George Lyon: Surely your department—not the boards—was negotiating the contract as employer, so it was incumbent on you to have that information before entering into negotiations.

Mr Palmer: As I said, survey work was undertaken before the talks. That took a sample of consultant activity. Data on consultant activity were collected and we entered into talks on that basis.

George Lyon: You talked about how you are evaluating the cost of the GMS contract and working through that with boards. How is extra funding distributed? In an urban situation, the out-of-hours part of the contract could be cost neutral, because of the benefits of undertaking out-of-hours services through co-operatives, for example. However, the cost will be disproportionate in rural areas, where such a model cannot work. Is money distributed according to the Arbuthnott formula or are individual board allocations based on rurality and the number of general practitioners in remote and rural areas?

Mr Palmer: Most of the money for the new GMS contract is distributed through a variant of the Arbuthnott formula that is called the Scottish allocation formula for GMS. That is similar to Arbuthnott in that it factors in remote and rural needs and extra costs highly. More money is distributed to rural and remote boards in recognition of their extra costs.

Because we make the allocations annually, we need to consider at the end of the financial year how elements such as out-of-hours reprovision have affected the financial pressures on boards. Once the full-year results are in, we will consider whether we need to re-examine the distribution of resources.

Mrs Mary Mulligan (Linlithgow) (Lab): Good morning. Mr Palmer, in response to Susan Deacon, you outlined increases to the estimates for pay modernisation—for the consultant contract, agenda for change and GMS. Your answer to George Lyon's last question started to go into how responsibility for those increases will be negotiated between the Health Department and health boards. Will you say a little about whether that will apply to health boards across the board? Were each health board's figures a little bit out, or will particular health boards have problems in financing the increase that is being identified?

Mr Palmer: Peter Collings might want to say one or two words about the overall approach to allocating funding to boards. Our approach is to provide almost all our funding to boards in general allocations and not to earmark or ring fence money for initiatives. Money is allocated to boards broadly on an Arbuthnott needs-allocation formula. Boards then manage pressures within their overall uplifts. The resource allocation formula should take into account the pressures of local geographical circumstances or populations in terms of the relative health need. The overall approach is not to second-guess that or redo that exercise to adjust everything and divvy up a bit more here or there, because that would get us into quite difficult relationships with boards.

Dr Collings: The uplift percentages for agenda for change and the consultant contract do not vary much between territorial boards. The impact of agenda for change on the Scottish Ambulance Service is a particular issue that we have been dealing with because of the unsocial hours arrangements. We have to make an exception, as there is a particularly large impact on that service.

Mrs Mulligan: So, given the revised figures, you are not aware of any board that will have more problems than others. There will be a general approach and the boards will all come in at somewhere under the original estimate.

Dr Collings: Yes.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): How many consultants have refused to take up the new contract?

Mr Palmer: The take-up rate is around 98 per cent.

Margaret Jamieson: Is the rate worse in any particular area? Does any board have a greater proportion of people who are saying, "No thanks"?

Mr Palmer: Not that I am aware of.

Margaret Jamieson: How will things be managed? Obviously, the new contract has been hailed as benefiting patients, but how will the department deal with that matter? If individuals say, "No thanks," there will be no benefit to the patient in that area.

Mr Palmer: We are quite pleased with a 98 per cent take-up rate. We think that that is a comprehensive take-up rate of the contract and that 2 per cent represents a pretty small number. We would expect local managers to be able to manage such a proportion of people not taking up the new contract and to manage consultant activity with their colleagues in a way that does not detract from the contract's impact on how consultants' workloads are managed. That is a matter for local managers. Given that the figure is only 2 per cent, we would expect managers to be able to do that.

Margaret Jamieson: Is an opt-out available to anybody in respect of the GMS contract and under agenda for change?

Mr Palmer: There is the potential for opting out with the GMS contract. GPs have not been deciding to opt out—the take-up has again been comprehensive. We have put out a pay circular that says that all staff are expected to sign up to agenda for change on the basis that they voted for it in their trade union ballots.

Margaret Jamieson: Did consultants have the same democratic process? Are they treated differently? Can they opt in or opt out?

Mr Palmer: At the outset of the consultant talks, it was agreed that the question whether consultants wished to stay on the old contract or be under the new contract would be put to them. When agenda for change was negotiated, the staff unions did not require that condition to be put in. In Scotland, the health service is structured in such a way that national terms and conditions are applied through NHS boards; we do not have local trust freedoms. Staff unions in Scotland were therefore keen to have things applied across the board. They have been keen to have harmonised terms and conditions applied for all their staff throughout Scotland and they see that as a positive benefit for their staff.

Margaret Jamieson: Are costings available for the backdating of the consultant contract throughout Scotland? Has the patient benefit that has been gained been measured?

Mr Palmer: If we include the annual 3.225 per cent pay inflation award, the figure for 2003-04, which is the backdated figure, is £70 million.

10:45

Margaret Jamieson: What was the patient benefit?

Mr Palmer: The contract was not operable during 2003-04, so consultants were still working under the old contract. The contract was not implemented in that period.

Margaret Jamieson: Forgive me if I am not understanding this. Are you saying that the cost was £70 million, but we got nothing for it?

Mr Palmer: The £70 million is the result of the agreement that we reached with the British Medical Association to pay consultants as if they had been on the new contract from April 2003. That was decided on the basis of an agreement that had been reached in other parts of the UK that, because the original commitment had been to implement a contract from April 2003, the consultants should receive the pay from that time. We agreed with the staff unions that agenda for change would come in from 1 October this year, so that will be backdated as well.

Margaret Jamieson: Nice work if you can get it.

George Lyon: I have just a small question, convener.

The Convener: One small question often burgeons into five, but I am happy to allow it, because the subject is important.

George Lyon: I seek clarification on a response from the department on the benefits of the consultant contract. The response from the tail-end of last year was that the contract would end the practice of having to pay consultants twice for the same work. What does that mean? It seems bizarre to the rest of us that the health service would pay consultants twice for the same work under the old contract.

Mr Palmer: That refers to the practice in some aspects of activity. For example, consultants were able to do family planning work in their NHS time, receive their NHS salary for it and receive a fee on top of that. They got an extra fee for work that they were doing in NHS time and for which they were getting paid an NHS salary. When we negotiated the contract, we agreed that we could not accept that, so we have written it out of the terms and conditions.

The Convener: That is interesting. I am glad that I let George Lyon ask that question. Before we finish, I want to clarify that the 2 per cent of consultants who did not take up the contract are not lost from the service and have not gone private; they are still able to work under the old contract.

Mr Palmer: Yes. That is the case.

The Convener: I had not allocated as much time as we took on pay modernisation, but the subject is clearly of great interest to the committee, so I was happy for us to explore as much of it as possible. We will stay with financial planning, but move into different areas of it.

Dr Woods: I want to make one or two points about the discussion that you have just had, to which I have listened with great interest. It seems to me that the committee has three principal concerns. One is about the quality of the costing information. We hear the concern and we will take it away and consider it. I believe that we have tried to be as accurate as we can, but obviously we take on board the points that have been made.

Secondly, there is the issue of pressures that people in the health service face in relation to the awards. There are pressures because we are trying to implement a wholesale change in the way in which NHS staff are remunerated. It is important to remember that the systems that preceded the

new arrangements had been built up for 50 or more years. Unravelling all that and replacing it with something that is more suited to the development of the health service is bound to be complex and I suspect that there will be some pressures. We must do what we can to work with health boards to manage those pressures. The management challenge now is to secure the benefits associated with the contracts.

It is important to locate the pressures that I referred to in the overall growth in resources that boards have experienced. I have just been looking through my notes to see whether I could quickly locate the figures for 2005-06. Perhaps Peter Collings will mention what the real increase in board allocations will be for the next two or three years.

Dr Collings: We have not issued the allocations for 2005-06, but we are looking at an increase of 7 per cent—a 4.5 per cent real-terms increase—in cash terms next year and continuing increases over the following two years of the same order of magnitude. We have not worked out the figures yet, but the cash increase each year will be in the range of 6 per cent to 7 per cent. Significant extra amounts of money are going into the service to help to meet those pressures.

Robin Harper (Lothians) (Green): What steps is the department taking to tackle the rising cost of drugs to the NHS? Perhaps you will divide the answer into two parts: first, the cost of prescribing in general practice and secondly, the cost in hospitals, where I presume the problems are slightly different.

Dr Collings: For many years, the rate of increase in the cost of drugs in general practice has been well above inflation and the general rate of increase in NHS costs. That should not be viewed exclusively or even partially as a bad thing because the main reason why it has happened is that patients are getting new and better drug treatments. We have to ensure that we get value for money, but the increase is good news in many ways. For example, one of the big cost pressures in recent years has been the growth in prescribing of statins, which are important in reducing the incidence of coronary heart disease.

We are taking a range of measures to improve the situation; for example, we are trying to improve prescribing practice, which is done largely at board level, but also within the department. There has been a big increase in the percentage of generic drugs that are prescribed. There is room for improvement, although we are getting towards the tail end of the progress that can be made. Work is also on-going to establish electronic communications between pharmacists and GP practices, which should make the process better for patients, improve management of information and generally lead to better prescribing.

It is worth mentioning price reductions at UK, rather than just Scottish, level. This year, we expect the drugs bill to go up by much less than has been the average in recent years and the prospects are the same for next year. There have been significant reductions in prices of generic and proprietary drugs. This year, that will be worth approximately £35 million in price reductions to NHS Scotland. There will be further reductions, which we estimate will be worth £42 million.

Dr Woods: The issue of drug formularies is important. A lot of work is going on locally around Scotland on that and the Scottish medicines consortium is working on new drugs. That is important work and much of it is associated with hospital prescribing.

Dr Collings: The cost of hospital prescribing has traditionally been a much lower part of the overall prescribing bill—it is of the order of £200 million, compared to the £1 billion for GP prescribing. However, there is considerable potential for future cost increases because of a range of new drugs. For example, many new and expensive drugs for treating cancer exist and more are in the pipeline. The cost emphasis is in some ways shifting away from GP prescribing towards expensive drug treatments in hospitals. As Kevin Woods said, one key issue is to ensure that treatments are properly assessed before they are given; much effort is going into that through the Scottish medicines consortium.

Dr Woods: The committee might be interested to know that of the 150 new drugs that the SMC has considered so far, it has approved 33 per cent for use in Scotland and a similar amount for use in a limited way for particular conditions. It has rejected 33 per cent. That gateway for new medicines is helpful to everybody.

Robin Harper: For clarification, do you expect to make savings of £35 million in prescription drugs next year and £42 million in the following year?

Dr Collings: No. The figure is £35 million this year and £42 million next year.

Robin Harper: Okay. Do you envisage any cost pressures that might seriously affect the projection for next year?

Dr Collings: The main pressures are the potential increase in the prescription of effective drugs that already exist, particularly statins, and the volume of prescribing, which goes up year on year. Some drugs that are in the SMC's forward look, but which it has not yet considered, could be expensive. As I said, they will be used

predominantly in hospitals, rather than in primary care.

The Convener: I am conscious of the clock's ticking. I ask members to bundle their questions together if possible.

Margaret Jamieson: What drivers and incentives are in place in the NHS in Scotland to push forward service redesign and reform? I understand that some of the new contracts have a part to play in that. How does the Health Department ensure that service redesign proposals are robustly costed?

Dr Woods: I will make one or two preliminary points and invite colleagues to add to them.

It is a while since I was last involved in such issues but I believe that, as was the case then, considerable attention is paid to ensuring that large-scale redesign proposals are supported by appropriate business cases. I expect that that will continue. We have introduced and developed the centre for change and innovation, which leads a lot of the work nationally, although hitherto in my first week I have not yet had a chance to familiarise myself with all of that group's work. Colleagues might want to add a little more about redesign from the business planning point of view.

11:00

Dr Collings: Redesign varies depending on what is involved. It covers a range of issues from matters that are local—which we would not get involved in costing but in relation to which we would offer support—to major strategies. When a major strategy is produced, we expect it to be accompanied by an economic and financial analysis, which we will probe. If the strategy is approved, normally it will break down into a series of projects. If those projects are above the delegated authorities of the boards, the board normally has to submit to us an outline business case before it goes to the market to buy whatever it is that it wants to buy, such as a building or whatever. At that point, it will produce a final business case, which would normally be when the board was at the stage of detailed planning and would have received tenders and so on for the work. Each business case is a substantial document; we bring to bear on them a range of skills from within the department when they are costed.

Margaret Jamieson: My concern is about the smaller service redesigns. I have experience of that because my health board—Ayrshire and Arran NHS Board—is good at examining its services to find out how the patient journey can be shortened and outcomes improved. Although some boards are good at doing such work, and the department has created the centre for change and innovation, boards across Scotland have not even started the process. What cost benefit is there to having the centre for change and innovation if measures are not being delivered on the ground for patients?

Dr Woods: I am not sure that I can answer the specific question about the centre for change and innovation today. However, your concern about the possibility that lessons that are learned in one part of the NHS might not be transferred to other parts is important. Obviously, we must strive to ensure that those lessons are learned because of the benefits of redesign. Some of the projects that were developed in Ayrshire have brought great benefits.

I accept entirely the general point that we must ensure that learning that is developed in one part of Scotland is made available elsewhere. I cannot explain the position this morning, I am afraid, but I believe that the centre for change and innovation attaches importance to that.

Margaret Jamieson: If significant service redesign brought about double-running costs, would bridging finance and support from the department be available?

Dr Collings: A bridging scheme was available when we were getting a lot of the major long-stint institutions closed. At the moment, we do not have a bridging finance scheme.

Dr Woods: There are pros and cons in such developments and history has shown that the situation can be complex. Essentially, the resources would have to come off the top of the budget. We would then have to have some way of judging between competing claims on the money, which could raise concerns about whether we were being fair.

As I understand it, our recent approach has been to maximise the amount of resource that we can allocate to the service and to encourage the service to make provision for such elements using non-recurrent resources and so on.

Susan Deacon: Margaret Jamieson asked about how change is driven forward in the NHS in Scotland. I would be particularly interested to hear your thoughts on that, given that before you worked for the Scottish Executive Health Department, you worked in and studied various parts of the NHS. Can you share with us your thoughts on how you think the pace and scale of reform in the NHS in Scotland can be accelerated, and in particular whether you think that there are lessons to be learned from some of the approaches that are being adopted south of the border, of which you have experience? On the latter point I stress that it is important to get beyond some of the—dare I say it—headline debates about policies that apply in different parts

of the UK, and instead get into the questions of, for example, how major information technology changes and changes to prescribing practice, which Peter Collings touched on earlier, can be moved further and faster than has been the case to date in Scotland.

Dr Woods: That is a very big question. I will try to be brief. I preface my comments by saying that what might be appropriate in England might not be entirely appropriate in Scotland. My sense is that in Scotland we have to get an effective performance management system working for the NHS. Interestingly, from my recent experience in England, I know that that has been one of the most important drivers for change there, coupled with an energetic approach to modernisation through the NHS modernisation agency. Those two things have been extremely important, and we can learn from them.

I have not been here long enough to know what the current state of our performance management system is, but one of the characteristics of the situation in England is the emphasis on in-year measurement of progress. Concern has been expressed a number of times about the number of targets in England but, having worked in the system, my sense is that some of those targets have focused people's minds, and that close attention to in-year performance has driven through a number of important benefits. As I sit here today, it is impossible for me to judge the extent to which that is replicated in Scotland, but I will reflect on it as I go round the service.

George Lyon: One of the committee's concerns is that, despite record investment in the service and record increases in the number of consultants and allied health professionals, activity levels are declining. For example, elective episodes have declined. More worryingly, day-case surgery plateaued in 1999 and is now also declining. Some of that might be explained by out-patient activity but, unfortunately, it has not been measured well enough to capture the data. How do you view the need to improve productivity in the service and how might you incentivise it? It is clearly a concern of the committee, and it is one of the fundamental concerns of the country, that record amounts of money are going in but activity levels are declining rather than rising.

Dr Woods: We need to consider whether we are capturing all the changes in activity that are going on if people are being treated in other settings that are more appropriate to their needs, which surely is a good thing. I sense that our information systems have not necessarily caught up with some of that. I believe that the committee has been concerned about that matter, so my colleague Jill Alexander might want to say a little bit about the work that is being done to address that.

It is important that we keep at the front of our minds productivity and how we use resources. My understanding of our system is that we need to develop our performance management system. We come back to measurement. What are we using resources for? Do we know whether local targets are being set and achieved? It boils down to those sorts of things.

Mrs Jill Alexander (Scottish Executive Health Department): I am happy to say a bit about the work that we are doing, if that would be helpful.

George Lyon: Just a little bit, because we are tight for time, and I have further questions.

Mrs Alexander: As I think you are aware, a fairly major exercise was started by the information services division—ISD Scotland—more than two years ago to address some of the already obvious gaps in measurement of activity in the service.

Last summer, around August, we initiated a more general statistics review, which sat above the range of other activities that were going on, such as the review of our performance management system and the benchmarking work on costs across boards, which is trying to help boards to identify potential areas in which they could make efficiency gains. We are also working with the Department of Health, looking at measurements of output and productivity across the whole Government—the Atkinson review. We are involved in a number of important activities that all feed into the general understanding of what type of activity we need to measure and what indicators we should collect. That will all come together in the overarching statistics review when we report later this year—I hope that it will be in early summer—and in the recommendations that will flow from the report.

Another important strand is the consultation that we are about to undertake with a range of bodies, including parliamentary committees, Audit Scotland, NHS boards and other interested users of the information. That will feed into the overall picture of the gaps in information and how we might address them, both in the short term, by using existing information or re-presenting differently data that we have already collected, and in the longer term, by collecting new data and setting up new information collection streams. We will provide an initial report later this year about where we are heading.

George Lyon: When are the new data collection systems likely to be in place?

Mrs Alexander: We are reckoning on a three-year span, depending on the type of

improvements that we are talking about. Presentational changes can be made very quickly. Changes to how we analyse existing data could possibly be made over the next year or so. However, for new data collection that might mean putting in place new systems in NHS boards, we are probably talking about two to three years, at the very least.

Dr Woods: I want to point out that it is right that we seek to develop our information systems. I understand that there are well-identified weaknesses around costing, for instance. However, I do not wish the committee to think that all the data in Scotland are poor or unreliable, or anything like that. We have good hospital activity data with which we are able to do things that cannot be done in other parts of the UK. Much of the ISD's work is very high quality, but we must expand the range of data that it collects.

The Convener: Have you covered your area on benefits of resources and health, George?

George Lyon: I have one further question to ask.

The Convener: We shall take Susan Deacon's supplementary question during her questions on information technology.

George Lyon: On incentives, you seemed to suggest that setting targets at board level and ensuring that they are met is one way of trying to drive the system to produce more and to increase activity levels. Is there a role for any form of incentivisation? A number of health professionals have put it to me that there are many perverse incentives in the system, which militate against the service upping its activity and productivity levels. One of the criticisms is that it is a referral service, because there is no incentive to try to treat at community level instead of in acute services.

Dr Woods: If perverse incentives are operating that cause actions that are not consistent with the direction in which we want to go, we obviously need to reflect on those and see whether we can address them. A good example of one of the current incentives, to which Mike Palmer referred in his evidence, is around the GMS contract. The new quality and outcomes framework is essentially a package that encourages development of new models of care and greater activity, particularly in respect of management of long-term conditions in primary care. That is highly desirable and our evidence suggests that it is being taken up with energy and vigour. Therefore, there are incentives in place beyond the performance management system. We should not lose sight of the fact that the NHS is a public health service and that the people who lead it have a responsibility to fulfil statutory duties and to meet objectives that are agreed with ministers.

The Convener: You have covered that area. That is fine. Susan Deacon has questions on information and information technology developments.

11:15

Susan Deacon: I am grateful for Jill Alexander's comments about data collection systems. Her comments pre-empted many of the questions that I was going to ask. Colleagues will be pleased to know that I will not repeat what has been said.

However, I will ask whether you believe that the pace of change can be accelerated beyond the timetable that was previously set. How would you do that? When can we expect improvements in our being able to see information on, for example, nurse-led clinics and one-stop clinics? We all agree that such clinics represent modern and effective clinical practice but, sadly, no one from ministers down can get a clear picture, as Dr Woods says, of the extent to which activity has changed on the ground. I presume that that is a matter of concern to you, not only in that such a picture would provide transparency and reflect what is going on in the service but because the lack of such information could potentially drive performance in the wrong direction. Can we expect to see some early wins in those areas and some early information on that?

Mrs Alexander: The examples that Susan Deacon mentioned are already being looked at by the data development project, as you may be aware. Those are not in the timetable of the more general statistics review; they have had a head start. Information—experimental data—on practice teams and on nurse-led clinics was published by the ISD in mid to late 2004. As the information starts to come in from boards, it has to go through a period of quality assurance and consistency checking. That is already coming on stream.

For the next nine to 12 months, activity is under way to consider more nurse-led clinic activity, allied health professional activity, out-patients activity and waiting times analysis for those areas. We expect to see reports on that between summer 2005 and early 2006, which will give us a picture of what the ISD thinks is possible. I hope that in some areas it will give us early findings.

The ISD will also consider sampling, which is a fairly new area for it. That work will focus on accident and emergency data and GP data. We are looking for early results in the next year to suggest what might be possible, which should give us the opportunity for early wins rather than for setting up big comprehensive systems.

Susan Deacon: I will respond briefly to that. I appreciate everything that has been said about the range of activity that is taking place. However, we

all want a situation in which ministers can stand up and not just have to talk about waiting times for consultant-led out-patient clinics, but say with clarity and transparency to Parliament and the public what is going on. I acknowledge all that you have said, but I remain concerned that there seems to be some way to go before we achieve that degree of transparency.

You touched on the other matter that I will raise. On e-health and the development of information and communications technology in general, the last e-health strategy that was published by the Scottish Executive Health Department stated that it represented an incremental approach rather than a big-bang approach. It compared that approach directly to that which has been taken elsewhere, for example by the Department of Health, which levered in significant investment and some major contracts. How does the Scottish Executive Health Department intend to take the work forward? I am particularly interested in Dr Woods's thoughts, because I am sure that it is an area of concern to him.

Dr Woods: I understand the urgency around measurement and I accept the point entirely. The trick that we have to pull off is to ensure that, wherever we can, we gather data as a product of clinical activity. We must also ensure that the data that we collect are clinically helpful and clinically relevant. Otherwise, people will feel that it is just another administrative burden and, as it were, an information tax on their activities.

As far as information management and technology are concerned, I should hand over to Peter Collings, because I am not familiar with where we are in Scotland in relation to some of the points that you raised.

Dr Collings: We have procured a national information system for accident and emergency and are—I hope—close to signing contracts for a national picture archiving system which, because it stores digital images from X-rays and so on, means that we do not have to use film any more. We have also gone out to the market for what is called a generic clinical system, which will provide clinicians with IT tools to help them in their work. Moreover, we are running an e-pharmacy project that will apply uniformly across Scotland. We are implementing a range of measures to fill gaps in existing IT arrangements and the trend is towards taking a national approach to these matters rather than carrying out a series of local procurements.

That said, we are not carrying out a wholesale replacement of all the major IT systems in NHS Scotland. Instead, we are trying to fill gaps. When people want to replace things, we take the opportunity during the full procurement to try and get much more standardisation.

Susan Deacon: As the benefits of these projects work through the system, we would expect improvements not just in the quality of service but in efficiency. Indeed, over time, we might even expect—dare I say it—savings. However, taking such projects forward obviously raises major investment questions. Where does the resource come from to take forward work on the health strategy, changes to pharmacy and prescribing practice and so on? Does it come from the department's central budget, or is it a combination of central funding and funding from local health board budgets?

Dr Collings: It is a combination of the department's central budget and some money that is spent locally. As figures that we published following the spending review show, the size of the central budget will increase significantly from about £35 million to £100 million to cover these matters.

Susan Deacon: Will that money be spent specifically on e-health?

Dr Collings: Yes.

Susan Deacon: I would be grateful for any further written information that the department could make available on that.

The Convener: We will now move on to discuss cost pressures.

Mrs Mulligan: Dr Collings helpfully reassured us that health board budgets would be increased for the next financial year. How will that increase in funding compare with the increased costs of, for example, pay modernisation, the drugs that we discussed, pensions, ICT and increased demand in general? In making those comparisons, will you tell us what scope will be left for NHS boards to develop new services and respond to new demands?

Dr Collings: According to our figures for next year, the cost pressures that you have mentioned come to less than the uplifts that boards will receive. Undoubtedly, they will take up most of that uplift, but not all of it.

I should also point out that, as Mike Palmer said, quite a lot of our work, including the drugs bill and agenda for change, forms part of our strategy for improving services. Similarly, the Audit Scotland report highlights the cost of additional health professionals as a cost pressure—and quite rightly, because such a measure will cost money. However, more patients will be treated as a result. In broad terms, we think that the cost pressures currently come to less than the uplift, but not a great deal less. Health boards, like the rest of the public sector, are expected to produce efficiency savings and to recycle them into improved service provision.

Mrs Mulligan: You said "most of that uplift". Do you have a figure for that?

Dr Collings: I am looking at the latest figures that we have. You will be aware from our earlier discussion that the figures are moving around. As regards the uplift in the broad budgets, which will be of the order of £550 million, the main pressures that we have been discussing will take slightly in excess of £400 million to £450 million out of that total.

Mrs Mulligan: We have mentioned a few of the cost pressures that we would expect. Is there anything that the Health Department can see on the horizon, of which we are not presently aware, which might add cost pressures to the health boards?

Dr Collings: The only one that I would mention, which I do not think has yet been discussed with the committee, is one that kicks in in 2007. It is called modernising medical careers, which is a reform of the training of doctors. Because it is still quite far off, we have not yet discussed it with the committee—it has not been brought to your attention. That is the new pressure on the horizon, although, as I have said, it is a bit of a way off.

Mrs Mulligan: I am sure that we will be considering it at some stage in the future.

George Lyon: I seek some clarity on the figures that you have given. You mentioned an uplift of £550 million for 2005-06. Is that right?

Dr Collings: It is roughly that amount. The minister has not yet taken the final decision.

George Lyon: Can you give us a breakdown of that for GMS, the consultant contract, agenda for change, the prescribing costs and normal pay inflation?

The Convener: If you would like to send that in writing—

Dr Collings: I would rather do that in writing, if I could, please.

The Convener: That would be acceptable to the committee. That covers our questions on financial planning. Before we take a break, we have some questions on financial monitoring, which I anticipate will be short. I invite Margaret Jamieson to start on the monitoring of financial performance.

Margaret Jamieson: Dr Woods, we were advised by your predecessor that the Health Department does not manage NHS Scotland, but that it does monitor the financial position of individual health boards. How do you assess the quality of boards' financial plans and their in-year performance? How often is that done?

Dr Woods: As I understand it, the current practice is that, every year, the Health Department receives a five-year financial plan from each health board, as well as a statement of its service plans. Those are considered by officials in the department. If boards are developing major service change proposals, it might occasionally be necessary to take the plans for ministerial consideration. However, most of the consideration of the finance plans and service plans that come in is undertaken by officials. Dr Collings will no doubt be able to add some information on how the financial plans are assessed within the department.

Dr Collings: The first thing I would add is monitoring. We get monthly returns from each health board on how things are going and on the projected outturn, from the end of the first quarter onwards through the financial year. Those returns can be compared to the financial plans. Where necessary, boards send us revised financial plans. As regards how we assess the plans, we have a small group of accountants, one of whom you will be meeting later. They go through the plans and the monitoring returns, assess whether they look credible, work out which bits look like they might be high risk and then go back to the board with questions. They visit each board, typically two or three times per year, to run through in detail both the plans and how that year is going. It is generally a matter of analysis and of probing boards on these issues.

Margaret Jamieson: If there is an area of disagreement, where in the process is the final decision taken, and by whom?

11:30

Dr Woods: We are moving on to some issues on which I was going to comment in relation to Argyll and Clyde NHS Board. The important point is that we must not lose sight of the boards' responsibilities. Their job is to deliver services within the available resources. It is our job to work with them to test the assumptions with which they are working and to test the quality of the proposals, and Dr Collings has referred to that to some extent.

We want to ensure that we do not have a situation where there is disagreement about those plans. It is for us to work with the boards to find common ground and a way forward. I do not think that we are into doing anything like arbitration over such issues; it is about the quality of the dialogue between the parties and seeking to ensure that the boards fulfil their responsibilities for developing balanced proposals.

The Convener: I have to ask about an issue related to funding gaps. The Audit Scotland report identifies that Lanarkshire and Greater Glasgow NHS Boards have funding gaps for 2004-05, but

they have financial recovery plans in place to manage those. How confident are you that their plans will be achieved? How did the Health Department satisfy itself that the board savings plans were realistic and that the planned used of non-recurring money was appropriate? As it is now only two months from the year end, can you give us the up-to-date position of those two boards?

Dr Woods: Peter, would you comment on those two specific cases?

Dr Collings: Lanarkshire's plan for this year is to try and achieve in-year financial balance; it has a cumulative deficit. At the moment, it looks like the board is close to doing that; we expect it to achieve it or miss it by a fairly small amount.

Greater Glasgow NHS Board has given us plans for ending the year with an overspend of £4.6 million, which is a small amount on a £1 billion budget, but we have been pressing for the overspend to be eliminated. At the moment, our best estimate is that they will come in in balance at the end of this year. Given that it is such a small margin, it will presumably be on one side or the other, but our central estimate is that the board will be in balance at the end of this year.

The Convener: That does rather suggest that their plans were realistic. How did you go about satisfying yourself that they would be?

Dr Collings: We went through the plans line by line. In each case, they had a series of specific items where savings could be found, and they had an amount that was specified as further savings that they would need to look for. We have been keeping in touch with the boards through the year to make sure that they have found those elements.

Mr Welsh: How do you monitor that ring-fenced funds are used for the intended purposes? How much is involved? Will you assure the committee those ring-fenced funds are being used for their allocated purposes?

Dr Collings: We ask boards for a plan of how they will use ring-fenced money. The distribution of the money depends on our receiving a plan that we consider to be adequate. We go back to boards during the year to check up on how they are getting on. Quite often, we find that there is slippage in a plan and when that happens we seek an assurance from the board that in future years it will make good the service delivery developments that were in the plan.

By and large we accept boards' assurances that ring-fenced moneys are being used for the purposes for which they were allocated. However, we are regularly in touch with boards and their developments and we often visit the facilities for which they have said that they will use the money. If the funds are to be used for material purposes, the auditor is likely to take an interest in whether funds have been used for the purposes for which they were intended. The situation is different from that of local government, in that the auditor is not under a statutory obligation to audit ring-fenced moneys. However, the auditor takes an interest in the matter in the context of their overview of boards' accounts and controls.

How we identify the amount of ring-fenced funds depends on our definition of ring fencing and whether it includes funds for GMS, for example. Currently, the main elements of ring-fenced funding are £25 million for cancer services, £20 million for coronary heart disease and stroke services, £30 million for delayed discharges and £20 million for drug misuse expenditure. A further £4 million is ring fenced for audiology services. There is a range of ring-fenced funds, but different people use different definitions. For example, GMS moneys represent a major fund that can be used only for that purpose, but they are not usually regarded as ring fenced.

Mr Welsh: You say that there are different definitions of ring-fenced funds and that you go back to boards during the year to see how they are getting on and ask them to make good any failure to apply funds. In other words, you take a retrospective look at what goes on. Is anything preventing you from ensuring that specific allocations are specifically allocated?

Dr Collings: We ensure that such funds are specifically allocated. I was trying to explain that we avoid making the financial year end an artificial barrier, so that if boards are delivering what they said that they would deliver, but the timing of the delivery is different, the boards still receive the funds that were promised to them. We would not wish the artificiality of 31 March to mean that a small amount of slippage in, for example, a major change programme meant that the programme would no longer be funded.

Mr Welsh: The money would have to come from the next year's budget, so boards would use funds that might have been allocated to something else. Funds chase funds. Is that a sensible way of operating?

Dr Collings: If, in a given year, boards do not use ring-fenced funds for the purpose for which they were intended, they have a choice. On the one hand, they may keep those funds as part of the moneys that they are allowed to carry forward at the year end and use them the following year. On the other hand, we allow boards the freedom to use the ring-fenced funds for something else in the year, if they identify opportunities to do that and can budget to use other funds to do the work in the following year. Our concern is that the

change—or whatever we are funding—is delivered for the money that we put in.

Susan Deacon: Given what you just said, should the Health Department do more to monitor outcomes?

Dr Collings: We monitor intensively the outcomes of many programmes, particularly those that relate to cancer and coronary heart disease.

Susan Deacon: It is true that you monitor those areas. However, you mentioned other areas, such as audiology, which is a classic example. Ministers gave assurances in good faith that greater priority and resources would be given to audiology. The inference and expectation is that there will be resultant improvement; however, it is quite difficult to see how the Health Department tracks either the input of resource or the results that flow from that. I acknowledge that it is not all about money, but I think that every member of the Scottish Parliament would agree that that area is an issue.

Dr Collings: In audiology, there is a specific partnership agreement commitment relating to digital hearing aids. The extra money that is being invested in audiology is linked to that commitment. We are at an early stage in the programme for delivering on that commitment, but we will monitor boards' progress in providing that service so that we can measure whether they have met the partnership agreement commitment.

Susan Deacon: I appreciate that specific response on audiology. If we were systematically to go through each announcement that has been made over the past one or two years that has indicated the release of targeted—more often than not referred to as ring-fenced—resources in specific service areas, would you be able to give us equivalent answers on where the resources have gone and, more important, what the resultant improvements have been? Could you give a similar answer for each of the services, or does more work require to be done on that?

The Convener: Although that is an important question, we could get an answer to it in writing. I am conscious of the time. If you could give us an answer to that in writing, Dr Collings, elaborating on those issues, that would be perfectly acceptable.

I thank our witnesses for their evidence on the financial performance overview. I propose that we now take a break until 10 to 12, after which we will discuss Argyll and Clyde NHS Board.

11:41

Meeting suspended.

11:54

On resuming—

"The 2003/04 Audit of Argyll and Clyde Health Board"

The Convener: We resume the meeting for agenda item 4, which is consideration of the Auditor General for Scotland's section 22 report on Argyll and Clyde NHS Board's accounts for 2003-04.

We have with us some new witnesses from the Scottish Executive Health Department: Mrs Julie McKinney, who is the finance manager for the NHS boards in the west of Scotland; and Ms Carmel Sheriff, who is the head of performance management for the boards in the west. I thank them for joining us.

George Lyon: I will be reasonably brief. The first issue that we would like to explore is financial recovery plans, because evidence from the accountable officer of Argyll and Clyde NHS Board, Neil Campbell, and the previous accountable officer of the Health Department, Kevin Woods's predecessor, Trevor Jones, indicates that two areas of disagreement underlie the failure to agree the financial recovery plan for Argyll and Clyde NHS Board: the time period over which the savings should be achieved and whether the cumulative deficit can be recovered locally. When do you expect to reach agreement on the financial recovery plan with Argyll and Clyde NHS Board and what are the practical consequences if you fail to reach agreement on the plan?

The Convener: I ask Dr Woods to respond. If he has any preamble on the general subject, he should feel free to make it now.

Dr Woods: My preamble addresses some of those points, but I will try to answer the question more directly, if I may.

We all view the matter as one of great seriousness; we are very concerned about the situation. The minister has made his concerns about it plain, so it is a priority for us to try to achieve a resolution. The minister has also made it plain—in response, I think, to a question that Mr Lyon asked—that he will not rush the decisions and that he wants to have the benefit of the committee's analysis of events before he makes any final decisions on the way forward.

The disagreement is quite prominent in the evidence that I have seen, and I was struck by a couple of points. The first is that, although there have been many meetings between the board and the department, there does not appear to have been a great deal of meeting of minds. We must

move on from that. The significant differences that I have perceived between the views of the board and those of the department essentially are about the pace at which recovery could be achieved. As I understand it, the board has always taken the view that five years were necessary, and the department was anxious about such a lengthy period of time because of the consequences for the accumulation of a deficit, which is what we are now faced with. That situation has not yet been reconciled, which is what the minister wants to try to achieve, but, as I said, he wants to have the benefit of the committee's considerations. The message that I take from all that is that we need to find a common way forward and to learn lessons about how boards and the department will conduct business if the need for recovery plans arises in future.

Those are some of my initial reactions to what I have read. Might it be helpful if I take the opportunity to give you an update on what I believe the current position in Argyll and Clyde NHS Board is?

The Convener: Certainly. I am sure that it would be of interest to the committee to hear your views on that matter.

Dr Woods: As I understand it, at the start of the financial year 2004-05, the board expected to overspend on its recurrent revenue by £46.4 million. It is aiming for, and is well on the way to making, recurrent savings of £10 million in the current year, which suggests that it will finish the year with a recurrent, underlying deficit—that is a really important point—of £36.4 million.

Using non-recurrent resources of about £11 million, the board forecasts that this year's in-year deficit will be £25.4 million. As it started the year with an accumulated debt of £35.4 million, that means that, in 2005-06, the accumulated debt in Argyll and Clyde will have reached £60 million. The two key things that we need to reach an understanding with the board on, and which lie at the heart of the matter, are how the board will resolve the underlying, recurrent position and how the accumulated debt can be managed in the longer term.

12:00

The Convener: Thank you. That is helpful.

George Lyon: I refer to the evidence that Trevor Jones gave us a couple of weeks ago. It is clear that there was a fundamental difference of opinion about the financial recovery plan that was presented to the Health Department. The committee's question is about the basis on which the department evaluates the plans and decides whether they are robust. The answer was not made clear in the evidence from your predecessor. We should not forget that the recovery plan envisages 180 job cuts in Argyll and Clyde NHS Board, five hospital closures and ward closures throughout the primary care sector. The question that occurred to us after the evidence-taking session two weeks ago is: how many more cuts will there be and where do you believe that the board has not made enough progress on recovering the financial position? It is clear that big changes are going ahead in Argyll and Clyde.

Dr Woods: As I understand it, the difference centres on the timescale within which changes should have taken place. The department's view is that changes should have happened sooner, whereas the board's view is that that was not possible. Its priority was to stabilise the situation—as it would describe it—to get it under control and to put in place a series of service plans that entail the changes that you describe. I recognise that that has been going on for two or three years and that I have not been part of it, so I invite Dr Collings to talk about the financial issues. Carmel Sheriff might want to add something on the nature of service planning.

Dr Collings: As Kevin Woods described, the issue between us and the board has been the pace at which the in-year deficits can be brought down. George Lyon said that there is no agreement about how to handle the accumulated deficit. I have consistently said to Argyll and Clyde NHS Board that it should not spend all its time worrying about that issue. When we have a clear plan for getting down to in-year balance, we can consider the range of non-recurring ways to eliminate the accumulated deficit. The priorities on the financial side are to get the in-year deficits down as quickly as possible so that the accumulated deficit is as small as possible, and to produce a plan that will deliver and in which we all have confidence.

The biggest factor behind the financial problems is that the board increased its staffing by more than 8 per cent during a three-year period without having the recurring resources to pay for that.

George Lyon: Is that figure based on full-time equivalents or on head count?

Dr Collings: It is based on full-time equivalents. After the new management team came in, systems were not in place adequately to control the increase in staffing and, for a while, the number of staff continued to rise, albeit more slowly. It is only now that the number is reducing. There is a graph to link clearly the financial issues with what the board did on employment.

Stabilisation involves re-establishing proper management control over all aspects of the budget, including pay. However, that has not reduced the size of the underlying deficit, which is

of much the same order this year as it was last year.

Our view was that other boards had been quicker in taking action to reduce the recurring deficit. In most cases, that was a matter not of taking one major measure, but of establishing tight management control and finding many small savings rather than a few big ones. We have been working with NHS Argyll and Clyde to help it to do that. For example, I facilitated a discussion between its director of finance and the directors of finance of boards that have had more successful savings plans, so that he could get ideas about additional things that he could do to get the deficit down quickly. We have had assurances that NHS Argyll and Clyde will reach balance and that the accumulated deficit will be as small as possible.

Ms Carmel Sheriff (Scottish Executive Health Department): First, I should say that service planning has not taken place in Argyll and Clyde for a number of years. NHS Argyll and Clyde now finds itself in the position of having to reduce its spending base through a mixture of good housekeeping initiatives—which include measures to make administrative and non-clinical savings—reductions in spending in service areas and the reprovision of services that are modern and more appropriate for where we are today.

We have recently received a proposal from NHS Argyll and Clyde to redesign its mental health services, its learning disability services and its services for older people. That proposal is currently going round the department so that colleagues can comment on it. When we get it back, we will put it to the minister for consideration.

Mr Lyon made a point about ward closures and other service changes over the past couple of years. Those changes have indeed taken place, but they have not been due solely to financial considerations; they have also been driven by wider issues such as the working time directive, changes in junior doctors' hours, improvements in technology and changes in how services are delivered. I go back to my original point about the service-planning blight that existed in Argyll and Clyde for so long.

George Lyon: I want to be clear about which part of the recovery plan you disagree with. Do you disagree with the timeframe or with the proposals themselves? A team was put in place to evaluate what was going on in Argyll and Clyde, then the four chief executives resigned and the new management came in. That took place a few years ago. Are you arguing that that should have happened on day one, or do you disagree with the actions that NHS Argyll and Clyde proposes to take?

Dr Woods: My reading of the evidence is that our principal disagreement is with the timing. The department's view was that recurrent savings should have been secured sooner.

As Carmel Sheriff has outlined, the proposed service plan changes in Argyll and Clyde are intended not only to save costs, but to replace the pattern of provision of mental health and learning disability services with a model that is more appropriate for the future. I am not in a position to comment on whether that is right, as I have not had a chance to study the plans, but I am advised that the board spends significantly more on those services than do boards in other parts of Scotland and that it seems to have a greater reliance on institutional provision.

As I say, I can pass no comment on whether that is appropriate or the new plans are better until I have had a chance to examine them. However, the proposals appear to be to make service changes, to improve services and to reduce costs. The difference is that the department wanted those sorts of changes to happen earlier.

Ms Sheriff: It might be helpful if I explain how we assess those proposals now that we have them. As I said, the proposals are passed around the department for comment and consideration by colleagues in policy and other areas of interest. We consider the adequacy of consultation, whether that consultation has been carried out in adherence with Executive guidance and whether the proposals fit with policy in the areas of service that I have described, including mental health services, learning disability services and services for older people.

George Lyon: On a point of clarification, you mentioned earlier that there are no schemes to help with double-running costs. However, it is clear that the schemes that are envisaged in the plan will require double-running costs, because the community mental health facilities will have to be put in place before the institutional facilities are closed. How would the board deal with that matter? Is that part of the discussions?

Dr Collings: Yes. The board has asked us to consider options for giving some assistance in that regard. We have asked for more detailed figures on the costs and what the money would be spent on. At that point, we will determine whether there is a way in which we can assist the board.

George Lyon: On the second point of disagreement, how does the department envisage the recovery of the cumulative deficit, which Dr Woods stated will stand at £60.8 million at the end of this financial year?

Dr Collings: Fundamentally, that needs to be done through non-recurring means. In other cases in which boards have deficits, we are clear that

money will come from profits on asset sales because they have disposal programmes for surplus assets. NHS Argyll and Clyde also has a significant asset disposal programme. It does not look like it will be sufficient to cover the deficit, but we think that it will go towards recovering it. We will consider a range of other options and put them to the board and to ministers.

The important point is to stop the deficit growing further. One can see ways of recovering £60 million, but it is much more difficult to see ways of recovering £100 million.

George Lyon: The accountable officer of NHS Argyll and Clyde has told the committee that it would be impossible for the board to retrieve the cumulative deficit without there being serious consequences for local service. Have you and the board carried out a joint assessment of the impact on services of recovering that cumulative deficit as part of the financial recovery plan?

Dr Collings: We have made it clear to the board that we do not expect it to deal with the deficit by making recurring surpluses, which means that it has not been necessary to carry out such a joint assessment. Together, we will examine any non-recurring ways of eliminating the deficit, because it is impossible for the board to run by substantially underspending its budget on a recurring basis.

George Lyon: Do you accept that, currently, the deficit cannot be repaid?

Dr Collings: I accept that it cannot be repaid by making recurring surpluses. As I said, there are a number of other ways in which it might be repaid, the most obvious being asset disposal, which we are examining with the board.

George Lyon: In his evidence, Trevor Jones confirmed that the department did not provide the board with written assurances that it would receive enough cash to meet the costs of its in-year operational activities through to 2007-08. Does the department plan to provide written assurance in that regard?

Dr Collings: To be honest, I think that that is unnecessary, because the minister gave the Health Committee such an assurance, so it is in the Parliament's *Official Report*. That deals with the very precise point.

12:15

George Lyon: What is the status of that assurance and how do you account for it? How does the department justify cash allocations and payments from public funds that are based on verbal assurances?

Dr Collings: As I said, that assurance is in the *Official Report*. We can certainly give Argyll and Clyde NHS Board an assurance on that point, but we felt that the minister having put the assurance on the record should be adequate for the board and its auditors.

As for the reasons, a fundamental budgetary control is now on a resource basis rather than a cash basis, although global controls on our budget are on a cash basis. That gives us some room for manoeuvre in how we manage cash across the health programme. That is what we use to ensure that Argyll and Clyde NHS Board has the money to pay its wages and bills and to assure the people who deal with it that that will continue. We could not allow a situation to develop in which that did not happen.

George Lyon: Is that not an unusual accounting position?

Dr Collings: Nobody could be comfortable with the position, but nobody could be comfortable with the size of the deficit.

Dr Woods: The important point is that the minister is trying to convey the fact that, as I have said, he wants the situation to be resolved once we have gone through all the evidence. He wants to give an assurance that no precipitate change will occur because of a cash problem in the board. I understand that the financial regime under which we operate enables him to give that assurance. The assurance that cash will be available to pay bills and staff and that we will have in place plans to achieve a recurring balance is important.

Mrs Mulligan: I return to the previous issue of the cumulative deficit. Is the department concerned that NHS Argyll and Clyde's use of non-recurring resources to offset in-year deficits will reduce its ability to use such resources to address the cumulative deficit? Is the board selling assets, which means that it will not have them to address the cumulative deficit? Is the board using non-recurring resources inappropriately?

Dr Collings: For a range of obvious reasons, I wish that the board was not using non-recurring resources to the extent that it is. Julie McKinney can correct me if I am wrong, but I think that any profit from one significant asset disposal in the programme will be used to help to fund some of the changes that the board needs to make. The other asset disposals are a fair way down the track.

Mrs Julie McKinney (Scottish Executive Health Department): The board's five-year plan includes asset sales. Other sales are still outstanding, because the board does not know their timing or how much it will receive for them. Some use of non-recurring resources from asset sales is built in.

Dr Woods: The member puts her finger on the important question whether using non-recurrent resources in the short term will leave scope to deal with the accumulated deficit later. We need to assess that with NHS Argyll and Clyde and have clarity on that matter, and we will do so.

Mrs Mulligan: Does the department have a view on the percentage of non-recurring resources that NHS Argyll and Clyde should use? Trevor Jones has said that the department accepts that health boards will use non-recurring funds on occasion to keep themselves in balance.

Dr Woods: I do not think that there is a formula—a fixed sum—that one can apply. In his report, the Auditor General drew attention to the danger that people can become too reliant on using non-recurrent resources to sustain a weak underlying position. It is a matter of judgment in specific circumstances, and that rests on the quality of the dialogue, our understanding of what is proposed and the way in which we test those plans. I do not think that there is a rule of thumb beyond saying that, in an ideal world, non-recurrent resources would be used as little as possible. We fully accept that they are a useful tool for financial management; however, we should not become dependent on them to sustain weak recurrent positions. It is important that boards deal with those weak recurrent positions, difficult though that might be.

Margaret Jamieson: I want to pick up on the statement about Argyll and Clyde NHS Board having had no service planning for many years. How many years are you talking about? Five years? Fewer? More?

Ms Sheriff: I will use the example of the proposals that we are currently considering around mental health services, services for older people and services for the learning disabled. Many places in Scotland are much further forward in having done that redesign work. Argyll and Clyde NHS Board is considerably further behind other places in Scotland in that respect. That is evidenced by the amount of money that the board spends on institutional care, as Dr Woods said, which is no longer appropriate for people in those service areas. That is one example of an area in which progress would, ideally, have been made considerably earlier.

Margaret Jamieson: We are all aware of performance assessment frameworks and all the boxes that have to be ticked. Why was the matter not picked up before? Why is it an issue now, when we have performance management throughout the system?

Dr Woods: I am not sure that I know the answer to that in relation to Argyll and Clyde NHS Board. My understanding is that the board has needed time to consult and engage in dialogue with all the interested parties locally to get agreement and ownership of some of the substantial changes. I suspect that, if you were to go through the accountability review letters—you have probably done so—you would find quite a lot of dialogue in them about the need for service plans to be developed to support changes. I am not sure that I can tell you, from this vantage point, why that has taken longer in Argyll and Clyde than it has taken in other places.

Margaret Jamieson: For me and other members, that calls into question the robustness of the performance assessment framework and the action that can be taken when somebody fails in some part of that.

Dr Woods: I do not know whether the problem is the robustness of the performance assessment framework—which is, essentially, an information tool—or the quality of the dialogue about service planning changes. That is something on which we need to reflect.

The Convener: Given the evidence that you have provided, are you close to having a target for when agreement might be reached with Argyll and Clyde NHS Board?

Dr Woods: I would like to make two points, if I may. First, I am pleased that the chief executive of the board believes that we are now working more effectively on these things. That is an important statement, which he has made in the correspondence around the accountability review. I regard that as an important step forward. Secondly, I reiterate what I said at the beginning, which is that, although the minister regards the situation—as I do—as a matter of great seriousness and priority, it is not the sort of thing that should be rushed or on which hasty decisions should be reached. He wants the benefit of the conclusions of the committee to help to inform his consideration of the issues. It is important that we get to the bottom of this, agree a way forward on the recurrent position and think about the accumulated deficit; however, we need to make progress at an appropriate pace and not reach hasty decisions that might not be sustainable.

The Convener: That ends our questions. I thank you and your colleagues—and the witnesses who appeared earlier in the meeting—for helping us with our inquiries. It has been a most helpful exchange of views. What was particularly refreshing was your positive attitude in trying to heal things and come to conclusions on the case of Argyll and Clyde NHS Board.

Dr Woods: Thank you for those comments, convener. I reiterate my opening point: I hope that we will develop a dialogue during my tenure in my present position. I would be happy to arrange for

briefings and so on for the committee on specific issues, as we are dealing with extraordinarily complicated and changing situations. I am happy to engage with the committee in a way that the committee considers appropriate.

The Convener: Very good. The committee will consider that. Dialogue is guaranteed because, once we produce our report, there will be an opportunity for the department to respond to it.

12:26

Meeting continued in private until 12:56.

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