AUDIT COMMITTEE

Tuesday 21 March 2006

Session 2

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by Astron.

CONTENTS

Tuesday 21 March 2006

AUDIT COMMITTEE
4th Meeting 2006, Session 2

CONVENER

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

DEPUTY CONVENER

*Mr Andrew Welsh (Angus) (SNP)

COMMITTEE MEMBERS

*Susan Deacon (Edinburgh East and Musselburgh) (Lab)
Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Mrs Mary Mulligan (Linlithgow) (Lab)
*Eleanor Scott (Highlands and Islands) (Green)
*Margaret Smith (Edinburgh West) (LD)

COMMITTEE SUBSTITUTES

Chris Ballance (South of Scotland) (Green)
Mr David Davidson (North East Scotland) (Con)
Marlyn Glen (North East Scotland) (Lab)
Mr John Swinney (North Tayside) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Barbara Hurst (Audit Scotland)
Claire Sweeney (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

John Connaghan (Scottish Executive Health Department)
Dr Kenneth Ferguson (Golden Jubilee National Hospital)
Dr Bob Masterton (Ayrshire and Arran NHS Board)
Dr Kevin Woods (Scottish Executive Health Department and NHS Scotland)
Jill Young (Golden Jubilee National Hospital)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Clare O'Neill

LOCATION

Beardmore Conference Hotel, Clydebank

Scottish Parliament

Audit Committee

Tuesday 21 March 2006

[THE CONVENER *opened the meeting at 09:51*]

Items in Private

The Convener (Mr Brian Monteith): Now that everyone has taken their seats, I open the fourth meeting in 2006 of the Scottish Parliament's Audit Committee, which is taking place at the Beardmore Conference Hotel beside the Golden Jubilee national hospital. I welcome to the meeting the Auditor General for Scotland, Audit Scotland staff, committee members and members of the press and public. I remind everyone to turn off their pagers, mobile phones and such like. We have received apologies from Margaret Jamieson, who cannot attend today's meeting. It appears that everyone else is present and correct.

First, I seek the committee's agreement to take in private items 4 and 5. In item 4, we will consider the evidence that will be taken in item 3 on the Auditor General for Scotland's report "Tackling waiting times in the NHS in Scotland" and, in item 5, we will consider the committee's approach to the report "Implementing the NHS consultant contract in Scotland". Do members agree to take both items in private?

Members *indicated agreement*.

"Implementing the NHS consultant contract in Scotland"

09:53

The Convener: We move to item 2. I invite the Auditor General for Scotland to brief the committee on his report "Implementing the NHS consultant contract in Scotland".

Mr Robert Black (Auditor General for Scotland): My report was published on 9 March. The new consultant contract was introduced in April 2004 as part of United Kingdom-wide pay reforms across the national heath service. The other reforms are the general medical services contract and agenda for change.

The contract is the first change to consultants' terms and conditions since the original 1948 agreement and represents a significant change in how their work is planned and managed. My report reviews the background to the new consultant contract and comments on the implementation, cost and impact of the new contract on patients and consultants.

I highlight four main findings in my report. First, the new contract undoubtedly offers an opportunity to focus consultants' work on priority areas and to improve patient care. However, it is not yet being used to its full potential and there is limited evidence of benefits to date. Because of its complexity and cost, the contract's implementation has certainly proved to be a challenge for the NHS. Boards have focused on the practicalities of transferring consultants to the new contract, so they are only now exploring its potential to improve services. If the contract is to be used to deliver improvements in patient care, boards must have well-developed job plans for consultants, but there is evidence that such plans are not well developed and that, during the first year, there was still much work to do.

In general, boards think that it is too early to see comprehensive changes that would result from the consultant contract, although there are some examples of improvements. Some boards are starting to use the contract to redesign the way in which consultants work, and to create additional posts. We undertook a national survey of consultants and we got a good response. Consultants do not think that the new contract has yet led to improvements in patient care; only 7 per cent of consultants who are on the new contract and who responded to the survey agree that patient care has improved since the contract was introduced.

My second key finding is on future benefits. Before the new contract was introduced, the

Scottish Executive Health Department set out a number of anticipated high-level benefits for the NHS in Scotland. However, it did not identify specific performance measures, nor did it ensure that boards planned for them from the outset. In July 2005, the Scottish Executive asked boards to produce action plans to demonstrate how they were using the new contracts to achieve national priorities and improvements in patient care. The plans show some areas of service change, but they are not comparable between boards and they do not act as a robust monitoring tool, although we should note that work is continuing in that area.

Thirdly, the report identifies weaknesses in planning for the contract at both Scottish Executive and board levels. Planning for the contract should have been more robust from the outset, and uncertainty contributed to cost pressures on boards. The initial national costing model that the Health Department used was not accurate because there was a lack of information on consultants' working patterns at local level. The model underestimated the overall financial impact by about £171 million for the first three years. As more information on consultants' working patterns became available, the estimates were revised and there was a convergence towards the actual costs. We give details on pages 10 and 11 of the report.

The Scottish Executive, boards and the British Medical Association worked in partnership to develop and implement the contract in Scotland. That involved issuing joint guidance, although much of the guidance on detailed areas of the contract was not issued until after the contract was implemented.

Finally, on costs, the annual pay bill for consultants before the new contract was £257 million. The bill rose to £335 million by 2004-05 and is projected to rise to £354 million in 2005-06. The cumulative additional cost over the three years is £235 million. It is reasonable to say that the Scottish Executive, boards and consultants need to continue working together to ensure that the investment delivers benefits for patients. The investment by the health service is clearly significant.

My report offers recommendations for the future. It is important for the Health Department to issue good guidance at an early stage on major complex contracts such as the consultant contract. It is important to be clear about the expected benefits to patients and to monitor whether those benefits are being delivered. It is also important to provide reliable cost information before implementation so that boards can plan properly.

Boards need to undertake good job planning if benefits for patients are to be achieved. It is important that there is strong financial planning early in the process so that the cost consequences can be taken fully into account in financial planning. Finally, it is essential to have good management information about how consultants use their time—and the results that are delivered—in order to reduce costs over time and to drive out the benefits.

As ever, my colleagues and I will be happy to answer any questions.

The Convener: Thank you. Later, members will discuss how we should respond to the report, but at this point we can seek clarification or ask questions of the Auditor General.

10:00

Mrs Mary Mulligan (Linlithgow) (Lab): It is disturbing that we have spent an extra £235 million, but the consultants are not working the amount of hours that was foreseen—they are still overrunning their times—and of those who responded to the survey, only 7 per cent say that there has been an improvement in patient care. That causes me concern.

I have a question that requires a short answer and one that requires a more detailed one. You say that the cost estimate for that increase was fairly different from how the Health Department initially saw it. Was it nearer to the estimates that the health boards were giving when the contract was being drawn up? That question wants a quick answer. A longer answer is required for this: can you say a bit more about the plans that were announced in 2005 to monitor the contract and improved care? If we are to see what benefits have arisen, that monitoring will be crucial.

Mr Black: Your first question relates to the relationship between the boards' estimate of the cost and the department's estimate. The first estimate was prepared by the department; there was no estimate by the boards. The boards did not have high-quality information about how consultants were deploying their time. They did not, therefore, have a good estimate of the costs of the consultant resource and activity at that time. The original estimate was prepared by the department; then, there were two other estimates. The second estimate was, initially, for two years. It underestimated the cost by almost £32 million as a result of the department's asking the boards to produce their first estimate. The third estimate, which was also for two years, underestimated the cost by £11 million as a result of the department's asking boards to return a monitoring form. We got convergence as the information got better about what consultants were doing.

Your second question related to—

Mrs Mulligan: The plan to monitor changes.

Mr Black: Yes. Barbara Hurst and Claire Sweeney are closer to what is happening in the boards in real time; therefore, I ask them to answer that question.

Barbara Hurst (Audit Scotland): I will kick off and then hand over to Claire Sweeney. Initially, the department published a statement of what the benefits should be, which is appendix 5 in the report. It was fairly high level. In July 2005, the department wrote to boards, asking for more detail on all three of the pay modernisation agreements. Health boards are developing their own ways of monitoring the benefits and, at that time, our view was that if there had been a clearer picture up front about what benefits were expected, the situation could have been monitored from the outset. Monitoring is only now starting to be done. The early plans that the department got back from the boards are still not measurable against one another.

The monitoring of improvements needs to go back to the initial benefits that were supposed to come out of the contract, which were a reduction of consultant hours to ensure that consultants are working appropriately and an improvement in services for patients, which would probably cover improved waiting times, patient satisfaction, and all the things that need to be set in place up front. Those are the sort of things that we expect to be put in place pretty quickly to enable us to monitor the situation against them.

Claire Sweeney (Audit Scotland): Boards will also work together locally to secure benefits from the various peer modernisation initiatives. There is, at present, no standard approach to measuring the benefits or the impact of the changes across the piece. That work will feed into the regular benefits realisation plans that the Health Department has requested from boards. Work is on-going to make those plans more robust.

Mrs Mulligan: Why can you not compare benefits across boards?

Barbara Hurst: Because the benefits realisation plans are made from the bottom up, the boards are using different measures to measure the benefits. With a national contract, one would expect some national benefits to have been identified up front. That is what we are trying to push for through the report, which will enable us to examine what is going on across Scotland.

Mr Black: There is a short section in the report that might help the committee. In paragraph 45 on page 16, we talk about boards taking different approaches to implementation of the contract. Some boards concentrated mainly on sustaining existing activity levels, but others tended to be driven by the need to minimise costs. Understandably, it appears that boards that faced the most difficult financial constraints gave priority to keeping the costs down, and accepted that there might be some risk to the activity levels that they were delivering as the contract was introduced. Boards on which the pressures were less severe were able to accept higher costs to avoid the risk of activity levels coming down. We must, therefore, recognise the different local circumstances of boards, which explain why boards took different approaches to embedding the contract in their ways of working. That leads to the risk, which is identified in the report, that it might be difficult to monitor consistently what benefits are realised.

Mr Andrew Welsh (Angus) (SNP): The contract was launched without clear goals or targets. What was the contract meant to do and what specific improvements was it meant to produce?

Mr Black: In exhibit 1 of the small summary, we have attempted to capture as best we can what was the expected impact of the new contract. We list the expected benefits, the impact on patients and the impact on consultants to date. We could go through that in detail if that would be helpful to the committee. You will find in that exhibit the level of narrative that was applied to the expected benefits when the contract was introduced. It is important to bear in mind that it is a UK-wide contract and that, therefore, the amount of control that was open to the Scottish Executive Health Department was limited. Negotiations were taking place at UK level.

Mr Welsh: I am trying to link expectations to the reality in health boards. If specific performance measures to ensure that boards planned for those goals and targets were not in place at the beginning, what assurances are there that those specific performance measures can now be sensibly introduced?

Mr Black: That question would perhaps be most appropriately addressed to the Health Department. As I hope we have emphasised, we are conscious that this is a moving picture. A lot of activity is going on to embed the new contract, which is really quite complex.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): As you said—and as you say in the report—the contract was part of a UK-wide move to reform pay across the NHS, and the agreement that was reached for Scotland was based on a UK-agreed framework. I want to ask a few questions about the way in which NHS Scotland was engaged in the process. My first question is factual. The report notes that

"Discussions started in 2000, and the four UK health departments produced a draft framework in June 2002."

I have struggled to find a copy of that framework agreement. Would it be possible for us to see that?

Mr Black: We might struggle to give you a wholly satisfactory answer to that because the focus of the study was implementation of the contract in Scotland. My remit self-evidently does not extend to the rest of the UK and does not go back beyond devolution. The early days are not really covered in the report; however, I am sure that the team will have some information to help you.

Barbara Hurst: We do not have much more than that. We did not look at the negotiation process because it was done on a UK basis. We started our project at the point where the detail was being fleshed out in Scotland on the back of some of those UK agreements. There was certainly some flexibility around some of the conditions of the contract; for example, we know that Wales went more down the recruitment-and-retention-premium route than Scotland or England has done. Can we try to provide more detail for you? Do you want to see the framework agreement?

Susan Deacon: The framework agreement was agreed in 2002; two years were spent on agreeing the draft framework, and that clearly underpins what was the eventual outcome of the process. I would certainly be interested to see that.

Although I understand the limitations of Audit Scotland's work for the purposes of the study, it is vital that the committee understand how the Scottish dimension was addressed within the negotiation process. You just touched on one of the differences that Wales agreed to; it is important for us to understand what scope there was for Scotland to introduce a distinctive approach to any aspects of the contract, and the extent to which such a distinctive approach was agreed.

There are some very obvious and well-documented differences between the NHS in Scotland and in other parts of the UK—there is greater rurality and less private practice in Scotland—so I would be interested in any additional information that could be provided that would help us to understand how such matters were addressed during negotiation. However, I am happy to leave that to be addressed later.

Barbara Hurst: I can come back briefly on a couple of issues. On back pay, I do not think that Scotland had much choice about whether it paid that year's back pay because it was agreed in, and strongly led from, England.

I do not know how much happened in some of the negotiations around Scotland-specific issues. Exhibit 6 on page 20 shows one of the very few instances of our being able to pin down the impact of a national policy initiative on islands and remote areas. The final column of exhibit 6—the percentage increase in the pay bill—shows that Orkney, Shetland and—if it had a full complement of consultants—the Western Isles have a disproportionately high percentage increase. It would be interesting to pursue how much of that was taken on during the negotiations; we do not know that. It is interesting that we have clear evidence of an impact.

Susan Deacon: My final question fast-forwards us to the implementation process. Given that this is part of a UK contract and pay framework, can you advise us of any information that is available to you, or of any mechanisms that Audit Scotland has in place, to compare how the costs, the impacts and the implementation vary—or do not vary, as the case may be—in different parts of the UK?

Mr Black: I can tell you that our sister organisations in England—the National Audit Office and the Audit Commission—are committed to examining the consultant contract. I know that they are interested in the work that we have done in Scotland, so there must be a good prospect that we will, in the fullness of time, get some information that will allow comparisons to be made.

Margaret Smith (Edinburgh West) (LD): The questions that I was going to ask have been covered.

Eleanor Scott (Highlands and Islands) (Green): I should probably draw the committee's attention to my entry in the register of interests that says that I am still a member of the British Medical Association, which has more or less said, "We told you so". It felt that there was a lack of appreciation of what consultants actually do when it came to writing it down and their being paid for it on a different basis. Consultants were previously paid in an holistic and professional way; they took on the job and did whatever the job threw at them in whatever hours they could find to do it in. That system is clearly open to abuse as well as to good practice. I can see why we wanted to move away from that. Was the BMA right? I know that you did not examine the negotiation stage, but was there a feeling that the profession had said, "If you actually pay us for all of the hours that we work, it will cost you," and that those in charge had said, "No, you cannot possibly be working that much"?

10:15

Mr Black: The general pattern that comes through from the survey of consultants indicates that, on average, consultants have been and are working more than the hours that are provided for in the contract. Some 93 per cent of those who replied to our survey said that they were working more than 48 hours a week and had not signed a

waiver. Clearly, that raises an issue about overtime working in the NHS that needs to be taken into account when the consultant contract is embedded more firmly. About two thirds of those who responded said that their hours had not reduced.

Barbara Hurst: The basic contract is for 40 hours, and the extra programmed activities can take it up to 48 hours. On average, the full-time consultants who replied work just over 52 hours a week. We have been keeping an eye on what has been happening in England, so we can say that that level is common across the United Kingdom.

Mr Black: I wonder whether that might partly explain why we are not seeing evidence of increases in aggregate activity. The committee will recall that, in the performance overview that I brought to Parliament in December, we had a chart that showed activity data for emergency admissions, day cases and elective admissions. We are not seeing increased activity in those, although it is important to qualify that by saying that the contract does not cover elements such as out-patient clinics and the training and supervision of doctors. However, that leads to a concern that we do not yet have good measures of whether the injection of extra resources into the consultant contract will deliver more and better care. That question still cannot be answered.

Eleanor Scott: The out-patient graph was interesting because it showed that there was, following implementation of the contract, a bigger trough than there had been previously. One could imagine that that was due to people doing less because they were busy working at their job plans. Following that trough, there was a bigger peak than there had been previously, which might have been to do with people catching up. It will be interesting to follow that over time. If the contract is working as it should, the peaks and troughs should even out.

A lot of other things are happening in the NHS, such as the agenda for change, which will impact indirectly on consultants' workload because other people's professionalism will be developed such that they will be able to work more independently and, perhaps, to do some work that consultants might do. Another issue relates to the modernising medical careers programme, which will have an effect on consultants because of changes to what junior doctors do. Has the approach been the wrong way around? Should those elements have been put in place before the consultant contract was introduced?

Mr Black: That is a question for the Health Department rather than for us, although those factors must increase the pressure on boards. The modernising medical careers project offers the prospect of doctors in training being less available to work on wards, which will, I presume, have to be covered by others including consultants. At the same time, there will be expectations about the contribution that consultants make to training, which will place extra pressures on the system.

The Convener: I thank the Auditor General and his staff for that briefing on the consultant contract. We will return to this issue in private, under agenda item 5.

"Tackling waiting times in the NHS in Scotland"

10:21

The Convener: Item 3 is evidence taking on the Auditor General's recent report "Tackling waiting times in the NHS in Scotland". I thank all the witnesses for coming to our cosier Audit Committee meeting—it is good of them to make the effort. I welcome and thank our hosts, who are Jill Young, the chief executive of the Golden Jubilee national hospital, and Dr Kenneth Ferguson, the medical director and deputy chief executive of the hospital. I also welcome Dr Kevin Woods, who has visited our committee several times—he is the accountable officer for and head of the Scottish Executive Health Department and the chief executive of NHS Scotland. We also have John Connaghan, the director of the Scottish Executive's national waiting times unit, and Dr Bob Masterton, the medical director of Ayrshire and Arran NHS Board. We hope that the session will be valuable and will allow us to gain further knowledge about tackling waiting times.

I remind everyone that the committee considers financial rather than policy issues. In today's meeting, we will pick up issues from "Tackling waiting times in the NHS in Scotland", with a particular focus on the challenges that are ahead and the value for money and sustainability of current approaches to reducing waiting times. Before we ask questions, I ask Dr Kevin Woods to introduce the members of his team and say what their roles are. Dr Woods may make a brief opening statement, after which Jill Young will explain the role that she and Dr Ferguson have at the Golden Jubilee national hospital.

Dr Kevin Woods (Scottish Executive Health Department and NHS Scotland): I will not elaborate too much on what you said about the members of the team, convener. John Connaghan has recently been appointed director of the delivery group, which we have talked about previously. The committee may wish to return to that for an update on what we are doing. Dr Bob Masterton is the medical director of NHS Ayrshire and Arran. We thought that it would be helpful to have someone who is closer to patient care to talk to the committee about what are important issues. Jill Young and Kenneth Ferguson have significant roles in organising and running the Golden Jubilee national hospital and will be able to give the committee an insight into some of the issues and developments.

With your permission, convener, I would like to make a few preliminary comments about the report. I welcome the Auditor General's recognition that the NHS in Scotland has made significant progress towards meeting waiting time targets. I am sure that everyone will be glad to acknowledge that. Since the report was published, we have brought into the public domain the most recent statistics on waiting times, which are for the end of December 2005. It might be helpful if I gave the committee a brief summary of what those numbers show. We have maintained the eight-week wait for heart investigation and the 18-week wait for heart treatment—the best waiting times in the United Kingdom for those services. We have delivered a maximum wait of six months for in-patient and day-case treatment and a six-month wait for out-patient treatment. The waiting list for patients with a guarantee now has fewer than 75,000 people on it, which is a 9.5 per cent reduction in the past year.

In the past two quarters, the number of people who are waiting with availability status codes, which the report covers, has also reduced. In the past year, the number of people on the out-patient waiting list has reduced to 67,000, which is a reduction of 26 per cent. As I said, all that has been achieved while the number of ASCs that have been recorded for in-patients and day cases has reduced and while we are making significant progress towards achieving our next target, for December 2007, of a maximum 18-week wait for out-patients, in-patients and day cases. That is a very impressive record of achievement for the NHS in recent times. As I said, I thought that it would help the committee to have the most recent statistics.

I will add a few comments about several specific items in the report. The main point that I would like to register about the Golden Jubilee national hospital, which I have no doubt we will talk rather more about in a moment, is that the budgeted activity in the hospital has continued to grow since it was taken over in July 2002. Since then, the activity in the hospital has increased tenfold. In the forthcoming financial year, budgeted activity here will increase by a further 18.5 per cent.

We are preparing for the more challenging targets that we have set for the future and for the abolition of ASCs—I noted what the Auditor General said in his report about that challenge. We are confident that we are on track for that and that we can meet the challenge. The modelling and planning work that is undertaken in the Health Department and in NHS boards means that we have a clear view across the NHS of the numbers of patients who will need to be seen and treated. The NHS has capacity plans in place at board level to deal with all that.

As members know, we will abolish availability status codes by the end of 2007. All boards have included their detailed planning to achieve that in their local delivery plans, which were submitted to

the department on 1 March. It is sometimes said that ASCs represent hidden waiting lists, but they do not. We publish all the details of the ASCs and we often say that nine out of 10 people who are waiting with ASCs do so because of their particular medical needs or because of preference.

I will look to the future and the sustainability of the use of non-recurring funding. Audit Scotland's report observes that in the financial year 2004-05, £116 million was used to tackle waiting times. Of that, £74.5 million was used recurringly and £41.5 million was used non-recurringly. It is entirely appropriate to use non-recurring resources on that task. If we do not, we will have fixed resources in places where we might not need them in the future. That has been an important part of our approach to reducing the backlog of long waiters.

I very much support the thinking that is described in the Auditor General's report on the whole-system approach. He emphasises the need to consider the management of waiting times in a whole-system way. Committee members will be familiar with my diagram of the whole system of the NHS and the work that we are increasingly doing to manage patient flows across the totality of that system. The work that we do on that through the centre for change and innovation is extremely important to achieving that transformation.

We have set out our plans more fully in "Delivering for Health", which we published in October 2005. In that, committee members will find a clear exposition of how we want to shift the balance in our care that is entirely consistent with a whole-system approach. That is another way of achieving greater sustainability in managing waiting times.

10:30

The Convener: Thank you, Dr Woods. Our first question will come from Andrew Welsh.

Mr Welsh: I want to pursue the issue of future waiting time targets. The introduction of the future waiting time targets is only one year and nine months away, and it is clear that they are demanding. The new target of 18 weeks between the first out-patient appointment and treatment as an in-patient or day case is to be introduced by the end of 2007. Waiting time targets for other treatments are also being reduced. The targets are demanding, but are they realistic?

Dr Woods: Yes, I believe that they are. As I hope that I illustrated in my remarks, we do a lot of detailed work on understanding the likely demand that is associated with the targets through our capacity planning work, which is done at the board level. We look carefully at how we are going to meet that demand through the services that are available largely within the NHS but also using the facilities here at the Golden Jubilee national hospital and, at the margins, making some use of the private sector. We are confident, on the basis of the analyses that we have done, that we are on track to meet the target of 18 weeks for in-patients, out-patients and diagnostics, and to abolish the ASCs.

Mr Welsh: I hope that that is the case. Can you assure us that the proposed targets will be met with existing staff levels?

Dr Woods: The NHS workforce is larger than at any time in history and we are continuing to invest in its expansion. However, it is not a question just of workforce numbers; it is also about capabilities within that workforce. As I have explained to the committee on other occasions, we have a number of programmes that are designed to extend the scope of many of our clinical staff. For example, the Auditor General's report on waiting times refers to the scope for extending the roles of practitioners in the area of orthopaedic work—podiatrists and so on. Extending those roles creates more capacity in itself, which is bound to help. I have described previously the work that we have been doing to train non-medical endoscopists, which we discussed in the context of colorectal cancer. Those are a couple of examples of how we are increasing not only the number but the scope and capacity of the workforce. We think that we should be okay.

Mr Welsh: Let us be clear. Can the targets be met with existing staff levels, or will there be increases in the number of certain staff?

Dr Woods: Each health board and region of the health service is currently preparing a workforce plan. We want to be sure that the planning that is going on in relation to waiting times is reflected in those workforce plans. In order to deliver the targets, it is necessary not only to increase the number of staff but to increase the capability of the existing workforce.

Mr Welsh: You say that there are plans, but there is a difference between theory and practice. In one year and nine months' time, there has to be practice. What cost calculations have been done by the department to meet the new targets? What resource studies have been done to ensure that you can deliver them?

Dr Woods: In planning our budgets, we think carefully about the additional pressures that the service will face. We set that out in the budget book. The more detailed planning takes place locally, in the context of local delivery plans. In the next few weeks, we will examine those local delivery plans, which will include specific financial investment proposals, to ensure that we can—across the NHS—meet the case load and

workload targets that are set out in them through the financial resources that are allocated. It is the principal responsibility of the boards to achieve a balance between capacity planning and the use of financial resources.

Mr Welsh: I understand the complexity, but there are cases in which the initial estimates of finances have been wildly out and have had to be revised and further revised. I seek reassurance that the costings will produce what we all want to see.

Dr Woods: I was not present for the earlier item, but I assume that you are referring to some of the costings for the consultant contract.

Mr Welsh: And other instances.

Dr Woods: Leaving that to one side, I would say that we need greater precision in the costing of the work that we do. We attach a lot of significance to that. We need to keep the balance between the pressures on the service and the resources that are available under continuous review. My colleagues may want to say a little more about how that can be done in the context of local delivery plans and capacity planning for waiting times.

John Connaghan (Scottish Executive Health Department): I will pick up on two points. Kevin Woods spoke about capability, demand and capacity planning. I would like to add to what he said by mentioning our redesign work. It is a question not simply of having more staff but of handling the work more efficiently and effectively. One example is one-stop clinics: instead of having to make several visits, patients make only one visit to hospital to have a number of things done. Well over 500 one-stop clinics have been established in Scotland.

I would also like to make a point about resources. A little over a year ago, the Executive published "Fair to All, Personal to Each", which lays out the plans up to the end of 2007. Those plans include many of our financial calculations for resource requirements. The document shows the financial trails for the targets, linking them back to the budgets. For example, sums of money are laid aside for the independent sector and for supporting the NHS as part of the drive to reduce waiting times to no more than 18 weeks.

Mr Welsh: We have an enormous range of things to cover so we will move on.

You have said that the number of people with ASCs is down. How exactly are the numbers recorded and monitored? How does the relationship between the boards and central Government work to follow the figures?

Dr Woods: The recording of availability status codes is done at local level as a result of the interaction between patients and the service. There are different categories of ASCs. Some codes relate to patient unavailability. They might include patients who did not turn up, or they might include patients who required a very rare, complex and difficult operation for which resources throughout the whole of the United Kingdom were very limited.

In all cases, an assessment is made—clearly, in the case of someone who has not turned up, the assessment is pretty straightforward. A code is attached to the person that exempts them from the guarantee. We have detailed guidance on the application of ASCs and we expect boards to use it. Committee members may be aware that in the most recent annual review round, which the minister conducted in the summer, we took great care to check with boards that they were applying ASCs in accordance with the guidance. I think that the guidance was issued in March 2005. We were assured by the chair of every board that they were applying the codes in accordance with the guidance. That is what we expect throughout the NHS. However, it is intended to phase out the codes and do away with them, and I have described how we plan to do that.

The Convener: The report showed that the number of people with ASCs increased by 24 per cent between June 2003 and September 2005. At the end of December 2005, ASCs accounted for just short of 35,000 people waiting for care. You have explained to us how the figures have now come down; perhaps you could tell us where we are now, in relation to the figures that I have mentioned. The evidence is that ASCs are not being used inappropriately, which is encouraging. The committee is not challenging their use or suggesting that they are being misapplied. However, we are curious as to why the figure increased. The answer to that might also suggest how you have been able to reduce the figure.

Dr Woods: There are two principal reasons why the figure increased—although we must bear in mind that multiple decisions are made across the NHS in relation to individual patients on these codes. One reason is the transition from the previous counting method—which was, I think, called a deferred list.

The other reason is that we have been removing a backlog and we have been seeing a lot of people in that way. When people are seen as out-patients, some co-existing illness that makes them unfit for treatment might be found, or the consultant might judge that they would benefit from additional therapy of some sort.

Those are two of the principal reasons. John Connaghan might have other facts and Bob Masterton might have something in his local experience that might add to that.

Dr Bob Masterton (Ayrshire and Arran NHS Board): I do not but, to confirm what Kevin Woods said, it is inevitable that doing a great deal more out-patient work not only puts patients on to the active waiting lists but increases the number of patients with ASCs. That was certainly one of the biggest drivers for change in my area.

The Convener: If you are able to tell us the nature of the change—the reduction in the number of patients with ASCs—that would be useful.

Dr Woods: Excuse me, do you mean the individual categories?

The Convener: No, I was talking about the global total.

Dr Woods: I will give you the up-to-date figures, if you like. My understanding is that the total waiting list in Scotland at the end of December was 108,548 and the number of people with ASCs was, rounding up, 35,000. Therefore, the number of people waiting with guarantees at the end of December was 73,571, which is lower than the 2002 target, which is the old target on waiting lists.

The Convener: It would be useful if we could have those figures broken down by board in writing, if that information is available.

Dr Woods: We would be happy to provide that. In fact, we have already published all those figures, so there is no difficulty with that.

The Convener: You have received the plans on abolishing ASCs from the boards but, given that there was an increase in their use—albeit that you have explained that that is now turning round—the situation seems to fluctuate. Can you be confident that they will be abolished on time?

Dr Woods: Yes, we are confident that that will be achieved. However, you are right that there is bound to be some fluctuation. That is because patients are being seen all the time and because the use of ASCs depends on individual circumstances and the individual clinical conditions that patients have.

As we described, we are putting in place in each board area a phase-out plan, which is intended to move us on. The two matters on which we need to make most progress are low-priority clinical conditions and the more complex cases. We have detailed revised guidance on how people who do not or cannot attend will be dealt with after December 2007. It explains how we will manage those patients by resetting the clock in some instances and referring patients back to their general practioners if they do not attend.

Those are all components of the phasing out of ASCs. We would be happy to let you have a note of the guidance or to elaborate on it now.

The Convener: You have anticipated my next question.

Dr Woods: I am sorry.

The Convener: No, that is fine. We would prefer to have the guidance in written form. That would be useful.

Dr Woods: It is very detailed.

The Convener: I rather suspected that, which is why I would prefer to have it in writing. We would like to take a look at it.

Before we move on to questions on the Golden Jubilee national hospital, do any other members have any points on the first section of questions? We will certainly have more questions for Dr Woods and his team later.

Mrs Mulligan: Dr Woods referred to the health boards preparing workforce plans. When will the plans be complete?

Dr Woods: We have received drafts of the regional plans and we are due to receive drafts of the individual board plans shortly. We want the definitive versions of the plans by, I think, September.

The Convener: Good. We will now have questions on the Golden Jubilee national hospital and its role in helping to satisfy waiting times targets. Mary Mulligan will start.

10:45

Mrs Mulligan: I suspect that my questions are probably best directed to Ms Young. However, I heard what Dr Woods said in his opening statement about activity increasing at the Golden Jubilee. Our information is that the activity was not as planned as it could have been. Can you tell us why that was the case?

Dr Woods: I am happy to say something, but I am equally happy to hand the question over to someone else. Who would you prefer to answer?

Mrs Mulligan: Whoever can give me the answer.

Dr Woods: I will let Jill Young do that, as I have said a lot.

Jill Young (Golden Jubilee National Hospital): As has been said, we have exceeded our targets. We are relatively new to the NHS family and are just coming into our fourth year. We are heading towards having done 63,500 procedures in our hospital since we became an NHS facility. All that activity is planned a year in advance.

We believe that our great strength is our flexibility to change the services that we offer at short notice to help boards when, for numerous reasons, they have peaks of demand. However, we must balance that carefully with the more

complex cases for which we must have much longer planning—for example, orthopaedic procedures such as joint replacements, and heart and lung surgery. There is a fine balance therefore between forward planning and flexibility. A year in advance, the activity and the breakdown of specialties are agreed with the boards. However, to be flexible, we work on a month-to-month basis and sometimes week to week for less complex procedures.

Mrs Mulligan: However, there seem to have been a number of cancellations by health boards. Why do you think that was? How do you respond to that?

Jill Young: We monitor our cancellations carefully to improve the services and to learn. We work closely with all the boards, but we do so particularly with the west of Scotland regional planning group, on which all the boards in that region are represented. The cancellations are made for numerous reasons. We have a breakdown of the ASCs, which we can share with you if that would be useful.

In the most recent nine-month period, we found that no patients cancelled because of short notice and few commented on the transport issues that had arisen, because we can accommodate those. We have been working with boards to try to complement local services. There has been major investment in the NHS around the country and we do not want to duplicate developments in local regions.

We have recently implemented various activities to try to reduce cancellations and increase our activity. One is a GP direct access pilot for dual energy X-ray absorptiometry—DEXA—scanning, which is related to the orthopaedic and osteoporosis service. We are doing a see-and-treat, one-stop clinic at the hospital in which there is out-patient and in-patient treatment and diagnostic care as a single package. We are also doing that in ophthalmology for cataracts. We are also about to implement a consultant podiatrist service, which is a first for Scotland. That will involve an extended role for the allied health professions. Numerous redesign projects are going on to increase activity and make best use of our capacity.

Mrs Mulligan: I appreciate what you said about the reasons why people did not cancel, but it would be helpful for the committee to see your breakdown of why people cancelled. What would you say was the main reason for cancellations?

Jill Young: I am not sure whether one reason stands out in isolation. There is perhaps a spread of about four or five reasons. On some occasions, the patient decides to accept an offer that they received locally. Patients get numerous offers; we are only one of the options for care. Perhaps after getting our offer, the patient decides that they would rather wait. Capacity is sometimes made available locally, so the local hospital can make an offer to patients. We would be informed of that and would then seek to substitute other patients for the activity. The numbers of cancellations therefore are broken down evenly over about three or four categories.

Mrs Mulligan: I see from the figures that capacity was never reached. Was that planned? If so, what is your safety margin?

Jill Young: Capacity has been exceeded year on year. All our activity targets have been exceeded every year since we became part of the NHS, although the specialties within those targets have changed. For example, we plan for X number of heart bypass operations a year in advance, at which point those patients are not in the system. Six months into the year, the board may realise that it does not require the number that it had booked and may change those planned operations into orthopaedic or other operations. There is a difference between the planned specialties and what is delivered.

Mrs Mulligan: If planned patient numbers and the mix of procedures are not realised this year, will the effect on costs and income be difficult for you? How would you respond to that?

Jill Young: We are on target for the current year, 2005-06. I can assure you that we expect to meet the target for the current year of 26,000 procedures being carried out. Those procedures are all planned in great detail. We have what we call our booking office, which is also known as a management referral centre. It has a robust, tight management team, which is in daily contact with every hospital and board that refers patients to us. As soon as we know that there might be a cancellation or that a patient cannot take up their appointment for some reason, the team immediately contacts the hospital or another board to see whether other patients are willing to take that slot. Within days, we can turn that round and fill the slot.

Dr Woods: It is entirely right that we should get the advance planning as good as possible. Increasingly, we are doing some of that capacity planning regionally. I do not know whether Dr Masterton wants to say a bit about what is going on in the west of Scotland in that regard, but capacity planning is an important component. Case study 5 in the Auditor General's report helpfully sets out the Forth Valley NHS Board example. We see such arrangements in many parts of Scotland; they are not limited to Forth Valley. However, if people are going to be offered the opportunity of treatment at the Golden Jubilee, that is a good example of the work that can be done locally to ensure a smooth transition.

Dr Masterton: To pick up Jill Young's point about why patients sometimes do not come to the Golden Jubilee, it is about patient choice. As waiting times have got shorter, patients have become happier to wait another couple of weeks to have a procedure performed nearer home. In addition, the planning that Kevin Woods spoke about invariably leads to increased capacity nearer patients' homes. I am part of the regional planning group that Jill Young mentioned—we work closely. An additional element that the Golden Jubilee provides for us, which has not been touched on yet, is flexibility. From time to time, as a result of consultant illness or for some other reason, such as someone retiring, we are unable to perform procedures that we had intended to do locally. The Golden Jubilee offers us flexibility. It is a significant comfort to us to know that we can have that flexibility. We need to build it into the planning.

Jill Young: The first task in the work programme of the west of Scotland regional planning group, which I chair, is a west of Scotland demand and capacity plan, to which all the boards are contributing.

Eleanor Scott: From exhibit 20 in the Audit Scotland report, it is clear that use of the Golden Jubilee hospital varies considerably between health boards and that such use is becoming increasingly variable. What are the reasons for that? In particular, what are the reasons for that increase in variability?

Dr Woods: Currently, boards in Highland, Grampian and Tayside are able to meet their waiting times targets with more local resources. Our aim is to try to provide patients with the opportunity to be treated locally, if at all possible. The more demanding targets that we are setting, however, might mean that that is increasingly not possible in the future and that more use of the Golden Jubilee might be required. That is also why we are planning for an additional treatment centre at Stracathro.

Eleanor Scott: Has there been research or discussion with boards about that?

Dr Woods: Yes.

Eleanor Scott: Boards might be concerned about the effect on local capacity of using the Golden Jubilee. What is the risk to boards of a loss of local capacity as a result of increased use of the Golden Jubilee?

Dr Woods: I ask Mr Connaghan to answer that question.

John Connaghan: It might be best if I explain how we construct the annual plan for the Golden Jubilee. Around the start of the calendar year, we ask boards to advise both the national waiting times unit and the Golden Jubilee of their requirements a year in advance. We then match that to the available capacity in the Golden Jubilee—it is very much a bottom-up plan.

In asking for access to the Jubilee, boards give consideration to their particular pressure points. The idea behind the plan is flexibility. One year, Lanarkshire might require a lot of general surgery, but the next year, it might require more in the way of orthopaedics because of the circumstances that Dr Masterton outlined. I reassure members that we use a bottom-up rather than a top-down plan that takes account of local pressures and capacity issues.

Mr Welsh: If I am right, it was stated earlier that capacity is exceeded every year. I thought that your system was subject to peaks and troughs and then we heard that, because of the new system with its new targets, there will be more patients in the future. If your capacity is exceeded every year, you are subject to peaks and troughs and you are going to get more patients, how does that all add up?

Dr Woods: What I was trying to say is that, in the current planning context that John Connaghan described, we are exceeding the activity targets at the Golden Jubilee hospital. The three boards to which I referred have not had to use much of the resource of the Golden Jubilee to deliver the existing targets, but as we move to 18-week targets, embedded in which is a nine-week diagnostic target, those boards have said in discussions with us that they would value having access to additional capacity at the Stracathro development. That is what I was trying to explain—I am sorry if I did not quite capture it for you.

Mr Welsh: Those are targets, as opposed to capacity.

Dr Woods: Yes, but the activity target implies a throughput rate, which requires a degree of capacity. That is factored into the planning that John Connaghan described.

The Convener: It appears that costs at the Golden Jubilee are relatively high compared with those at other hospitals. We are aware from the report that concerns about unused space are being tackled; there are cost concerns about the way in which doctors are paid; and as a result of the case mix here, many of the procedures that are undertaken are of the more expensive type. What more can be done to reduce costs at the Golden Jubilee so that the comparison with other facilities is more favourable? Is there a role for other boards and, indeed, the Health Department in helping to bring down those costs, rather than the Jubilee hospital doing that on its own?

11:00

Dr Woods: The key data in that regard are set out in exhibit 19, which shows that the principal factor is the overhead cost. That is a function of the fact that we have acquired a whole building and are progressively filling it up with new clinical services.

You will be aware of our intention to bring to the Golden Jubilee hospital the west of Scotland cardiothoracic centre. When the centre comes here, it will occupy the currently unused space in the building and provide for Scotland—the west of Scotland in particular—a world-class, state-of-the-art, cardiothoracic facility. We are faced with a terrific opportunity. The cost of that space is included in the overhead costs in exhibit 19. When the centre is operational, we would expect the cost profile to adjust.

The Convener: Would you characterise that adjustment as dramatic? Are you expecting there to be a significant change?

Dr Woods: Yes, because we would be dealing with high-value complex cardiothoracic cases.

Another factor stands out. We have just done an analysis of the case-mix complexity in the hospital. The Golden Jubilee hospital has a complex case mix. A great deal of the elective orthopaedic work that is done is major joint surgery, which also skews that cost.

Those are the two particularly important components in the cost profile.

Jill Young: The level of complexity in orthopaedics is high. Some 68 per cent of our total orthopaedic work is hip and knee replacements, which have the highest cost of any orthopaedic work. In addition, we have no accident and emergency department, which means that we tend not to deal with the more minor procedures, such as sprains and the application of plasters. Such work tends to bring down the average costs in other departments.

A complete level in the ward area, as well as six to eight theatres and 48 intensive care unit bays, are being prepared for the cardiothoracic centre. Once that facility is in place, there will be a significant reduction in the overhead costs.

The Convener: Have you encountered any reluctance from health boards to place with you work that would enable you to reduce your costs by increasing your productivity?

Jill Young: We currently meet—indeed, exceed—our activity capacity. There is no such reluctance on the part of health boards. We constantly strive to do more and to push the boundaries, which is why we work with boards to find out whether we can do things differently, such as redesigning services or offering alternative services. The overall position depends on the specialties that are involved because, in a session, we could do either two hip replacements or five or six cataracts. We have an agreement with the boards with regard to demand. That enables us to push the activity further.

The Convener: Your capacity is met, but it would appear that boards are able to fill in the capacity by picking up the slack where gaps fall. Are there any examples of boards not taking up the capacity that was planned, which would mean that your capacity is being met by other boards who favour giving you the work?

Jill Young: I am not sure that I could give you specific examples without referring back to the detailed information. If, a year in advance, a board cannot use the capacity in a specialty—say, cardiac—we go back to that board to fill that capacity with another specialty. Only if the board could not take up that capacity would we offer it to other boards.

The Convener: Is your ability to plan your capacity governed by the willingness of boards to work with you?

Jill Young: No.

Dr Woods: To contextualise the data that are shown in exhibit 19, which relates to how the case mix affects the cost of orthopaedic surgery, it might be helpful to the committee to know that the tariff price for a hip replacement is £6,759; for a knee replacement, it is £7,545. You can see that, if a disproportionate number of those operations are being done, that is bound to have an impact on the cost profile.

The Convener: We heard from Dr Masterton about the flexibility that the Golden Jubilee offers and from Mr Connaghan about how its planning is bottom up, not top down. One can see the efforts that are being made with regard to forward planning. Jill Young described how the hospital is able to respond on a month-to-month and week-to-week basis. As a national facility, it seems to provide what one might describe as a useful safety valve. For a variety of reasons, the hospital offers other boards flexibility when they are planning to bring down their waiting times. Is it fair to say that it provides that useful service?

Dr Woods: I am hesitating about the use of the term “safety valve”. The hospital provides us with flexibility and additional capacity for certain things. As I said in the context of capacity planning, we are trying to position the hospital in an overall context, so that we can get a close match between what we anticipate we need to do and actual needs, and therefore make best use of it. The term “safety valve” is perhaps a slightly pejorative way of describing what we are trying to do. We want a facility that is flexible.

The Convener: I certainly did not mean my phrasing to be pejorative, but I had a reason for choosing that soundbite. What might the future role of the Golden Jubilee hospital be, once it has delivered an effective solution to the difficulties that boards have had in the past with waiting times?

Dr Woods: That is the point at which I was driving. Clearly, the hospital will be a major centre of excellence for cardiothoracic work. It will undoubtedly have a continuing role in relation to orthopaedics, general surgery and ophthalmology, partly as a function of the fact that, with an aging population, there will be an increasing requirement for such surgery. Beyond the flexibility that the hospital provides in other specialties, it will have an important role in relation to diagnostics. In recent times, there has been major investment at the hospital in imaging, for which we have excellent facilities. Increasing our capacity around diagnostic imaging and so on is an important component of our overall approach to delivering on the nine-week diagnostic targets that we have set. John Connaghan or Jill Young may want to elaborate on that point.

John Connaghan: Dr Woods has said the very things that I intended to say. I will re-emphasise one point. The investment at the Golden Jubilee in areas such as orthopaedics and ophthalmology is designed to keep track of where we consider the greatest pressures will be in future years. We have an aging population and anticipate that there will be growth in demand for knee replacements, rather than hip replacements—that is a European trend. In the detailed modelling that boards and departments have done in relation to the delivery of future targets, we recognise that an element of non-recurring as well as recurring capacity is required. It is fair to say that, for the west of Scotland and beyond, the Golden Jubilee provides a significant proportion of recurring capacity.

Mr Welsh: Surely that will have knock-on effects on health boards. What is the thinking about the future relationship between the Golden Jubilee hospital, as services develop, and health boards elsewhere in the country? In other words, what are the effects on the overall system?

Dr Woods: The circle is squared by regional capacity planning, which we are doing at the moment.

Mr Welsh: What does that mean?

Dr Woods: We must think about the capacity that we have here in the context of the capacity that exists in individual boards. As John Connaghan described, we must work from the bottom up, decide what can be done in local capacity, what may need to be done at the Golden Jubilee hospital and what small amount of work may need, on occasion, to be done in the private sector. That perspective must be anchored in local analyses of trends in demand and an understanding of capacity.

Dr Masterton: As part of our regional planning, we are evolving ways in which local boards, in particular, work with the Golden Jubilee. Flexibility has been a key element of the Golden Jubilee's provision, but we are working to highlight the importance of sustainability and the need to continue to achieve the targets. The issues that Mr Welsh has raised are not sources of tension in our discussions with the Golden Jubilee. After all, NHS Ayrshire and Arran could never provide a cardiothoracic centre by itself. Such a facility is needed, and because we want the best that we can get for our patients, the centre will be based here. Similarly, additional elective orthopaedic activity and cataract work are not points of tension, but aspects of NHS's on-going capacity planning.

Eleanor Scott: Before we leave exhibit 19, will you tell me why your medical staff costs are about twice the Scottish average?

Dr Woods: Jill Young or Dr Ferguson might wish to elaborate on the matter, but I should point out that those costs partly reflect the hospital's transition from a reliance on visiting consultants to having a more stable and permanent workforce.

Jill Young: Our medical staff costs have fallen quite significantly since the period that is covered in the report. For example, at that time, we employed only one orthopaedic consultant and had to depend on visiting consultants, who cost more. We now have four orthopaedic consultants and all the work is done under standard pay terms and conditions. We are looking to recruit our own consultants in general surgery and ophthalmology this year. Moreover, when the cardiac unit transfers, all the medical staff will already be in place.

Dr Kenneth Ferguson (Golden Jubilee National Hospital): The issue is linked to capacity planning and service sustainability; after all, to be able to recruit consultants, we need some sustainability. Because we are now linked into that, we will be able to reduce costs significantly.

Mr Welsh: Sustainability and recruitment are issues everywhere. The west of Scotland has been mentioned quite a few times in that regard, but surely Highland, Tayside and Grampian face the same problems. Have you thought through any knock-on consequences? Where is the system going?

Dr Ferguson: Since the NHS took over the hospital, we have recruited 10 full-time equivalents, only one of whom has come from an existing NHS consultant post in Scotland. The rest have either come from outwith Scotland or were

not in those posts. As a result, we have introduced some additionality to the consultant resource. We are very much committed to that approach and to linking in with proper regional and national workforce planning and the department's projects in that respect.

The Convener: I thank the witnesses for answering those questions on the Golden Jubilee hospital. We now move on to discuss the issue of involving patients in the decision process.

Margaret Smith: Bob Masterton mentioned patient choice, which forms an important aspect of the committee's examination of the Audit Scotland report. That report seems to suggest that NHS boards believe that patients are unwilling to travel for treatment; indeed, it says that only 5 per cent of people are asked whether they want to do so. However, according to the patient survey, under the right circumstances, patients would be willing to travel—sometimes considerable distances—to alternative hospitals to reduce their waiting times. Obviously, your use of the Golden Jubilee is an attempt to pick up on that, although the report suggests that you have not quite got things right. Perhaps a number of patients have not been asked and their views remain untapped.

What are your views on the suggestion that consultants and boards might not want to raise with patients the possibility of travelling to alternative hospitals because of concerns that, after treatment has been carried out in a hospital such as the Golden Jubilee—which might well be 100 miles or more from where the patient lives—there might be problems with the provision of on-going patient care?

11:15

Dr Woods: You raise several interesting points. I agree that patients are prepared to travel to receive treatment if they can receive it more quickly, but they prefer—understandably—to be treated locally if possible. Our approach is intended to ensure that local treatment can be offered, whenever possible.

I am not sure whether Audit Scotland's report includes the fact that a quarter of those who were interviewed for an NHS user survey had actively discussed the choice of location for treatment with their GP. The most important discussion that needs to take place is with the GP. The waiting times database is available on the web to all general practitioners, who can refer a patient when they think that doing so is in their patient's best interests. The database sets out for all specialties and all consultants the maximum out-patient and in-patient waiting times. That information is important to helping with all those discussions.

I understand your question whether a separation or discontinuity of care might exist, which would be unhelpful. The evidence suggests that that is not a problem. Moreover, the other important dimension to choice is the need to offer services that are tailored to individual circumstances. We are trying to do that through the work that we are doing on our referral information services, our referral management services and patient-focused booking, which is described in the report. That is all very important. In our planned care improvement programme, which will be launched later this year, all that will be central to what we are trying to achieve.

I do not want to lose the point about continuity. I ask Dr Masterton to add to what I have said.

Dr Masterton: I will pick up on two points about continuity of care. A pathway of care operates when we send patients elsewhere—they start and end with us. We do pre-operative investigations. If a patient goes for theatre or a diagnostic intervention, that goes into the notes, wherever the relevant board is. That is part of a pathway and a continuum.

We are used to working in that way. Clinically, we have worked safely in that way for many years. We have always referred patients out of our board areas for other treatments. Where I work, a significant number of our patients go to greater Glasgow for cancer care, for example. That is the normal way of working.

When we send patients to another organisation—whether it is the Golden Jubilee hospital or the independent sector—we are always careful to be sure that its clinical governance arrangements and structures are at least the equal of those in the NHS. Communication and patient communication are part of those arrangements.

I return to your initial comment about discussing choice with patients. I was surprised when I read the statistic about that in the report, because in my experience, we talk to patients when we seek to refer them to other centres. Patients are offered choice. I was surprised by the figure and I wonder whether it might have changed as our ways of working have changed. We have the new definitions to which Kevin Woods spoke; we speak to people about why they could not or did not go to an appointment; and we have the new booking processes for where and when out-patient appointments will take place. Much more is going on than the report reflects.

Margaret Smith: The statistic that nearly half of all the patients who had been surveyed felt that they had not been involved in the decision about their treatment surprised as well as disappointed committee members. What came through from the report was a sense that there were not common standards for patient involvement in decisions of that kind. Some patients are getting access—at

board level or at GP level—to more involvement in such discussions and decisions than patients in other parts of the country are. What exactly are you doing to introduce some kind of standard to ensure that patients will have that involvement in future?

John Connaghan: We have already published two things. You have asked for the guidance that we published on ASCs, and in one of the sections of that—in appendix A—there is a page that deals with what is a reasonable offer of appointments and admission. It lays down some pretty clear, patient-focused guidance. Also, about three years ago—I cannot remember the exact publication date—we published a guide to good waiting times practice, from the national waiting times unit, which laid out some guidance on how patients should engage with their general practitioners. That guide has been followed up since by one or two Health Department letters, as I recall, that dealt with that territory. There is guidance to boards, and we expect them to follow that.

Margaret Smith: Given what is in the Audit Scotland report, I presume that you will be taking up the issue with boards to ensure that they make use of such guidance in future.

I want to pick up on one other small point. Mr Connaghan has touched on what the NHS views as being a reasonable offer of treatment and we considered whether there is an element of compulsion on the patient to take treatment. For example, if they are offered treatment at the Golden Jubilee hospital but turn it down, will they then lose their guarantee of treatment? What truth is there in that sort of fear?

Dr Woods: The first thing that I would say is that we are not about compulsion at all; we are about trying to meet patient needs, which we think are best discussed by the patient and the referrer, who is usually the general practitioner. We can provide information to help with that, but skilled interpretation in the light of individual circumstances is extremely important. As we make the transition from availability status codes to the new ways definitions, we are setting out clearly what we expect of boards in the offers that they make to patients. That is quite detailed, and I will ask John Connaghan to outline our note briefly for you, because I think that it will give you the reassurance that you seek. We will be glad to let the committee have a note of that, because we want to ensure that people are given reasonable offers that they have a reasonable chance of fulfilling, without any sense of compulsion at all.

John Connaghan: As I said, the committee will receive a copy of the note, which was issued to the service in March last year. I will read out two sections that may clarify the matter. The document begins with the question of what is a reasonable offer of an appointment, and states that

> "the patient should be offered a minimum of three dates all of which should be at least three weeks in advance",

so that they have time to digest the information and have a range of dates to consider.

The other quotation, which I hope will answer your question, is as follows:

> "declining a short notice offer would not result in any detriment to the patient as this will not be considered a reasonable offer".

It would not be a question of saying, "You have to come in tomorrow or that's it." There must be a degree of flexibility. I hope that, when you read the guidance, you will accept that it is written to protect patients and patients' rights.

Margaret Smith: When patients have come to the Golden Jubilee hospital from other parts of the country, particularly when they have had the full package of decision making and travel as well as receiving treatment, what do you do to monitor feedback on their experience?

Jill Young: We continuously monitor patients' experience. In the most recent patient satisfaction survey, 3,295 forms were returned by patients who had been treated at the hospital over the past year. The responses revealed that 100 per cent would recommend family, friends and other colleagues to have their treatment at the hospital and 99.8 per cent were absolutely delighted and satisfied with the care that they received.

The only transport and accommodation issue was the signage in the local community to enable people to find us. We have worked with the council and all the signage has now been renewed. We are delighted and reassured by the survey.

Margaret Smith: I put on record that Ms Young did not know that I was going to ask her that question.

The Convener: We can also put on record the fact that we found the hospital easily.

Susan Deacon: I noticed that one sign still has the fateful letters HCI on it, but we will move on swiftly.

Dr Woods: It is a heritage sign.

Susan Deacon: I am struck—

The Convener: Good, there is a question.

Susan Deacon: Give me credit. That was not the point that I intended to make.

I am struck by the numerous references to a range of interesting information about customer satisfaction with the Golden Jubilee hospital's practices on admissions, bookings and so on. References have been made to innovations, service redesign and flexibility, which has been mentioned repeatedly. I feel bound to ask Kevin

Woods whether there is any indication that the Golden Jubilee hospital has been able to be more creative and innovative and has perhaps developed higher levels of customer service—if I can put it in those terms—than has been possible in some more traditional settings within the NHS? If that is the case, can any lessons be learned?

Dr Woods: First, it will be evident to the committee that we are in a state-of-the-art facility. There is bound to be some connection between the quality of the care environment and how people feel about it. Members know about the various things that we are trying to do across the NHS to improve the service.

Secondly, it helps that we make special efforts. The example that the report gives from Forth Valley of the dialogue in relation to people who come to the Golden Jubilee hospital is a good one. Jill Young can elaborate on the special transport arrangements that we make: we provide a minibus service. When people come to the hospital, their relatives have the opportunity to stay in the Beardmore Conference Hotel. That is clearly an attractive package.

In addition to the excellence of the clinical treatment, some features underpin the service that we aim to provide at the Golden Jubilee hospital. Jill Young might want to talk about the transport arrangements.

The Convener: I know that Andrew Welsh wants to make a point, but we must move on to address the whole-system approach. We have quite a few points, so we will have to discipline ourselves and put our questions briefly.

Eleanor Scott: I have a general introductory question about the issue. We all sign up to the whole-system approach, but the feeling is that such an approach has not been taken. The initiatives so far have tackled symptoms such as waiting times; they have not examined the system as a whole and addressed the needs across the system. What is being done to move towards a whole-system approach?

Dr Woods: As I indicated at the beginning—forgive me if I am repeating myself, but it bears repetition—"Delivering for Health" is essentially about adopting a whole-system approach to the management of the health needs that we have in Scotland. I will not rehearse all the features of "Delivering for Health", but we believe that it is important to invest in primary and community health services and to develop more anticipatory care services to avoid, if at all possible, demand for hospital admission. After all, although the Golden Jubilee hospital generates a high level of satisfaction, most people do not want to be admitted to a hospital—they would much rather receive their care somewhere else.

Associated with "Delivering for Health", we have set out a clear programme of action that we want to take. We seek deliberately to separate the management of emergency and unscheduled care from the management of planned care, to ensure that we get a better flow of patients. We want to make day-case surgery the norm and ensure that we get continuity in patient care from start to finish, as Dr Masterton described.

A more specific point about the whole-system approach is that we are trying to develop a range of services that do not necessarily require people to be referred to a consultant in the first place. The Audit Scotland report contains the example of an e-mail system for dermatology services in, I think, Lanarkshire, which is a good way of managing demand. The direction of travel is clear, although we need to do more work. I mentioned earlier the work that we are doing on referral management services and patient-focused booking. We are taking a range of measures that add up to a whole-system approach to the management of flows across the system, a notion that is described in the rather complex diagram that I showed the committee earlier.

11:30

Mrs Mulligan: I have further questions about the whole-system approach. I genuinely congratulate everybody who was involved in reaching the targets for the end of December 2005, which was an achievement. We have invested a lot in dealing with waiting times, particularly the long waits, and the numbers have now dropped, although people are still waiting. How does the Health Department aim to move from simply providing funds to reduce waiting times, to funding delivery of the service?

Dr Woods: In answer, I may well go over ground that I covered earlier. The issue comes back to understanding the case load that we expect to arise in particular places and building up capacity plans from that. We then need to be clear about the contribution that local services, the Golden Jubilee hospital and, if necessary, the private sector will make. Within that, we are trying to shift the balance in our health care system even more towards non-hospital settings. If, instead of a consultant appointment, we can provide an appointment with another appropriate member of staff—I mentioned earlier the example of a podiatrist—that is highly desirable, especially if it is in a community setting. That is the direction in which we want to go. Over a period, we are trying to shift investment in that direction to support such models of care. That will not happen instantly overnight; it will have to be worked at for a long period.

Mrs Mulligan: It could be argued that continuing to fund boards that cannot treat people locally, even though it is often people's preference to be treated locally, as you said, compensates—I had "bails out" in my first jot—boards that do not redesign as quickly as possible. How do you encourage boards to redesign so that they do not have the sort of demand that produces difficulties with which the Golden Jubilee has to deal?

Dr Woods: In the redesign work, we have adopted a collaborative approach that includes everybody—large numbers of people are involved. For instance, the diagnostic redesign work will reach into all kinds of places. However, particular circumstances sometimes arise for boards. A recruitment difficulty might make a service less available than the board thought it might be, in which case the Golden Jubilee might need to be used. It would not be appropriate to penalise a board in that situation.

However, if performance in a local health system is not in line with the agreed plan and the agreed trajectory—we have built that into the local delivery plans that I talked about—we will intervene and be assertive in our dialogue about why that has happened. That is one of the reasons why we brought together the delivery group, which includes not only the existing performance management team and the financial performance people but the national waiting times unit and the centre for change and innovation.

We need and intend to identify local problems and to work with boards to address them. The term "performance trajectories" sounds a bit jargonistic, but they help us to identify how people are going to hit particular targets. We monitor the boards' performance and work closely with them to see whether they are on track. If necessary, we can deploy the resources that we are talking about and support them to get involved in faster redesign.

Mrs Mulligan: You said that the increase in services such as the cardiothoracic unit that will come to the Golden Jubilee will change the balance between responding and planning. Do you have a vision for the division of labour within the hospital? Should services be planned or should they be responsive to other issues in the system?

Dr Woods: The cardiothoracic work will be carefully planned and the major specialties of orthopaedics, general surgery and ophthalmology will be integrated into the capacity planning. However, there will always be circumstances somewhere—perhaps recruitment difficulties or the long-term sickness of a consultant—that cause the local capacity plan to be under pressure. In such cases, it might be easier to provide a replacement service at the Golden Jubilee using capacity that is brought in specially.

I acknowledge what you said about performance on waiting list targets and thank you for your recognition. As we get on top of the long waits, we will progressively move to 18 weeks. We will always need some capacity at the margins, but we are trying to move to a world in which there is careful planning and anticipation of demands so that we have capacity in the right places. That is our approach.

Mrs Mulligan: I think you said that the Health Department's contribution to the Golden Jubilee is about £74 million.

Dr Woods: The total budget is about £50 million. About 80 per cent of that comes from the Health Department.

Mrs Mulligan: I think you said that in the previous year there was £116 million, and that—

Dr Woods: That was the total spend on waiting times initiatives. It was not the budget for the Golden Jubilee.

Mrs Mulligan: Of that, about £74 million was recurring spending and about £44 million was non-recurring. Do you envisage that that balance will change?

Dr Woods: There will always be a need for recurring spending, but the precise split will vary from year to year. We are trying to get on top of the backlogs so that we do not need to use as much non-recurring resource to sort out problems. I would not like to predict precisely what the split will be, but we are moving towards using recurring resources for good advance planning of capacity and supply.

The Convener: Andrew Welsh has some questions on value for money

Mr Welsh: In seeking value for money, it is difficult to make financial comparisons between public and private providers. When will the 2005 NHS tariffs for Scotland and for England be published?

Dr Woods: As the tariff in England has recently been withdrawn because of a variety of problems with the coding and so on, I cannot give any answers about that. However, I can confirm that we have progressively introduced tariffs for orthopaedic and cardiac procedures in 2005-06 and we intend to continue to roll those out. We have information—which John Connaghan has just passed me—that compares, for some major joint replacements, the cost under our tariff with the private sector equivalent, which is what the question was about. As I mentioned earlier, the current draft tariff for a hip replacement is £6,759 under the NHS whereas the price in the Scottish independent sector in 2005-06 was £6,733. Thus, the two figures are about the same although the figure for the independent sector is slightly lower.

For knee replacements, our tariff figure is £7,545 whereas the independent hospital price is £7,425. For cataracts, our tariff is £1,087 whereas the independent hospital price is £1,600.

Obviously, the independent sector prices for spot price purchases are significantly more expensive than the numbers that I have quoted. Over the past three years, our moves away from spot purchasing towards planned purchasing have brought down prices in the independent sector towards Scottish tariff prices. We have been quite successful in doing that.

Mr Welsh: Can we be given those figures?

Dr Woods: We will be happy to provide a note on those if that would be helpful.

The Convener: That will be excellent. Susan Deacon has some questions on building in incentives.

Susan Deacon: All my questions relate to delivery and whole-system working, but I may move between the two issues.

I join colleagues in placing on record my recognition of the improvements and developments that have taken place in the NHS. It is important to acknowledge the amount of work that has taken place throughout Scotland. However, many of us around the table, if not all of us, want to get to the heart of how the pace of change has accelerated and whether that change is—to repeat a word that has been used frequently today—sustainable. I would like more information on that.

Promoting whole-system working is—let us be honest about it—a bit like being against sin: everyone buys in to the concept in the sense that they say they agree with it, but delivering the reality is quite different. Although we have heard about increased numbers of one-stop clinics and a whole host of good practice—for example, the Audit Scotland report gives many case studies of how good practice stripped unnecessary referrals out of the system—how is the service ensuring that its approach does not just promote short-term, one-off initiatives, but becomes embedded in culture and practice?

I will pause to allow that question to be addressed before I follow it up with specific questions.

Dr Woods: I express thanks for those comments about the NHS's achievements. First, we have a tremendous asset in the vocation of NHS staff and their sense of commitment to the service, to their patients and to doing everything possible to reduce waiting times. Without that asset, our improvements would not have happened.

I do not want to repeat what I said about sustainability, but I highlight the importance of our approach to demand assessment. In our approach to redesign, we have sought to link the work of the centre for change and innovation to that of the waiting times unit and to our performance management approach, so that that is central to everything that is being done.

11:45

The committee has had concerns about how to take examples of good practice that have been developed in one place and move them to another. That occupies our minds too. About two weeks ago, we held a two-day event at the Scottish Exhibition and Conference Centre in Glasgow, at which we brought together people from throughout Scotland and put on show the innovations and changes that they are pursuing. It gave them the opportunity to describe those innovations and changes and to find out about new techniques for improvement. In the end, innovation is often about applying well-developed improvement techniques that are based on measurement that can be adopted in all kinds of settings for queue management and other matters. The event was a deliberate attempt to try to accelerate the rate of exchange.

At a national level, I have been trying, with colleagues in boards, to consider different approaches to performance improvement, such as the citistat project, which was developed in the United States. We are increasingly trying to bring people together and to share experience.

Susan Deacon: I apologise if I am interrupting, but it is simply because I am conscious of time and I do not want to be cut off. No one doubts that a great deal is being done to share knowledge, but events, dialogue and discussion of that nature have been going on for some time—the key is ensuring that they are translated into practice. I would welcome further comments from you on that. Some people will grasp the opportunities to learn from others—they will take the ball and run with it and apply the lessons in their area of service delivery—but others will not, so how can change be made to happen? You have mentioned Health Department letters and guidance, but they are not the same as having incentives, rewards or mechanisms to ensure that change happens.

I see that John Connaghan is itching to come in.

John Connaghan: The best way to answer such a question is to turn to what is happening in practice. The biggest redesign programme in Scotland in recent years is the out-patient programme, because it covers 1.2 million new out-patient attendances annually, as well as 33 major hospitals and a number of minor clinics. It is a

prime example of how good practice, innovation and redesign have become embedded in normal practice.

Most new out-patient appointments are now put through the patient-focused booking system, which means that the patients have a choice. There is a six-week cycle of appointments, so the patients know exactly where they are in the system and, for the first time, they have a significant degree of control over the date and time that they come into hospital. We all remember patients being told that they had to turn up at 3.30 pm on a certain day and that, if they did not turn up, they would lose their appointment, but the new patient-focused booking system is now the norm for handling appointments in Scotland. That is a prime example of a redesign project that started a couple of years ago and that has now been mainstreamed.

Susan Deacon: You mentioned the out-patient programme, so I will pursue it, as it is a good example to explore further. What I am about to say does not detract from the progress that has been made. Paragraph 101 of the Audit Scotland report tells us that the centre for change and innovation's capital expenditure budget on that programme was underspent, and that one of the main reasons for that was that boards said that they could not meet the future running costs of some of the projects that were proposed and, I presume, deemed to be desirable locally and nationally.

If I may, I will put the situation in simplistic terms. This is often how it feels for the public and possibly for those on all sides of the table. Substantial resources have been dedicated through the centre for change and innovation to targeted work to provide pump priming where necessary. The CCI provides help and support on how that can be done and on how working practices can be changed. Record increases in spend are going to local boards and—by the by, referring to other discussions—what might be called shed loads of money are being invested to increase the number of staff and the pay of staff in the NHS. In spite of all that, certain projects do not go ahead because somebody turns round and says, "Yeah, it would be good to do it, but we can't meet the running costs in the future." I appreciate that there will be specific reasons why some projects do not go ahead, but the question arises why, when all that machinery and investment is in place, certain developments do not move on and budgets are, ultimately, underspent. That must be a source of frustration for all concerned.

Dr Woods: I cannot say what the specific capital projects were, as I do not have that detailed information with me. The capital dimension of the CCI is comparatively small.

The point that I would draw out is different. Over the past 12 months, we have been trying to make a connection between improvement and the delivery of demanding performance targets. If we have an approach to improvement with which people are progressing because they are enthusiastic, interested, and so on, that will undoubtedly produce some results. If we have a performance management process that is chasing targets of one sort or another, that will also produce some improvement. We have said that we want those things to be brought together, so that we can draw off the investment in improvement into improved delivery. That is what John Connaghan's new group is intended to push hard. The vehicle for that—I am sorry if this is jargon—is what is set out in the local delivery plan. I know that it sounds like the sort of thing that management gets stuck in, but we need such pieces of machinery to effect the link. Our approach is to bring those things together, so that the delivery of targets and service improvement is underpinned by the very things that you have been talking about.

The difficulty with the question how we do that is that there is no simple, single answer—it has to be worked at continuously. The collaborative methodology is so powerful because it engages many people who are close to the action and who have ideas. Nevertheless, we also need measurement to underpin a lot of that, and that is an integral feature of all the collaborative work that we do.

Susan Deacon: I want to draw some of the strands together. The delivery group was mentioned, and the director of delivery is sitting in front of us. What will that position and that group add to the previous efforts and mechanisms to increase delivery? One mantra might be that delivery is everyone's job. What will that mechanism add to delivery? To what extent will it look outwith the boundaries of what we have been talking about today—the aspects of performance improvement and management that lie directly within the bounds of the Health Department—and consider things, such as training, that lie at the hand of others and that will bring about sustained culture change?

John Connaghan: I start my new life as a civil servant on 1 April, and I would be delighted to come back in six months' time to give you better reflections on that question. I will answer by setting out the ambitions of the delivery group, to which Kevin Woods alluded in his answer to the previous question.

I like to think that the total is more than the sum of the parts that we are putting into the delivery group. We have mentioned the national waiting times unit, which focuses more on the

mechanisms for treating patients, removing backlog and arranging capacity in the NHS, the Golden Jubilee and the independent sector. We have also mentioned the centre for change and innovation, which focuses on sustainability, redesign and new ways of working. Those elements, together with performance management, are not it for the delivery group. You have hit the nail on the head by saying that delivery is everyone's responsibility. We will seek to work with all directorates in the Scottish Executive, and to be there as support in the first instance for boards. We are also prepared to push the frontiers of performance, where we think that that is possible, by attempting to embed in all boards best practice that we identify through CCI.

The delivery group also has a role in reporting the performance that it observes to NHS boards and the Scottish Executive. We should say where we are currently and where we need to get to, and we should ask whether we are hitting the milestones that we need to hit. If we are not, we should work with boards to get back on track and to take whatever corrective action is needed. There is an interesting mix of disciplines. I am sure that we will evolve our working practices as we move forward.

Susan Deacon: On training and education, you did not mention links to the various professional bodies and to NHS Education for Scotland and so on.

John Connaghan: The best way for me to address that is to give you a good example, which was worked up jointly by CCI and the national waiting times unit, and which is connected to the delivery of one of our key targets—the diagnostic target. In our risk assessment of the target, we looked at endoscopy services. I believe that the committee has discussed those services in relation to colorectal and bowel cancer. We realised that we needed to provide a little more pump-priming funding to increase the number of non-doctor endoscopists—nurse and allied health professional endoscopists. We have constructed a programme with NHS Education for Scotland, funded by the national waiting times unit and CCI, to increase the number of endoscopists this year and in future years. That is a prime example of how we look not just at capacity but at redesign and new ways of working.

The Convener: As members have no further questions, I thank all the witnesses for coming through today or for hosting us. Thank you for your evidence, which was very useful. Our clerks will be in touch with you for follow-up information and to clarify which written material we would appreciate. At a future date, we will deliberate on our response to the Auditor General's report. Your evidence was helpful in enabling us to get behind some of the detail in it.

Dr Woods: I thank the convener and other committee members for their acknowledgement of the significant progress that NHS Scotland has made.

The Convener: I suspend the committee for five minutes to allow witnesses to leave. We will resume in private session.

11:59

Meeting suspended until 12:06 and thereafter continued in private until 12:31.

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

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, Scottish Parliament, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

Tuesday 4 April 2006

PRICES AND SUBSCRIPTION RATES

OFFICIAL REPORT daily editions

Single copies: £5.00
Meetings of the Parliament annual subscriptions: £350.00

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committees will be published on CD-ROM.

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Standing orders will be accepted at Document Supply.

Published in Edinburgh by Astron and available from:

Blackwell's Bookshop
53 South Bridge
Edinburgh EH1 1YS
0131 622 8222

Blackwell's Bookshops:
243-244 High Holborn
London WC1 7DZ
Tel 020 7831 9501

All trade orders for Scottish Parliament documents should be placed through Blackwell's Edinburgh

Blackwell's Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0131 622 8283 or
0131 622 8258

Fax orders
0131 557 8149

E-mail orders
business.edinburgh@blackwell.co.uk

Subscriptions & Standing Orders
business.edinburgh@blackwell.co.uk

RNID Typetalk calls welcome on
18001 0131 348 5412
Textphone 0845 270 0152

sp.info@scottish.parliament.uk

All documents are available on the Scottish Parliament website at:

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by Astron