AUDIT COMMITTEE

Tuesday 30 May 2006

Session 2

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AUDIT COMMITTEE
9th 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)
Russell Frith (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

Colin Baird (Scottish Executive Enterprise, Transport and Lifelong Learning Department)
Julie Burgess (Formerly Scottish Executive Health Department)
Tim Davison (NHS Lanarkshire)
Aileen McKechnie (Scottish Executive Enterprise, Transport and Lifelong Learning Department)
Mike Palmer (Formerly Scottish Executive Health Department)
George Reid (Scottish Executive Enterprise, Transport and Lifelong Learning Department)
Philip Rycroft (Scottish Executive Enterprise, Transport and Lifelong Learning Department)
Dr Charles Swainson (NHS Lothian)
Dr Kevin Woods (Scottish Executive Health Department and NHS Scotland)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Clare O'Neill

LOCATION

Committee Room 2

Scottish Parliament

Audit Committee

Tuesday 30 May 2006

[THE CONVENER *opened the meeting at 09:33*]

Items in Private

The Convener (Mr Brian Monteith): Good morning and welcome to the ninth meeting of the Audit Committee in 2006. I am pleased to welcome the Auditor General for Scotland and his team from Audit Scotland as well as members of the public and the witnesses who will give evidence later.

I remind everyone to switch off mobile phones and pagers not just because I do not want them to ring but because they interfere with the public address system when they are switched on. I ask members of the public to check that any such devices are switched off.

We have apologies from Andrew Welsh, who is unable to make today's meeting. Susan Deacon has also apologised because she will be absent for part of today's meeting.

We have a busy schedule today, with two evidence sessions, a briefing from the Auditor General and consideration of some draft reports. Agenda item 1 is to consider whether to take items 5, 6 and 7 in private. Item 5 is to consider the evidence that is taken for items 3 and 4 concerning the section 22 report on Inverness College and the report on the consultant contract. Item 6 is to consider the remit and arrangements for the committee's inquiry into the teaching profession. Item 7 is to consider a draft report on tackling waiting times.

Is it agreed that we take agenda items 5, 6 and 7 in private?

Members *indicated agreement*.

National Fraud Initiative

09:34

The Convener: For agenda item 2, we will hear a briefing from Audit Scotland on the recent publication "No hiding place: the National Fraud Initiative in Scotland". I invite the Auditor General for Scotland to introduce the report.

Mr Robert Black (Auditor General for Scotland): It might be helpful if I take a moment to explain the nature of the report. "No hiding place: the National Fraud Initiative in Scotland" is not a formal report from the Auditor General to Parliament but a paper that Audit Scotland has prepared that arises out of its auditing of public bodies in Scotland. The report captures the results of a major data matching exercise in some key audited bodies that was facilitated by Audit Scotland with the help of the Audit Commission, which has run similar exercises for a few years now in England and Wales.

Russell Frith, who is director of audit strategy for Audit Scotland, led the project for us. I invite him to give a quick summary of the project and its key findings.

Russell Frith (Audit Scotland): I briefed the committee about 18 months ago, before we started the exercise, so this is a follow-up to report on the results of the exercise.

All public bodies have a duty to minimise fraud and overpayments. As part of our audit of public bodies, we undertook the exercise with the aim of helping them to improve their efficiency and effectiveness in doing that. The exercise involved all 32 councils, the joint police and fire boards, the Scottish Public Pensions Agency and the Student Awards Agency for Scotland. The data that were matched included payrolls, the local government, national health service and teachers pension schemes, information about students and the Department for Work and Pensions register of deceased persons. The exercise was carried out with the assistance of the Audit Commission, which has carried out similar exercises in England and Wales. The Audit Commission will publish the report on its latest such exercise this morning.

As a result of the exercise, we found £15 million of overpayments, fraud and forward savings. That compares to £96 million in England and Wales. That total splits roughly into £5 million in housing benefit, £5 million in the local authority pension scheme and £5 million in the NHS and teachers pension schemes. The total can also be split between overpayments of about £6 million and forward savings of about £9 million.

The results included 270 cases of occupational pensions that were paid to deceased persons, 215 cases of housing benefit overpayments to students and 564 cases of housing benefit that was paid wrongly to public sector employees or pensioners. Of those, 53 cases have either had prosecutions instigated or been referred to the procurator fiscal for further consideration.

Those bodies in which very little fraud or overpayment was found can take positive assurance from the exercise about the integrity of their staff and the quality of their systems. We believe that the exercise was worth while whatever the outcome for particular bodies.

We believe that the exercise was successful and we intend to run it again from October this year, when we hope to widen the range of bodies that take part. In that respect, we have had constructive discussions with the Scottish Executive Health Department with a view to using NHS data and we hope to have similarly constructive discussions with the Scottish Executive shortly. We also intend to widen the data sets to include things such as blue badges and care home payments.

That is all that I will say by way of this short briefing, but I am happy to answer questions.

The Convener: Members now have the opportunity to ask questions.

Eleanor Scott (Highlands and Islands) (Green): If my arithmetic is right, it sounds as if Scotland has a proportionately greater problem of overpayment than England and Wales do. Is that right? Is there a reason for that?

Russell Frith: It is difficult to make a conclusion at this stage, as this was the first such exercise that we have run in full across Scotland, although we piloted some elements of it two years ago. It might well be that, in this case, we are catching up with a number of longer-standing overpayments or frauds that would have been picked up in England and Wales in previous exercises. We are probably covering cases over a longer time period this time. If the results are still higher next time, the conclusion that you draw would be reasonable.

Eleanor Scott: Fifty-three prosecutions out of a £15 million overspend does not seem to be that many. Does that suggest that it is more a case of systems not working than deliberate fraud, or is it just that there were only 53 cases in which the allegations would stick?

Russell Frith: We do not have a great deal of information about that, but we know that all the local authorities consider carefully the circumstances of the cases. For example, if a very elderly pensioner claims housing benefit without declaring some or all of their occupational pensions, the local authorities tend to decide not to prosecute. Filters are applied.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I would like further clarification on the cases that were reported to the fiscal. During the past few weeks, some of those cases have come to court and they involve quite substantial figures. Do you have any information that would provide us with an average figure for those 53 cases?

Russell Frith: No, we do not have the information at that level on each of the cases.

Margaret Jamieson: Would it be possible to get that information in the future so that we could see it at a glance, as well as some of the case studies? I have seen reports of some of the cases in the local paper. One involved an employee and housing benefit; the sum in that case was somewhere in the region of £7,000. At the weekend, there was a story about a family and the DWP and the figure was somewhere of the order of £40,000 because the family were continuing to claim. It would be helpful if we could have a breakdown of the sums involved in those prosecutions.

Russell Frith: We will certainly try and do that for the future.

Mr Black: We need to be careful about data protection, particularly if there are current court proceedings. We are talking about a small number of cases.

Margaret Jamieson: Yes, but it would be helpful if we could see a range of the figures involved.

Are the police and the fire and rescue services included in the areas that you have looked at?

Russell Frith: Yes, they are.

Mrs Mary Mulligan (Linlithgow) (Lab): What, if any, were the common themes that you found in the difficulties that arose?

Russell Frith: Some of the matches that we are doing are ones that the local authorities could not have done for themselves. We have been helping the authorities to do things that it would be difficult for them to do. I would not say that the matches that we have seen show particular weaknesses in the authorities' systems, because we have been able to cross-match data that cannot usually be matched.

In some of the pension cases, there is a lack of clarity of understanding of what a pensioner can and cannot do. There are commonly held beliefs—unfortunately untrue—about being entitled to continue claiming pensions when someone has died. One of the things that could help in future is greater clarity in the information that is given to

pensioners about whether they can continue to claim the full pension or not if they claim other benefits or go back to work, which might be an increasingly common thing. Different schemes have different rules.

Mrs Mulligan: Were the issues that arose the same as the ones that you mentioned two years ago? You have done pilot research in the same area; did the same issues come up?

Russell Frith: Yes.

09:45

Mrs Mulligan: How should public bodies use the information that we have in front of us to ensure that when the exercise is carried out again in 12 months, the same problems do not arise?

Russell Frith: We will find some of the same problems, because it is difficult for some bodies to check such matters for themselves, particularly if people do not declare income when they claim housing benefit.

Mrs Mulligan: Why would it be difficult for organisations to check that?

Russell Frith: Because the local authorities and the pension schemes do not have the power to match the data. For example, if somebody claims housing benefit and does not declare that they are a pensioner, it is difficult for a local authority to demonstrate that they are a pensioner. They are looking for something that they do not know exists, which is always difficult.

Mrs Mulligan: Are you saying that we will only ever be able to find out about such matters in retrospect?

Russell Frith: Yes, in some cases. As long as the data protection rules remain on a United Kingdom-wide basis, it will be difficult for public bodies to be sure that they are making the correct payments.

Mr Black: One benefit of the exercise that we are convinced exists but which is impossible to quantify is the deterrent effect. Perhaps Russell Frith can say whether the Audit Commission has found evidence of a deterrent effect.

Russell Frith: It is difficult to say, because each time the Audit Commission has carried out the exercise, it has found greater levels of overpayment and fraud, but it has constantly expanded the data sets and the number of bodies that are involved. There is no clear trend.

The Convener: Mr Frith talked about the UK data protection rules. I presume that local authorities south of the border have the same difficulty with finding out information.

Russell Frith: Yes.

Margaret Jamieson: Might the way in which registration officers will now work—they will be organised according to the 32 local authority areas—have an impact? When a death is registered, a special form is given to the DWP. That may impact on payments through occupational pension schemes and housing benefit. Have you considered that?

Russell Frith: Not specifically. The data set that we use is the DWP's UK register.

Margaret Jamieson: So that does not fit with the computerised system that the registration officers in the 32 council areas will operate.

Russell Frith: If that is the case, we will need to consider the impact.

The Convener: I would like to follow up on the £15 million of savings that the initiative has made as a result of identifying fraud and overpayments. The document explains that £5 million of the savings relates to housing and council tax benefit overpayments; £5 million relates to pension-related overpayments by, and forward savings for, councils; and £5 million relates to pension-related overpayments by, and forward savings for, the Scottish Public Pensions Agency. However, the total saving in overpayments is £6 million, which suggests that the majority of the savings—£9 million—are forward savings. Is that correct?

Russell Frith: Yes, particularly with pensions.

The Convener: You mentioned the Student Loans Company, which obviously does not deal with pensions. Therefore, is the degree of fraud minimal in relation to that?

Russell Frith: I think that you mean the Student Awards Agency. The category of students who are eligible to claim housing benefit is very small. In 215 cases, it was found that students who should not have claimed housing benefit were doing so.

The Convener: Thank you for correcting me—of course it is the Student Awards Agency.

The success of the national fraud initiative in bringing errors and overpayments out of the pension system may mean that you will suffer from diminishing returns in future years. Is that a possibility? Are you having to enlarge the data set to ensure that future returns are significant?

Russell Frith: There is the possibility of diminishing returns. However, if the exercise was being carried out properly and there were diminishing returns, I would see that as successful. Unfortunately, the evidence so far from the Audit Commission's work in England and Wales is that the diminishing returns have not shown up.

The Convener: Finally, the report findings show housing benefits claimed fraudulently or in error by

564 public sector employees or pensioners and 53 cases being reported to the procurator fiscal. Is that what one would normally expect as a proportion—I think that it is roughly 10 per cent—or would it be lower or higher in other cases?

Russell Frith: I am sorry, I do not know.

The Convener: Okay.

Mr Black: If I may, I will offer one final thought in response to your question on diminishing returns. I remind the committee that we contributed £71,000 to the Audit Commission for the data matching exercise. We managed the rest of the exercise within our existing resources. The return was made on a very small financial commitment from Audit Scotland; the exercise is more about smarter working on the part of the audited bodies with the good data that they are getting, which allows them to improve their prevention and detection of fraud. For a very small financial outlay, we are getting a better assurance on the way in which public money is managed.

The Convener: A point well made. I am sure that committee members are pleased to see such a worthwhile exercise, which is making an impact both financially and, hopefully, in the lessons and message that it is sending out.

Mrs Mulligan: I have a point of clarification. The convener asked about 53 housing benefit cases being reported to the procurator fiscal, but was the figure of 53 solely for housing benefit cases or was it the global figure?

Russell Frith: It was the global figure.

Mrs Mulligan: Thank you.

The Convener: Thank you for the briefing.

"The 2004/05 Audit of Inverness College"

09:54

The Convener: We move on to item 3, under which we will take evidence on "The 2004/05 Audit of Inverness College". I welcome Philip Rycroft, the accountable officer at the Scottish Executive Enterprise, Transport and Lifelong Learning Department, who joins us today with his team. I thank them for their evidence, which has been circulated to committee members. I will leave it to Philip Rycroft to introduce his team and make a short introductory statement, after which we will move to questions from the committee.

Philip Rycroft (Scottish Executive Enterprise, Transport and Lifelong Learning Department): Thank you for your welcome. I will introduce my colleagues. They are Aileen McKechnie, who is the head of the further and adult education division; George Reid, who leads the further education strategy team; and Colin Baird, who leads the review of Scotland's colleges.

I neither intend nor need to say very much by way of introduction. As the committee has been dealing with the issue for considerably longer than I have, members probably know far more about the background than I do. However, I will say a few words on how I see the overall context of the discussion.

I emphasise the huge importance that we attach to the vibrant and successful college sector in Scotland, which is critical to the learning and life chances of many thousands of people as well as to the skill capacities that we need to develop to help Scotland to thrive and prosper. It follows that we attach a lot of importance to the health—including the financial health—of the college sector, which is why we share the committee's concerns about what has happened at Inverness College. We know that the college does a lot of good work with and for its students, and we want that to continue. That is why we, like you, want to see the college back in good financial shape.

I remind the committee briefly of the governance structure for the college sector. Ministers set national policy and standards and provide a broad resource envelope. The Scottish Further and Higher Education Funding Council is responsible for the delivery of that policy through its work with colleges. Colleges themselves are autonomous institutions that are governed by their boards, which have responsibility for running the colleges under the terms that are set out in the funding council's offer of grant.

That system has worked well since the establishment of the Scottish Further Education Funding Council in 1999. We have moved from a position in which most colleges were in poor financial condition to one in which only two out of the 43 colleges are causing the funding council concern about their financial position. Funding has increased substantially, but learning output has increased faster, so the better financial position has been achieved alongside more efficient delivery. In that context, learning and teaching have also improved. Reports from Her Majesty's Inspectorate of Education show that the number of good and very good grades achieved by colleges has increased from around 80 per cent in 2000-01 to almost 90 per cent.

We recognise, nevertheless, that no system of governance is so good that it does not require regular review. That is why we have a governance and accountability work stream in the current review of Scotland's colleges. Our thinking on that will be influenced by the experience of Inverness College and other colleges. The written evidence that I supplied last week updates the committee on where we are with that review, and my colleagues will be happy to tell you more about that today, if you wish. We will be happy to answer your questions.

The Convener: Very good. Thank you very much, Mr Rycroft. What sanctions are available to the department when colleges perform poorly, and in what circumstances would those sanctions be used?

Philip Rycroft: That is a fair question. Ministers have the power to remove college boards, but that is very much a sanction of last resort and it has never been used. Ministers also had a power of direction of colleges but, to allow the colleges to retain their charitable status, they recently gave that up. That, too, was a power that ministers had never exercised.

Our ability to influence what goes on in the college sector operates through the funding council. It is the funding council's responsibility to ensure that the colleges to which it gives money have the proper processes and procedures in place for the proper expenditure of that money and to help colleges to stay in a sound financial position. On a day-to-day basis, that is effectively how we manage our relationship with a college through the funding council. Indeed, that is the appropriate mechanism and one that has proved pretty successful since the funding council was set up in 1999.

As I say, ministers have that reserve power, which would have to be exercised by order through Parliament. However, it is a power that would have to be used with great caution because of the signal that it would send to the many hundreds of people on the boards of colleges throughout Scotland who give a lot of their time, energy, enthusiasm and experience to support the work of those colleges.

The Convener: That time is given free of charge, of course.

Philip Rycroft: Yes, indeed.

10:00

Margaret Jamieson: You say that the use of sanctions would be an absolute last resort for ministers. What information is available to ministers and to your department that might result in such a decision being made?

Philip Rycroft: To some extent, that question takes us into the realm of the hypothetical.

Margaret Jamieson: The power has never been used.

Philip Rycroft: It has never been used. At what point would we recommend the use of that power? We are certainly not at that point with Inverness College or any of the other colleges, and it would be difficult to speculate about the circumstances that would take us there. All that I will say is that they would have to be pretty extreme. In using that power, ministers would effectively remove the body of people who are there to implement the solutions that the Executive wants. By removing the board, they would be taking away the instrument that they have at hand to ensure the good and proper running of the college.

We are a long way off that point in respect of the present circumstances of Inverness College. The board is working closely with the funding council to address the college's situation. It has accepted the advice that it received from the further education development department of the funding council—the FEDD team—and the funding council is providing a lot of support for the board. It seems to me that the board is doing what it needs to do to get the college back on track.

Margaret Jamieson: The Enterprise, Transport and Lifelong Learning Department and the funding council obviously do not believe that having two section 22 reports issued by the Auditor General is significant enough to merit further sanctions being taken. Is that correct?

Philip Rycroft: It depends on what one is trying to achieve.

Margaret Jamieson: We are trying to achieve financial balance.

Philip Rycroft: Sure, and to get the college back on track. Having brought in the FEDD team and provided the support that has followed that, the funding council is working with the college

board to help it to take the actions that it is required to take to get the college back on to secure financial ground. I am not sure whether sanctions might be required in that context or whether sanctions as a punitive measure would help the situation.

Underlying your question is the issue of whether we should have steamed in and taken punitive action, but that is a different issue altogether. From the evidence that we have of all the work that has gone on around the situation—from what work we know that the funding council is doing with the college—it is clear that that has not been necessary. The sanction that is available to ministers—removal of the board—is pretty extreme, and a pretty high hurdle would be required to justify that sort of action.

Margaret Jamieson: When we took evidence from members of the board of Inverness College, it was clear that the chairman was unaware of the facility that could be provided to him and other board members by the FEDD team. Does it give you cause for concern that individuals who are charged with the governance of colleges are unaware of the assistance that could be made available to them?

Philip Rycroft: It would be a cause of concern if the chairman was not aware of the support that was available to him. The funding council is addressing the provision of training for members of college boards in the support that they can get as a matter of course, so that they will understand the system in which they operate. Indeed, the leadership programme for college principals is worth mentioning in that context. All that should help to ensure that college boards are better aware of what support is available, of their relationship with the funding council, and so on.

If there are systemic issues that are of broader concern, we can pick those up in the governance and accountability work stream of the colleges review. That will enable us to see whether there is anything that we need to learn from this in terms of increasing the scope of that activity to ensure that we do not find ourselves in a situation in which it appears that some people did not know the extent of the support that was available to them.

Margaret Jamieson: I understand that the funding council cannot impose the FEDD team on a college and that the team can become involved only by agreement. Given that the Scottish Executive is delivering significant funds, are you concerned that colleges could keep the team at arm's length?

Philip Rycroft: In general, no. As I said in my opening remarks, of the 43 colleges in the sector, the vast majority are in good financial circumstances and are well-run institutions. The systems and support structures work pretty well for the colleges and the funding council. We do not need to change the rules as a result of the situation that we are discussing. The FEDD team has worked well with Inverness College. It has produced a good report for the college board that is helping the board to sort out the issues that need to be sorted out. As far as we know, the system works. If issues need to be addressed, the review process can allow that to be done.

The Convener: The committee is well aware of the improvements that have been made in the sector in recent years. However, the committee has been here before—in its previous life in the first session of Parliament, the committee examined issues to do with Moray College. We are interested in the line of accountability that runs through college management. I understand your point that we must formulate checks and balances that deal with the majority of situations, not just a small minority. Nevertheless, we are once again considering the financial difficulties that a particular college faces and its inability to deal with them, after previously making commitments to do so. We are interested in the lines of accountability, in relation not only to the accountable officer—the principal of the college—but to the board of management, the funding council and the Enterprise, Transport and Lifelong Learning Department.

Philip Rycroft described what is pretty much the last resort—the nuclear option, if I may call it that—which is to remove a board. Does the department have enough information to tell the funding council that it has lost confidence in a board, or would the process be the other way round? Is it expected that the funding council would tell the department that, after deliberations with a board, it had lost confidence in it? Would the funding council make a recommendation to you, or do you have enough information at your disposal to make the decision?

Philip Rycroft: In practice, the funding council would come to us. That must be the right way round, because the council works with colleges daily. The team that we have centrally is not much bigger than the team that is sitting at this table. The ministers took the decision to devolve the responsibility for the funding of colleges to the funding council. As I said, that model has been proved to work rather well. The funding council ought to hold the day-to-day information about what is going on in the college sector. It has the interchange on grants and ensures that colleges have systems in place to manage the money according to the financial memoranda. The council holds the information, but I assure the committee that regular dialogue takes place between the council and colleagues in the department. Therefore, we should be aware of any issues. The

relationship operates on the basis that there should be no surprises. If the funding council has concerns about any institution, we should know about that soon after those concerns arise.

The Convener: So, from your previous answers, we can surmise that concerns have not been drawn to your attention that might make you lose confidence in the board.

Philip Rycroft: Do you mean specifically in relation to Inverness College?

The Convener: Yes.

Philip Rycroft: Absolutely not. As I said, we are not at the point of advising ministers that they need to take extreme measures—the nuclear option, as you described it. If we consider the action that has been taken over the piece, it is clear that there was a financial recovery plan that seemed to be moving in the right direction. There has been a step or two back from that, but recent action by the board and the college seems to give much hope that the college will be able to get back on track. If there was a time to intervene, it is not now.

Eleanor Scott: How satisfied are you with the arrangements for appointing board members?

Philip Rycroft: That is a general question about how we manage the sector. If my memory serves me rightly, the matter was considered in the most recent review of governance, which took place two or three years ago. I think that the broad conclusion was that the arrangements are satisfactory, subject to the boards following public appointments procedures.

Many colleges reach deep into the community to find people to serve on boards, which gives colleges access to a reservoir of support and experience in the communities that they serve. We would disrupt at our peril such a system of links with communities. The arrangements for appointing boards have broadly worked well and continue to do so. There is always room for improvement and the review will give us the capacity to consider the details of issues that might need to be picked up.

Eleanor Scott: Our distinct impression is that the board of Inverness College was the passive recipient of papers from management and did not take an active role. Are the current arrangements working because boards work well or because other colleges' management teams perform well and their boards have to do no more than receive satisfactory reports?

Philip Rycroft: In my experience of institutions that have boards and executives, the system works well when there is a combination of an active board and a good management team and when there is good information flow from the executive to the board, which is crucial.

It is not my place to get deep into what happened at Inverness College. The committee has had the opportunity recently to speak to the chair of the board and members have views on the matter. However, boards rely on good information from the executive and to some extent the executive relies on boards to ask and prompt the right questions. That is true of any non-departmental public body or other body that has such an arrangement.

Eleanor Scott: A board that is entirely voluntary will be composed of people who have time on their hands and the lack of remuneration precludes the participation of many people. Is there a danger that the arrangements can become a little cosy when board members sit alongside the college principal, who is also a board member, and that there can be little incentive for board members to challenge what is happening?

Philip Rycroft: There is a risk that any board might get close to the executive and fail to challenge it sufficiently. However, I see no evidence that the risk is great enough in the college sector to be of systemic concern.

Eleanor Scott: Are there instances in which boards have challenged management? In the case that we are discussing, the committee thinks that the board did not do so.

Philip Rycroft: I am sure that there are hundreds of examples from boardrooms in which college principals and executive teams felt well challenged by boards. I am not long enough in the tooth in my job to be able to give you chapter and verse on that off the top of my head, but the team might thicken the broth.

10:15

Aileen McKechnie (Scottish Executive Enterprise, Transport and Lifelong Learning Department): In the main, the college sector is well governed and well managed. We see evidence of that in the fact that the vast majority of colleges have moved out of a position of financial insecurity into one of financial security, as the recent Audit Scotland report confirmed.

The Executive has an arm's-length relationship with the funding council and the colleges. We do not get involved in the day-to-day running of the colleges, so I cannot give specific examples of how college boards have challenged college executives; that is their business and, therefore, it is not our business. I believe that that is appropriate given our relationship with the colleges. We manage them through the funding

council, so we need to maintain that arm's-length perspective.

Eleanor Scott: I am trying to tease out whether the system works well in the way that is being claimed. If the management is getting along fine and the board has nothing that it needs to challenge, the system will seem to work well. However, we know of an instance in which the board should have challenged something but the system did not cope. Does the system work well because the boards are working well or does it work well because other elements of the system are working so well that the boards are not being tested?

Aileen McKechnie: Governance arrangements are audited as part of the annual audit. I assume that any issues with governance would be picked up. I am not aware that external auditors have expressed concerns about governance arrangements in particular colleges.

Eleanor Scott: We have been provided with the official document "Constitution and proceedings of boards of management", which seems slightly out of date. Are there plans to update it? For example, it makes reference to the secretary of state.

George Reid (Scottish Executive Enterprise, Transport and Lifelong Learning Department): Is that in schedule 2 to the Further and Higher Education (Scotland) Act 1992?

Eleanor Scott: Yes.

George Reid: Certainly, the references to the secretary of state were updated by the Scotland Act 1998 in the same way as references in other legislation. As was mentioned earlier, the current review of Scotland's colleges includes a significant work stream on accountability and governance. Therefore, the constitutional arrangements for colleges, which have been updated since the 1992 act in various ways, will continue to be looked at.

Eleanor Scott: I note that the review will also consider whether boards should be responsible for appointing their own membership, including the chair of the board. Will that be changed?

Colin Baird (Scottish Executive Enterprise, Transport and Lifelong Learning Department): When ministers reviewed the situation in 2000, they gave a commitment that they would conduct a further review to consider the impact of the measures. Given that, as Philip Rycroft said, ministers concluded then that they would not change the way in which boards were appointed, the review will now consider whether the impact of that decision is such that the issue needs to be reconsidered. However, I should say that the issue has not been raised as part of the review to date. There has been no clamour to suggest that there is something wrong with the current arrangements, but the commitment that was given to reconsider the issue means that it will be picked up in the next few months.

Eleanor Scott: How unique is it in the public sector that a body should be self-perpetuating with no input from elsewhere?

Philip Rycroft: I hope that the team has given the assurance that we are not complacent and that we are constantly looking at the college sector to see whether there are ways in which we can improve it. However, it seems to me that it is incumbent on us to set ourselves a pretty high hurdle for introducing major change in the sector given that the evidence suggests that it is, for the most part, working pretty well. Any change that we introduce should deal with the problems that we and others are aware of—everyone agrees that they need to be addressed—without undermining the value that we get from the many people who give their time to serve so well on college boards. We need to bear in mind the risk that a change might undermine quality when we consider how to address the issues that will inevitably crop up from time to time in any big complex system such as that of the colleges in Scotland.

Eleanor Scott: Would it improve the quality and perhaps the breadth of potential participation in boards if remuneration were to be provided?

Philip Rycroft: I cannot give a view on that today. We can pick up that issue as the review moves forward and listen to people's views. I would not want to say that our view on that should predominate simply because I have the advantage of sitting in front of the committee today. Many other people around Scotland will have views on that issue and we need to listen to those views before reaching a conclusion.

Mrs Mulligan: When was the previous governance and accountability review?

George Reid: It reported in 2003.

Mrs Mulligan: Are you confident that the report's recommendations have been delivered?

George Reid: The review made 14 recommendations, 12 of which have been implemented. Two recommendations are under consideration by ministers: the proposal to cut from three to two the number of four-year terms of office that a board member can serve; and the proposal to remove the current restriction on who can be the chair of a college board of management. Under the 1992 act, an elected member or employee of any local authority may not chair a board. Following on from the 2003 report, ministers consulted on the latter proposal and received a variety of responses. As I said, ministers are considering those two recommendations.

Mrs Mulligan: Will those two issues be picked up in the review that is now under way?

Colin Baird: Given that the issues are still under consideration by ministers and that we are looking to conclude the review in the spring of next year, it is unlikely that the review will look at them.

Mrs Mulligan: How will the present review add to the body of work that has gone before it?

Colin Baird: First, it will look at the impact of the measures that have been implemented. We have surveyed colleges to look at the procedures that they have put in place, including the procedures for the independent oversight of board appointments. Secondly, re-examining some of the issues a few years on from the previous review will make a difference. For example, we were asked about remuneration. Under the Charities and Trustee Investment (Scotland) Act 2005, which was passed since the previous review, colleges are no longer charities if all board members are remunerated.

Having a look at the changing landscape gives us a glimpse of some of the issues. It also gives us the opportunity to look at practices in colleges; indeed, we are in the process of commissioning research on the subject. We are also looking at how colleges compare with, for example, the Langlands good governance standard that was published in 2004. We are looking at governance issues and accountability issues, too.

We are learning from the higher education sector, other charities and the private sector. We want to see where college governance is at now and how it compares with other sectors. Our aim is to see what lessons can be drawn, in terms of both good practice and governance arrangements.

Mrs Mulligan: When you review the previous recommendations and look at the way in which the colleges are working, do you do that simply as part of the natural monitoring process or as a result of specific issues in the college sector?

Colin Baird: It is unlikely that we would have reviewed the college sector again but for the fact that ministers made a very strong commitment at the end of the 2003 review that they would do so. Since the 2003 review, nothing systemic has happened that would have caused us to undertake another review.

However, the review gives us the opportunity to look at accountability and governance issues in a much wider way than we did in 2003. The 2003 review was very focused in its remit: it picked up on the recommendations that the committee made in its report on Moray College. However, accountability and governance is now one of four work streams that are part of a wider review of the difference that the colleges make. We are looking—again, in order to draw lessons—to the strategic future of colleges over the next 10 to 15 years. We have an opportunity of looking at the much wider framework to see whether anything else can be picked up.

Mrs Mulligan: When do you expect the review to be completed?

Colin Baird: In the spring of next year.

Mrs Mulligan: I note the memberships of the core and working groups that have been set up and I see that Ms McKechnie chairs the group on accountability and governance. I do not want you to give away any secrets, Ms McKechnie, but given the issues around governance, particularly in relation to Inverness College, are there any particular aspects that you will be considering or which have arisen?

Aileen McKechnie: The initial stages of the work stream concentrated very much on issues arising out of the Charities and Trustee Investment (Scotland) Act 2005 and the impact that ministerial powers of intervention could have on the sector's ability to retain its charitable status. In the first six or seven months, we concentrated on reaching a conclusion about the need for powers of intervention to be retained; we gave advice to ministers and agreed the position.

We have now resolved that matter and moved on. As Colin Baird said, we are pulling together a research specification for benchmarking the sector in Scotland and outside against universities and private sector institutions. We want to be able to demonstrate where colleges sit in terms of their governance arrangements, and to see what lessons we might learn and what best practice we might disseminate across the sector. We are looking at those issues in the round.

We are mindful of issues such as Inverness College, the impact of the 2005 act and the changing landscape in which we operate. Those issues are having an impact on our thinking as the work stream progresses.

Mrs Mulligan: You will consider Inverness College.

Aileen McKechnie: We are mindful of Inverness College but, as Philip Rycroft mentioned, it is one of 43 colleges. We want to learn lessons from Inverness College. We expect to consider training and development opportunities and the potential for improving the training and development that are offered to board members and chairs, to ensure that they are fully aware of the support, advice and guidance that are on offer from the funding council or from peers in the sector. That is in our thinking and discussions are under way in that regard.

Lessons are being learned from Inverness College as we speak; they will not wait until the work stream concludes its activities in the spring of next year. Lessons are being learned today and the Association of Scottish Colleges is talking about training and development opportunities and needs and where they might be improved.

The Convener: What actions have been taken to improve training and support to board members following the committee's report on Moray College during the previous parliamentary session and the department's previous review of governance and accountability in the sector?

Aileen McKechnie: The ASC has set up a programme of training for board members, in which the funding council, the Executive and other bodies engage. The focus is on recognising that audit and finance are significant issues and that training needs could arise in those areas.

A national training programme has therefore been devised and delivered through the ASC. It is funded primarily by the funding council through the ASC and involves the Scottish Further Education Unit. My team has been involved in the delivery of some of that training so that we are collectively, as key interest stakeholders, involved in both identifying board members' training requirements and delivering the training programme. Lessons were learned from the recommendations of the previous Audit Committee.

10:30

The Convener: I presume that the training programme for board members is voluntary, not compulsory.

Aileen McKechnie: Indeed, it is. Board members are volunteers who give their time willingly and freely. We are not able to compel them to do anything. The fact that people volunteer to become members of college boards means that they wish to give of their time and want to perform well in the office that they have taken on. They are, in the main, willing to give up additional time to take up training and development opportunities that are offered to them.

George Reid: One of the activities on which the Association of Scottish Colleges has placed increasing emphasis is induction events for board members. The association regards it as highly important that, as soon as possible after new board members take up office, they know what is expected of them and the responsibilities that are placed on them. Such events have taken place around the country.

Closely linked to that training is the guide for board members, which is under comprehensive review. The consultant Baker Tilly International is matching the guide to board members' roles and responsibilities, and it is hoped that a comprehensively revised guide for board members will be launched at the forthcoming ASC conference on 8 June.

The Convener: Am I right in thinking that, although the Executive has the last resort of being able to remove board members, it does not have to approve the appointment of new board members? Is that an entirely separate, stand-alone issue for the incorporated colleges?

Philip Rycroft: That is correct, as I understand it.

The Convener: I just wanted to clarify that you do not have the power to ask new board members to undertake the training.

Philip Rycroft: No.

Mrs Mulligan: Do you deliver the training, or who does that?

Aileen McKechnie: We get involved in training board members in specific areas where there is a relevance. For example, when the funding councils were going through the merger process, we went out and spoke to board members about the process, our thinking behind the merger and our aspirations for the merger. We also heard board members' views on the merger. Our involvement is with specific issues in which we have a locus. We do not deliver training as such; the training is delivered in the main by the SFEU and private training providers, as appropriate.

Mrs Mulligan: You say "we", and you referred earlier to a training team in your section.

Aileen McKechnie: We do not have a training team. The training in which we are involved relates specifically to issues in which we are engaged. For example, the team that was involved in the merger of the two funding councils went out and delivered a session on the merger process and our aspirations for the new funding council. Since the merger, we have gone out to say, "Here is the new funding council"—not to board members but to other folk, although we could do it for the boards if we were asked. We have individuals with policy responsibilities who will articulate developments in relation to specific policies.

Mrs Mulligan: Are there a lot of those people? Mr Rycroft said earlier that yours is quite a small team.

Aileen McKechnie: There are about 18 folk in my division.

Margaret Jamieson: What is the current position regarding the management of Inverness College, given the fact that the principal is on extended sick leave?

Philip Rycroft: The management of the college is obviously a matter for the board. There is clearly an issue with the management of the college, but it is for the board to sort that out. It would not be appropriate for me to comment on that at this stage. I am, rightly, not privy to the details of discussions on that.

Margaret Jamieson: I am just asking whether someone has been appointed in place of the principal. Education still requires to be delivered.

Philip Rycroft: There is an obligation to ensure that there is an accountable officer in place, and there are time periods that must be respected in that regard. I spoke to the chair of the board on Friday to get an update; dealing with that matter falls within his responsibilities and he is aware of the timetable under which he must operate. I understand that steps will be taken to ensure that there is management in place to enable the college to continue to function properly.

Margaret Jamieson: So, at the moment, there is no acting principal.

Philip Rycroft: I cannot say precisely who is doing what at the moment. I understand that arrangements are in place because the current principal is away on sick leave. If that situation continues, an acting principal will be appointed shortly.

The Convener: Thank you, Mr Rycroft. That has helped to clarify a number of points for us. For the avoidance of doubt, I can tell you that the committee has not yet come to any conclusions on the performance or otherwise of the accountable officer or anybody else who is accountable for the performance or recovery of the college. That is something that we will consider later. The information that you have provided is helpful. I thank you and your team for your time.

I propose that we take a short comfort break before agenda item 4. I suspend the meeting until 10.40, when we will take evidence on the consultant contract.

10:37

Meeting suspended.

10:45

On resuming—

"Implementing the NHS consultant contract in Scotland"

The Convener: I draw everyone's attention to the job in hand. I am pleased to welcome one of our regular attendees, Dr Kevin Woods, and his team. In today's session, we will ask questions about the Auditor General's recent report, "Implementing the NHS consultant contract in Scotland", with particular focus on the negotiation and planning of the contract, the impact of the contract to date and the plans to use the contract to improve care for patients. With Dr Woods are several former members of the Executive team who have made some effort to be here, for which I thank them. I ask Dr Woods to introduce his team formally and to make his opening statement.

Dr Kevin Woods (Scottish Executive Health Department and NHS Scotland): As you say, convener, I am joined by colleagues who have moved to other jobs. On my left is Mike Palmer, who was formerly the assistant director in our human resources directorate and who played an important role in the consultant contract. On Mike's left is Julie Burgess, who is currently the chief executive of the Birmingham Women's Healthcare NHS Trust but, prior to that appointment, was responsible for the consultant contract as director of pay modernisation. I am grateful to Mike and Julie for returning to assist the committee today. On my right is Tim Davison, who is the chief executive of NHS Lanarkshire and who, as chair of the pan-Scotland NHS employers reference group, played an important role in the implementation of the contract. On his right is Dr Charles Swainson, the medical director of NHS Lothian. I am grateful to them all for coming along in support.

In my opening statement, I will mention the context for the contract and the planning that preceded its implementation, and then make one or two brief comments on its benefits and costs. As members know, the new contract is one of several strands of the pay modernisation process. Others include the new contract for general medical services, the agenda for change and new contracts for pharmaceutical providers. The pay modernisation process has been taking place throughout the UK and has embraced virtually the whole of the NHS workforce in recent years.

The most important point to make at the outset is that the process was the first root-and-branch review of pay and terms and conditions of service for NHS staff since the NHS was established nearly 60 years ago, in 1948. Against that background, we cannot underestimate the scale of

the challenge that we took on, or the longer-term importance of the changes in equipping our health service for the future. The reasons for the changes were first set out in 2000 in "Our National Health: A plan for action, a plan for change", which made an important point that I would like to reiterate: investment in our staff is investment in patient care.

Beyond that, in our view, pay modernisation is also a catalyst for change and will be important to the achievement of the goals that we set out in "Delivering for Health", on which I gave evidence to the committee on a previous occasion. We must also remember that consultants are highly skilled people who are part of a United Kingdom labour market and, indeed, have skills that are sought after by other countries. If we are to be able to recruit and retain consultant staff, their pay has to be comparable with that in other labour markets.

Against that background, I turn to planning. As I indicated, planning for the new contract began from the end of 2000. After two years of negotiation, the four UK health departments agreed a framework for the new contract with the British Medical Association in mid-2002. I think that the committee has been given a copy of that framework. I point out that the objectives that were set out in that framework have been met.

When the framework was published, the plan was to implement the new contract from April 2003. In the event, the complexity of the negotiations delayed implementation until February 2004. Throughout that period, extensive discussions were held with and detailed guidance was issued to NHS Scotland. Further guidance on the contract has continued to be issued since then. For the committee's benefit, I have brought with me copies of all the guidance pre and post contract implementation, which are in the rather large folder in front of me. The detailed guidance includes Health Department letters, circulars, pay modernisation team letters and the other extensive guidance that was issued to the service. I am happy to leave the folder with the committee at the end of the evidence session.

The Audit Scotland report explains that it is a study of the planning for and implementation of the contract, not a study of its negotiation. I believe that, to some extent, that is a false distinction as it does not recognise the reality that negotiations with the consultants' trade union were a continuing and complex feature of the planning and implementation of the contract. We should also not lose sight of the fact that implementation required every consultant to prepare and agree a job plan with their employer. That was also a process of discussion and negotiation. As the committee will know, we have in excess of 3,000 consultants working in NHS Scotland.

The contract now provides, for the first time, a formalised, transparent relationship between employers and consultants. It provides a means of effectively linking service objectives, service redesign and the use of consultant time through a process of job planning and appraisal. For the first time, it gives proper recognition to the on-call work that consultants do and it removes the double payments for work that formerly attracted a fee. Finally, it brings clarity over consultants' private work, which must not conflict with their NHS responsibilities.

Those are some of the immediate benefits from the contract, but we are determined to pursue additional benefits from those changes. All boards have produced pay modernisation benefit plans, which we will discuss with boards in the context of the forthcoming annual reviews that the minister will conduct in public over the summer. My colleagues who are with me today will be pleased to share their experience of the benefits to be derived through that process. All boards are also committed to delivering an annual 1 per cent time-releasing saving from increased consultant productivity as part of our efficient government programme. That work is being progressed on our behalf by board medical directors.

Finally, I will say a word on costs. The benefits that I have described obviously need to be paid for. The Audit Scotland report makes much of the initial estimate of costs, which was just that—an initial estimate. That first estimate was based on a study that was conducted throughout the UK in partnership with the BMA and adjusted where possible for Scottish circumstances. That was necessary because the operation of the previous contract did not produce the detailed information that was required by the cost model that had been developed for the new contract. The report also presents data on the subsequent actual costs on a cumulative basis against the estimate and includes issues surrounding the payment of back pay that arose from the delayed implementation of the contract.

In acknowledging that there was indeed a difference between the first estimate of cost in March 2003 and the actual cost in the first year of the contract, which was 2004-05, I hope that I will have the opportunity to explain how the subsequent estimates of cost came much closer to the actual cost and how those costs compared with the resources that were available to NHS boards in 2004-05.

I am conscious that this is a complex subject. As we answer questions, we will do our best to provide the committee with as much clarity as possible.

The Convener: Thank you, Dr Woods. Your statement has helped to shape the context for us.

Thank you for the guidance material that you said you will make available to the committee. Our clerks will no doubt receive that from you.

I think that I am right in saying that the guidance material was made available to Audit Scotland in preparing its report and that the facts are agreed in the report.

Dr Woods: Yes. I have no reason to believe that anything in the material or in what I have said this morning was not made available to Audit Scotland. All of the material is in the public domain. I brought it to committee simply to demonstrate the scale of advice that we offer to NHS Scotland.

The Convener: Okay. We move to questions from committee members, which will cover the negotiations on, planning for and impact of the contract. Susan Deacon will open our questioning on the subject of the negotiations.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): Thank you for that helpful introduction, which helped to remind us of the background to this complex issue. I will explore in particular the recurrent question of the extent to which the contract reflects distinctive Scottish needs. The question has arisen both at committee and in the Audit Scotland report. In your opening remarks, you noted the general recognition that there is good reason for having a UK framework for pay in the NHS, both for consultants and other staff groupings. That is worth noting; indeed, we stated that explicitly in a previous report.

However, from the outset, concerns were expressed about the need to reflect in the contract distinctive Scottish circumstances. I guess that I should put on record the fact that I was the Minister for Health and Community Care when the discussions started in 2000. I well recall the robust discussions that took place at ministerial and official level between the various devolved Administrations and the UK Department of Health on how we could ensure that the contract had a UK core but also a Scottish—and, in turn, Welsh and Northern Irish—differentiation that suited the circumstances of the devolved Administration.

First, to what extent did the ensuing negotiating process—which you summarised for us today in your opening remarks—provide the appropriate opportunities for distinctive Scottish needs and aspects of the NHS in Scotland to be considered? Secondly, and perhaps more important, how was that reflected in the outcomes?

Dr Woods: I agree very much about the benefits of addressing the issues on a UK basis. We needed to do that to recognise the mobility of labour. It would not have been advantageous for a market to develop across the UK; that would only have caused people to try to outbid each other on pay and conditions. For a long time, having a UK basis for the contract has been a central plank of ministerial policy.

I am sure that my colleagues will want to say something about the detail and the extent of the engagement of Scotland-based officials and colleagues in some of the UK negotiations. Before they do so, I have two points to make, the first of which relates to the survey that I mentioned earlier. Five factors were built into the survey, which was undertaken to provide the base material that was needed to assess the likely cost of the contract. Two of the factors—where data permitted—used explicitly Scottish information. That information related to the proportion of consultants on maximum part-time contracts and the seniority of doctors, which were important considerations. Some of the early work was tested in Scotland. Dr Peter Terry, who is a leading figure in the BMA, worked with his local trust—the former Grampian University Hospitals NHS Trust—to test some of the work. That gives a flavour of what was going on.

This is a minor point, but it should not be lost. Audit Scotland's report refers constantly to boards, but many of the changes that we are considering were taking place when there were still 28 NHS trusts in Scotland, so employers were not just boards but trusts. That point should be acknowledged.

Perhaps the most significant point is that the contract provides a job planning framework that can address circumstances in different parts of Scotland as well as in Scotland as a whole. Our aim is to capture how we structure consultants' working time, which might be different in rural areas from how it is in other areas. The job planning framework that was created has the capacity to be adjustable to distinctive circumstances.

My colleagues might say more about the negotiations.

11:00

Mike Palmer (Formerly Scottish Executive Health Department): I am happy to comment. I was present at the negotiations in London that led to the framework agreement in 2002. There was direct input from all four health departments into the negotiations, and ministers in all four countries were kept abreast of progress.

The reality on the ground was that because many proposals had been generated in Whitehall, the thrust tended to come from Whitehall. Therefore, the core of the proposals developed from ideas that were generated in London. However, there was every opportunity for the devolved Administrations to take the proposals

home, analyse them and consider whether they wanted to run with them.

The Scottish Cabinet decided that the core of the proposals, which was the job planning process, was sufficiently responsive to local needs to be able to be applied consistently throughout the UK, as Dr Woods said. It was certainly applicable in Scotland. A rural board can adjust the job planning process and mould the basic unit of 10 programmed activities to whatever circumstances are desired. For example, a board could ask a consultant to carry out some programmed activities in Raigmore hospital and others in the Belford hospital. Mobility and flexibility are built into the contract, so it can respond to local circumstances. That key principle drove the thinking behind the negotiations around the framework. Not only the Health Department but NHS Scotland management had a direct input to the negotiations.

Susan Deacon: That is helpful. I have a final question about the negotiation process before we move on to consider its outcome. After the negotiations at UK level, was there a mechanism—a parallel process or grouping, for example—for considering how the emergent ideas and proposals could be shared and road tested with stakeholders in Scotland?

Mike Palmer: The NHS Scotland management representatives who took part in the UK negotiations kept NHS trusts and boards in Scotland abreast of developments. There is a wee caveat around that, because confidentiality rules were placed around some of the more sensitive areas of negotiation. Given that negotiations were continuing, we did not want those elements to be in the public domain and, for tactical reasons, not all the details could be divulged. However, the main elements—such as the thrust towards job planning, a more transparent organisation and better management of consultants' time—were communicated to the trust and board chief executives regularly. The feedback that we got from the service in Scotland was that the proposals were useful because they would create and provide us with the management information that we need if we are to start managing consultants' time more effectively.

Susan Deacon: I presume that, as part of that process, there was a relationship with the BMA here in Scotland. One of the interesting factors is that, in the vote on the contract in 2002, the medical workforce in Scotland voted differently from people in other parts of the UK. Is it fair to deduce from that—or simply to record—that the BMA in Scotland was involved in a parallel dialogue with its membership and the department?

Mike Palmer: Yes. The relationship between us and the BMA was constructive and positive throughout the period. There was an open door to communication between us and there was a lot of communication. I contrast that with some of the relationships with the BMA in England, where the two parties were slightly more polarised. That might reflect the fact that England is a much bigger country and it is more difficult to get people around the table to communicate things regularly. In Scotland, regular dialogue was maintained between us and the BMA. It is clear that the BMA was at pains to keep its members abreast of developments.

Susan Deacon: Thank you. I will resist the temptation to explore that even further, fascinating though it is.

I move on to the end result of the contract process and the extent to which Scottish issues were effectively addressed. I will roll together three specific areas that are highlighted in the Audit Scotland report. You touched on one of the main issues, which is the extent to which the contract has addressed effectively rurality—or more accurately, perhaps, remoteness—in the NHS in Scotland. I know that you have given some examples already, but I am sure that you agree that substantial questions are still raised about whether, overall, we really have a contract that is able to respond fully to Scotland's remoteness and sparsity of population distribution.

The second area that I would like you to comment on is waiting time payments, which are an area of difference that was negotiated specifically for Scotland. According to the Audit Scotland report, NHS boards are now paying for the work at a higher rate and there has been a substantial increase in their costs since the new contract was introduced. It would be useful for you to comment on that.

Finally, another specific area that the Audit Scotland report highlights is the impact of the more onerous on-call requirements that have developed and the higher levels of extra programmed activities, given the lower staff numbers that are involved.

Will you comment on those three areas?

Dr Woods: I do not believe that the contract contains any special provisions on remote and rural areas, but one factor that is integral to the contract is an acknowledgement of consultants' travelling time, which might have had a cost impact in remote and rural areas even though only a comparatively small number of consultants work in those places.

As the committee knows, the Arbuthnott formula guides resource allocation to NHS boards, and it explicitly includes an adjustment for remoteness and rurality. No doubt, if representatives of the boards from the more rural and remote parts of

Scotland were here, they would say that they would like to discuss the nature of that adjustment, but those factors are already taken account of in resource allocation policy across Scotland. I will invite Mike Palmer to say a bit more about one or two of the other points that were raised.

On waiting times, the main point is that, at the time, there was quite a lot of variation in the rates that were being paid across NHS Scotland. The report indicates that although two or three boards were paying less than triple time, others were paying more than that. The triple-time payment became a kind of standard. However, more important than that is our determination to do away with such payments by using the provisions in the contract and making use of the direct care sessions. The most recent information that I have is that the amounts that have been paid out in the past year are less than the amounts that were quoted in the Audit Scotland study and are on the way down. They are very much at the margin of the consultant pay cost issue.

Mike Palmer may want to elaborate on some of the other points.

Mike Palmer: On the waiting time initiative payments, I stress that the triple-time payments are only for ad hoc waiting time initiatives. We were careful in writing that into the contract. As Dr Woods has said, the thrust of the contract is to enable boards to programme ahead, on a regular basis, extra sessions that consultants can take in order to meet waiting times targets without those being classified as ad hoc sessions, which would attract triple-time payments. We are definitely seeking to reduce the amount of triple-time payments as we move towards a more programmable and programmed approach to meeting those targets. As Dr Woods says, the evidence is beginning to show that, through the falling level of payments across a number of boards.

When we inserted the triple-time clause into the contract, there were several cases of consultants being paid more than triple time. It was felt to be advantageous—in the view of not only the department but NHS managers—to apply a cap, so that the market could be controlled.

Susan Deacon: I am sorry to interrupt, but it would be useful to clarify this point before you move on. The Audit Scotland report expressly states:

"The SEHD expected waiting time initiative payments to decrease, but instead, they are rising".

You have just said the opposite. Is that because the data are historical? Are you saying that the trend is now on the way down?

Dr Woods: Yes. I do not know how a diagram can be recorded for the *Official Report*, but although we acknowledge that the payments went up, they are now firmly on the way down and are now well below 1 per cent of the current consultant pay deal.

Susan Deacon: Okay. I appreciate the fact that, in relative terms, the payments are marginal to some of the wider costs, but it is important that you have highlighted something that is markedly different from what is in the Audit Scotland report.

Paragraph 71 of the report states:

"All boards are now using only the higher payments, except NHS Lothian".

Has that situation changed?

Dr Woods: I need to refresh my memory of what the report says. The suggestion is that all boards are paying triple time rather than using time off in lieu, although I do not know what NHS Lothian is currently doing. Perhaps Charles Swainson can update the committee on NHS Lothian's practice in relation to that, bearing in mind the fact that we are trying to get rid of the payments altogether.

11:15

Dr Charles Swainson (NHS Lothian): I have taken the view that such work is additional, ad hoc work above the 48-hour working limit that the contract proposed, so it would be wrong to pay consultants triple time for it and to expect them not to have appropriate rests. NHS Lothian is prepared to pay up to double time and expects the additional component to be taken as extra rest, which ensures that consultants are fit to work for the NHS when they return to their normal duties. The work is additional and the extra payment is for work outside the normal contract. The result of our policy is the lower payments that we have made in Lothian.

Like all boards, we have been working our way out of waiting list initiatives altogether. The job planning process in particular provides a good opportunity to do that by reworking what consultants do and where and when they do it. I imagine that waiting list initiatives will reduce everywhere.

Tim Davison (NHS Lanarkshire): Although the payments are tailing off, as Charles Swainson said, boards have often decided that they were a significantly cheaper and more efficient alternative to sourcing extra activity in the private sector. We often calculated the cost of using ad hoc payments in-house—even triple-time payments—and compared that with ad hoc sourcing of activity from the private sector. Often, such payments were a much more efficient use of NHS resources, so they were helpful at times, although we all

acknowledge that we would not want to sustain them in the long term.

Dr Woods: I will give members some data for NHS Lanarkshire and NHS Lothian, to provide them with a sense of the size of such payments. In the six months to the end of December, Lothian's expenditure was £137,000 and Lanarkshire's expenditure was £175,000. That gives members an idea of the contribution of such payments, although they are at the margins.

Susan Deacon: That is helpful. I have a question about use of the private sector, which Tim Davison touched on. We know that the private sector in Scotland has traditionally been much smaller than that in England. I do not know whether trends are changing, but it is clear that the NHS in England is making substantial use of the private sector in a host of ways. You draw to our attention the fact that the comparison that you made was of NHS costs with NHS costs as distinct from what the cost in the private sector might be. In relation to the Audit Scotland report or to the wider debate about new arrangements for the consultant contract, do wider issues of which we ought to be aware arise that are a function of the different sizes of the private sector north and south of the border?

Tim Davison: I do not think that any material issues are not already in the public domain. The contract gives us a much more structured way of managing the extent to which consultants engage in private sector work and it gives us a much more formalised and explicit framework for ensuring that we know where our consultants are and that we can audit that. It also makes when consultants will undertake private sector work an explicit part of the job planning agreement. Although the market is much smaller in Scotland, and even more so outside the cities in Scotland, we have a much more structured way of managing the interface. That construct has been really helpful.

Eleanor Scott: First, I declare an interest in that I am still a member of the British Medical Association.

Before negotiations started, what data did you have on consultant working patterns?

Dr Woods: Do you mean the data that we had back in 2000?

Eleanor Scott: Yes.

Dr Woods: Very little information was held centrally in comparison with what was held locally, but even that was not as complete as was necessary to cost the contract.

Eleanor Scott: At what stage in the process did you feel that you had enough data to make a costing?

Dr Woods: The survey that was undertaken throughout the UK with the BMA was important in that respect. I do not know the precise dates on which the survey was conducted. It happened between 2000 and 2002—perhaps Mike Palmer can say precisely when. The survey was intended to fill the gap. Mike Palmer might wish to add a little to this, but my understanding is that the survey was, when it was conducted, regarded as being a reasonable basis on which to carry the contract forward to its next stage. As the Audit Scotland report shows in retrospect, a number of underestimations in the survey became clear.

Mike Palmer: I do not have with me information on exactly when the survey was undertaken—it was in 2001. I am sure that we could furnish the committee with more precise dates for the survey, but it would have been carried out just prior to the opening of the framework negotiations, which took place around the middle of 2001. About 300 consultants were surveyed and were asked to draw up diaries of their working patterns. The survey was conducted jointly with the BMA and was endorsed by the profession.

Eleanor Scott: Was that the survey that informed the first national cost estimate in March 2003?

Mike Palmer: Yes. There were cost estimates prior to March 2003, which would also have been informed by the survey.

Eleanor Scott: Why did the first national cost estimate underestimate the cost of the contract by £171 million?

Dr Woods: First of all, the figure of £171 million is a cumulative figure over three years. In the first estimate, it was believed that costs would increase by about 8.6 per cent. Once NHS boards did more detailed work in the period that followed that estimate—in other words, when we had more data from boards and consultants in Scotland—it became apparent that that was an underestimation of the likely additional cost. The principal reason why the cost was underestimated was that the survey indicated that it would be necessary to buy about one third of a programmed activity beyond the 10 programmed activities in the contract; in fact, by the time of the contract's implementation, further work had shown that it would be necessary to buy an extra 1.4 programmed activities. In the course of the first year of the contract's implementation, that actually turned out to be 1.5 programmed activities, as opposed to 1.4. That trend was observed throughout the UK. In other words, the survey underestimated the amount of programmed activity that would have to be bought over and above the 10 programmed activities in the contract.

Eleanor Scott: Has analysis been done of why the survey underestimated that? Was it because of what the surveyed 300 consultants put down or was it to do with the interpretation of the survey?

Dr Woods: Mike Palmer might wish to elaborate on this, but I will say that there were a number of individual components to on-call duties that added up to additional programmed activities.

Mike Palmer: Our analysis of why the survey underestimated the original costs shows that some cost assumptions that were made as a result of the survey information turned out to be overoptimistic. For example, it was assumed that a large element of the extra on-call costs could be offset against the notional additional half days that were given to some consultants under the old contract in recognition of on-call duties. The number of notional additional half days that were assumed to be in the system, and which was put into the costing model, was higher than what turned out to be the case. Therefore, the savings that we could get from offsetting the extra costs against the notional additional half days were proportionally less. That was one fairly significant factor that led to the initial estimate's being lower than it should have been.

Over and above that, it is important to stress that the costing model is a long-term costing model. The original costing model that was constructed looked at an outturn over the working life of a consultant, over a 20 or 30-year timeline, and at the more efficient working practices that would be developed throughout that period.

The situation that we are in at the moment is that we have just started to implement the contract. As it is only just into its third year of full implementation, it is really still a baby in terms of the length of time one would expect such contracts to last, so we are seeing the up-front investment and the cost without necessarily yet being able to judge and assess the kind of savings that can be made in the longer term. The original cost model looked at a long-term savings profile.

Eleanor Scott: Dr Woods mentioned the need for consistency across the UK, but there was not complete consistency—some areas were left to local negotiation. Can you say what those areas were and why they were left to local negotiation?

Dr Woods: The general point is that those areas were very much at the margins and probably represent less than 5 per cent of the total contract. Issues around the contract were left to local negotiation. Mike Palmer will set out what they were.

Mike Palmer: As Dr Woods said, the areas that were left to local negotiation were very much at the margins. The key elements that drive the working patterns and the costs for the contract are all consistent, and the terms and conditions lay out plainly which are the elements around job planning, on-call supplements and out-of-hours payments. The marginal elements that were left to local negotiation included, first, a specific issue about recognition for covering on-call rotas for absent colleagues. Secondly, they included discussions about the meaning of the phrase "minimal disruption" in relation to payment of fees, because we put into the contract a caveat that said that if a piece of potentially fee-paying work caused only minimal disruption and if that was agreed with the manager, the fee could be retained by the consultant. There was clearly a need to define specifically what that meant, so that was left to local negotiation.

The third element was the drawing up of local appeals and mediation lists—the lists of the people who would sit on appeals panels. That was something that we felt was best left to local decision making and determination, because local people would know who to put on their appeals lists.

Fourthly, there was the issue of approaches to time-shifting for fee-paying work. We put into the contract an option to allow people either to time-shift their work if they were engaged in fee-paying work, so that they would do that work at a different time to their programmed activities, or to time-shift their programmed activity work so that they could do their fee-paying work within core NHS time and retain the fee. That was clearly a local working-pattern issue that was best determined at local level.

The final element was the treatment of resident on-call. We said clearly that that is a practice that should be avoided if possible, and the BMA was in full agreement with us. However, if it really was not possible to avoid it, we left the decision to local determination.

We agreed with the BMA that it would be preferable to leave all those matters to local determination, mostly because it was most appropriate for those decisions to be taken locally because they were about responding to local circumstances. In one case—in the first case that I cited, about on-call rotas for absent colleagues—we would have liked a national determination. We attempted to develop one and spent many hours with the BMA drawing up draft joint guidance, but it was not possible to agree.

Eleanor Scott: You have touched on the guidance that was issued to boards. How much of it—by volume, if you like—was issued after implementation of the contract?

11:30

Dr Woods: I am not sure what the measuring rod is for the volume of guidance. A lot of guidance was produced. Mike Palmer has described the period prior to the framework's being introduced. Discussions were held immediately on publication of the framework and letters were issued to the service in July 2002, July 2003 and subsequently. However, that does not really do justice to the number of discussions that took place. Tim Davison will elaborate on some of the work that the pan-Scotland NHS employers reference group, which met fortnightly, undertook. Residential events were held to brief chief executives and medical directors. Guidance and advice were issued before the contract was implemented and discussions took place. We continue to issue guidance in response to any situations that arise, so that has been a continuous process. I am not sure that there was any absence of paperwork.

Tim Davison: The contract has been implemented 3,500 times—it is important to stress that the contracts are with individual members of staff and involved individual negotiations and discussions over about a year. Although there was a date from which the contract applied, it was implemented on an individual basis over a period of months. Most of the guidance was issued before and during contract negotiations with individual consultants. It took us several months to get every consultant, or the vast majority of consultants, on to the new contract. Job planning discussions were often straightforward, but they were sometimes extremely complex and took place over a number of months.

Julie Burgess (Formerly Scottish Executive Health Department): I will clarify the situation a little more. The consultant contract was a negotiated set of terms and conditions and so it was, in effect, the rule book. Boards had to apply for a variation if they wanted to move away from the negotiated terms and conditions. Over the 18 months to two years in which I was involved in the project, there were only about half a dozen requests for variations, which related to specific circumstances. As health boards started to go through the job planning process, they had the rule book, which on first reading appeared clear, but as they started to apply it to individual circumstances, they needed further clarification. We sent out a number of documents in the following months to clarify how to handle particular circumstances.

It was the first change in the contract for more than 50 years. During that time, different health boards had applied the old contract in different ways, so not everybody was starting from the same point. There was a need to clarify handling arrangements as we implemented the contract.

Mike Palmer mentioned some of the issues that were left for local determination. The health boards asked whether there could be a united line on certain things. In a number of areas, we sent out agreed letters in partnership. For example, the residential on-call payment was an agreed line, which we put out in partnership in July 2004. Some of the guidance provided clarification and some related to interpretation throughout Scotland.

Eleanor Scott: Such a major exercise must have taken up a huge amount of management time. Apart from sending out letters, which would add to the stress rather than relieve it, what supports did you make available to boards during the implementation process?

Dr Woods: I will invite my colleagues to say a little more on this matter in a moment. I have looked at the record and, put simply, those matters were standing agenda items in our regular meetings with chief executives and medical directors. As I have said, a number of residential events were held to allow people to immerse themselves in the detail.

As a member of the BMA, Ms Scott might have seen a copy of the terms and conditions of the contract, which I will be happy to circulate to the committee. It reveals the contract's detailed and complex nature and why people needed the support that I have just described to be able to apply its terms, as Tim Davison has indicated, to 3,000 consultants who were working in many different places and specialties. Considerable effort went into the process, but perhaps those who participated might wish to say a little more about it.

Tim Davison: I will explain the process a little more, and perhaps Dr Swainson will describe the detailed discussions that took place at health board level.

Because, when the contract was agreed, there were 49 separate employers—the 28 NHS trusts and 21 health boards—we felt that it was important to co-ordinate the contract's implementation. Of course, by that time, negotiations had ended and the contract itself had been agreed. Its cost drivers were very straightforward: indeed, 98 or 99 per cent of the cost was driven by only three or four clear elements, the first of which was the basic pay rise. Consultants' being given the ability to work up to eight hours of extra programmed activities a week potentially accounted for another 20 per cent of costs and, for the first time, we were paying consultants for their out-of-hours and on-call work

and we were making availability payments based on how frequently they were on call.

Boards tended to be interested in the process of implementation, and we provided a lot of written guidance to them on that. Four briefings that we held were extremely well attended by the chief executives, medical directors and human resources directors of all the trusts; those briefings focused on the implementation process and on the need for a consistent methodology of engagement with specialties, directorates and individuals. I said that the contract was implemented 3,500 times; however, we wanted to be as consistent as possible across specialties such as anaesthetics or orthopaedics, and to be as clear as possible about the length of time we expected consultants to spend in theatre, on out-patients and in out-of-hours work. We were simply clarifying the process of implementation. As I have said, the cost drivers in the contract were very straightforward.

The Convener: Before we go on, I want to clarify the relationship between trusts and boards. The contract was implemented in 2004 and backdated to 2003. When did responsibility for employing consultants transfer from trusts to boards?

Tim Davison: Although trusts were dissolved on 1 April 2004, the contract itself was agreed at the end of 2003, which gave us an important window of opportunity to get our act together on implementation. As the majority of consultants were employed in the 28 trusts, the trusts assumed responsibility for co-ordinating implementation—although, as Dr Woods has pointed out, health boards were also heavily involved in the process. From 1 April 2004, all NHS consultants came under the employment of NHS boards, and the majority of contracts were signed from then on.

The Convener: Given that trusts had been brought under the auspices of boards before then, to what extent did trusts and boards operate separately? I presume that the boards were co-ordinating what was happening in trusts.

Tim Davison: Although health boards employed, for example, public health consultants, the trusts, which were statutorily independent organisations, employed the vast majority of consultants and were therefore responsible for implementing the contract.

Although the trusts existed until 1 April 2004, their dissolution was signalled a year or so earlier, so we were beginning to work in single systems, although single-system working did not mature fully until a year or two after dissolution of the trusts. Trust chairs and chief executives were full members of NHS boards at that time, so by 2003 there was greater connection than ever. From 1 April 2004, we started working in single systems following the dissolution of trusts. That was a factor, but not a particularly material one, in the outcome of how the contract was implemented.

The Convener: Forgive me, but either it was a material factor or it was not. The evidence that we are getting is that a significant contract, which was not a stand-alone contract because other contracts were being considered at the same time, was introduced at a time of reorganisation for the health service. Is the message that reorganisation of the health service contributed to the problems that we are discussing today? Was that a large factor?

Tim Davison: I do not believe so. Scotland is a small place where it is easier to work in single systems. It was a great strength that I could, as chair of the implementation group, get every trust chief executive, medical director and HR director into the same room three or four times to talk about how we were overseeing the implementation of the contract.

The Convener: That is helpful.

Dr Swainson: I felt that plenty of guidance was available. The contract was not published in its final form for us all to look at until relatively late in 2003. As Julie Burgess said, we were offered a set of terms and conditions, which we used to figure out how to implement the contract. Employers in boards and trusts were considering at an early stage what was different about the new contract and how they could use it to gain benefits for employers and, by implication, for patients.

There were a couple of areas in which the mechanisms that have been set out by Julie Burgess and Tim Davison were extremely helpful. As the pay modernisation director, Julie was in continuous e-mail contact with HR directors and medical directors because we had a lot of questions. The mechanisms that Julie Burgess and Tim Davison outlined to the committee were useful in getting answers to those questions.

The mechanism to do with fees and minimal disruption was particularly important because the phrase “minimal disruption” in the terms and conditions could be interpreted in many different ways. Through discussion between the medical directors of boards and trusts, we were able to arrive at a position in Scotland where we were saying that we really did not want to pay the fees. The majority were incurred during consultants’ normal working activity, so it would have been a bureaucratic nightmare to distinguish the seven minutes that were devoted to a certain activity from the rest of the day. It was far better value and it was common sense to agree to take all that work into the contract and not to pay for it separately. We therefore negotiated, as part of the individual

job planning, that the fee-paying elements would simply form part of the consultant's normal work, which is how it was delivered under the old contract anyway.

It would have been very difficult to do that on an individual basis without pay modernisation director Julie Burgess's support in getting us to an agreed position, or without Tim Davison and the employers group discussing that and then reinforcing how we wanted to move on.

The Convener: Members have no further questions on that subject, so I invite Margaret Jamieson to take us on to questions about the impact of the contract.

Margaret Jamieson: We have spoken a lot about the impact of the contract on boards and individual consultants. I believe that boards and the Health Department decided very late in the day to consider what the improvements in patient care would be. Will you explain why that change came so late in the day? What specific performance indicators and monitoring systems have been introduced?

11:45

Dr Woods: You are referring to the fact that the HDL on the benefits realisation from pay modernisation was not issued until July 2005. That reflects the sheer scale of the implementation process that people were working their way through. People believed that the first year of effort needed to involve such a process, for the reasons upon which my colleagues have elaborated. We fully accept that we needed to be clear about the improvements for patients that we wanted to result from the consultant contract and from the other pay modernisation contracts that we have been discussing. That is why the HDL that was issued in July 2005 addressed all strands of pay modernisation.

As far as monitoring is concerned, we have required boards to let us have their plans for up to the end of March this financial year. Those plans are now in, and we are analysing them. As I said, we will wish to discuss all the detail under the annual review process. As I hope was spelled out clearly in the HDL, we are looking for improvements in some of our key objectives for activity, waiting times, efficiency and cancelled operations. Those are the sorts of matters that the committee would expect us to be thinking about, and which we have identified among the 28 key targets for ministers. Those are now central to the local delivery plans, as agreed between the Health Department and individual boards. We are looking for evidence that people are making the connections between service objectives, job planning and the big targets. We are encouraged by what we are beginning to see. We need to do more, obviously, but there has been progress.

There is one specific strand that I would like to introduce into the discussion, which is the efficient government target relating to 1 per cent consultant productivity. We are committed to securing significant productivity gains over the current spending review period. We are exploring the use of what we call a balanced scorecard, ensuring that, as well as considering activity and efficiency, we also consider patient experience and quality issues, so that we assess performance in the round. We are looking to use the consultant contract and the process of job planning to bring that to life. We have a list of examples of how boards are going about that and I note that one example is used in the Audit Scotland report. That reflects the time when the fieldwork was done and the material was put together. Now, we have a much more comprehensive picture of what is unfolding. Are we satisfied? No. Obviously, we want to do more but, as Mike Palmer said, we are on a journey on which we are trying to secure more benefits.

It might be helpful to the committee if I invite my colleagues, Julie Burgess, Tim Davison and Charles Swainson, to elaborate on the subject and to bring it to life in terms of what it means for the connection between job planning and service improvement.

The Convener: Certainly, although we should be relatively brief so that we can ask our remaining questions in our allotted time.

Julie Burgess: I reiterate that getting the 3,500 consultants on to the new contract was a massive task for the first year. It was necessarily a big issue. In the past year, it became increasingly clear to managers—I speak from personal experience—that having a requirement to agree service objectives with consultants was a key tool. As they entered the job planning process in the implementation phase, a number of organisations began to see the power in using service objectives to maximise how much they got from each consultant. They started to appreciate how that would help them to deliver organisational benefits and improve patient care. During the implementation, there was a dawning among a number of organisations that were flagging up issues that, over time, they would be able to demonstrate real improvements in patient care. However, to reinforce the point, it was always agreed that the first year would be implementation—that we would get the basics right and then build on a solid base to deliver the benefits.

Tim Davison: I will take orthopaedics as an example, because NHS organisations in Scotland have found it the most difficult specialty in which to

get waiting times down. Under the old contract, consultants spent a lot of their time seeing routine out-patient referrals. Those patients often waited more than a year to be seen as out-patients before potentially being listed for procedures.

We get the greatest benefits when the new contract is allied to service redesign, and that is what we are seeing. Through the job planning process, we wanted to ensure that consultant orthopaedic surgeons would see fewer out-patients and spend more of their time in theatre carrying out operations. By redesigning services, we introduced into the NHS new roles, which other pay modernisation schemes, such as agenda for change, also facilitated. For example, we have introduced extended scope practitioners—physiotherapists and podiatrists—who are able to take on up to 40 per cent of the new out-patient referrals that consultants saw hitherto and they are able to see them more quickly.

The majority of out-patient referrals are returned to primary care without a procedure. Only about 30 per cent of all out-patients in orthopaedics are progressed to operating procedures, so it was important, when sitting down with individual orthopaedic consultants, to agree how we shifted out-patient time into theatre time. That was quite good. We constructed programmes and got consultants to focus on new out-patients or out-patients whom the extended scope practitioners had triaged. We determined which out-patients the extended scope practitioners could deal with and which the consultants really needed to see, so we concentrated the consultants on the patients on whom they could really use their expertise.

It was also important to agree how much time consultants would spend in theatre. In orthopaedics, we had an agreement that the baseline in a consultant's job plan should be three elective operating theatre sessions a week, in addition to emergency surgery for trauma.

Consultant productivity was interesting. We agreed the average numbers of minor procedures and major procedures that consultants would carry out on a theatre list and the difference between a primary hip replacement and a hip replacement revision, which takes much longer. We were able to profile consultants' activity, multiply it by how many sessions, cases and weeks they did and, for the first time, get a clear handle on the kind of productivity for which we were looking.

The balanced score card to which Kevin Woods referred is important, to reflect the fact that productivity is measured for teams. Under the new contract, consultant orthopaedic surgeons might see fewer patients, but they focus their time on the work that they should be doing, which is operating on patients, not sitting in out-patient clinics seeing hundreds of patients who end up not requiring procedures.

That is a clear example of how the new consultant contract and job plan allows for an explicit understanding. The pan-Scotland NHS employers reference group, which I chaired, was trying not to second-guess 3,500 individual negotiations but to set parameters for specialties to segment the out-of-hours work, the elective work, the amount of time spent on out-patients and the amount of time spent in theatre. Those parameters were the lion's share of the cost of the contract.

Dr Swainson: I will give some practical examples. In the first year of the contract, one of the major benefits that we saw for patients in NHS Lothian was a reduction in cancellations of theatre sessions. Cancellations by the surgeon dropped by more than 40 per cent and they have remained at low levels ever since. In the second year, across a range of elective specialties, we saw productivity increases of 6 per cent—that is an average across the elective specialties for which we are counting waiting times. By the end of 2005-06, we saw productivity improvements of more than 10 per cent—measured in additional procedures and new out-patients—for the same number of consultants across individual specialties. That was achieved solely through the application of good job planning and good service redesign.

Every consultant is required to undergo a regular appraisal by their manager—typically their clinical director—which is linked to the process of job planning. For example, feedback can be provided to consultants that they require to improve their communication skills as a result of complaints from patients or observations from other staff. That can translate directly, through the job planning process, into a requirement for the consultant to undergo specific training, leading to a subsequent reduction in complaints.

The other point that I want to draw attention to, which relates to Susan Deacon's questions about Scottish needs, is how we tackle inequalities, which is a particularly Scottish problem. Evidence from the job planning process, which is linked to redesign, shows that we have been able to reduce inequalities in access to specialist cardiology and some aspects of gynaecology. The redirection of consultants' activities to particular places and groups of patients has brought measurable benefits.

Margaret Jamieson: Audit Scotland advises us that when the report was published, in certain areas, including mine, around 6 per cent of consultants had opted for the new contract but had not yet signed it. What is the figure now?

Dr Woods: I believe that about 99 per cent of consultants have accepted the new contract.

Margaret Jamieson: Is that being monitored?

Dr Woods: I do not have the information centrally, but I have seen the figure in the briefing that I have. I could confirm it for you.

Margaret Jamieson: You could check it and get back to us.

Identifying performance indicators and monitoring data to track the impact of the new contract will have an effect on the good initiatives on waiting times. Do you see that work being driven forward even further with the new guarantees that are available to patients throughout Scotland? Do you have sufficient data to ensure that you will be able to meet the ministerial objectives?

Dr Woods: The important point is that we now have absolute clarity about the key objectives and targets that we expect NHS boards to deliver, which include some of the indicators to which you referred. The data are captured through the work of our delivery group in monitoring local delivery plans. We expect boards to ensure that the connection between the targets and job plans is put in place.

I refer to an important point that Dr Swainson made. Many aspects of our work are not connected to the targets, although quite a lot are, for obvious reasons. People will want to pursue local objectives and long-term objectives in relation to health improvement. The contract gives us a way into all those things. We must not lose sight of that.

It would not be an Audit Committee appearance for me if I did not refer once again to Dr Logie's letter in *The Scotsman* in January, in which he talked about the way in which medicine has developed, the role of multidisciplinary team working and the danger of trying to measure productivity and improvement through a simple ratio of patients treated to resources committed. What we want boards to do—we have approached our benefits realisation in this way—is to use not just the consultant contract but the new GMS contract and agenda for change to consider improving performance in an integrated way. That is a substantial management job. Our clinical leaders and medical directors in particular have an important role. That is how we will conduct monitoring and connect results back to the big objectives.

12:00

Margaret Jamieson: Speaking as a constituency member, it would be helpful for us to see how that approach impacts in each of our areas. We might find that some of the effects are vastly different. It would be good to be able to measure the impact of the consultant contract in different board areas. The minister might well consider that when he visits each board in the summer. The primary issue that we are considering is that your department has not established a specific timescale for when the benefits will be achieved under the new consultant contract.

Dr Woods: In a sense, that is because we will continue to pursue benefits every year. We have asked for six-monthly progress reports on pay modernisation plans. That is how we are tracking them. It is not a case of having a particular set of benefits by a particular date. We will want new benefits as we proceed, which will reflect ministerial, departmental and local priorities, connected by service objectives and job planning.

Margaret Jamieson: Is that not a significant change to the way in which negotiations for pay, terms and conditions have previously been undertaken in the health service? There was always a goal that management was trying to achieve in the end.

Dr Woods: It does constitute a significant change, in the sense that we are making things much more explicit. Many things used to be implicit, and a lot of management effort went into making it all work. The significant change that is being brought about is one of the benefits of the contract.

Margaret Jamieson: I will now ask you some questions on how consultants feel about the contract. According to the Audit Scotland survey, 7 per cent of consultants believed that the new contract had led to improvements for patients. That figure is worryingly low, would you not agree?

Dr Woods: We have spent quite a bit of time trying to understand what that could mean. It is hard to know what connections consultants might have been making in their own minds when they were asked that question. Perhaps I could invite Dr Swainson to comment on this subject. We may be talking about an issue of attribution. By that I mean that we have a new contract and quality improvements, but it is not clear whether we are putting them together and thinking in the most effective way. I invite Charles Swainson to elaborate.

Dr Swainson: I have spoken to a number of colleagues about the question, how they might have interpreted it and the significance of that very low value. Most people took the question as asking what relationship their benefit from the contract had to the way in which they looked after patients. Most of them felt that the contract that they worked under bore no relationship at all to the

way in which they personally looked after patients, that is, what and how they were paid did not particularly affect their individual care of patients. The people with whom I spoke did not think of that question in the same way that we have been discussing it for the past 10 minutes, with regard to benefits realisation for the wider system.

Margaret Jamieson: That is interesting. I turn to the issues relating to the reduction in consultants' working hours and the number of them who have still not signed a waiver under the European working time directive. I note that 98 per cent of them continue to work more than 48 hours without that waiver. Where are we with respect to eradicating that practice?

Dr Woods: There is a clear obligation on employers under health and safety at work legislation to address that issue, and that is what we expect them to do. That involves securing waivers in cases where consultants work beyond 48 hours. What has been reported is something that we have known about in relation to many people who work in public services. They have a strong sense of vocation and commitment to the work that they do and to the people whom they serve. In Scotland, the vast majority of consultants are very committed and hard working and they want to go the extra mile for their patients. I suspect that that, as much as anything, is what the survey is reporting. Again, colleagues might want to comment on the matter.

Tim Davison: It is difficult to know what 3,500 people thought when they filled in a survey.

On your first question, because many consultants were already working the hours reflected in the contract, they felt that, for the first time, they were receiving proper recognition, particularly for out-of-hours work. The previous contract had neither properly acknowledged that acute physicians in busy Scottish hospitals do a lot of work out of hours and at the weekend nor remunerated them for it. As a result, many consultants justifiably felt that the contract rewarded them for work that they were already doing and that it did not, in itself, bring any additional benefits to their daily working lives. I agree with Dr Swainson that some of the broader redesign opportunities offered by the contract might be apparent to managers but invisible to individual consultants.

Margaret Jamieson: What monitoring process have you asked boards to put in place to ensure that the contract complies with working time legislation and how is that reported centrally?

Dr Woods: Although we do not intend to monitor compliance centrally, we expect boards to do so locally through the discussions that individual consultants have with their managers, who are usually clinical directors.

Tim Davison: Because we review job plans at least annually, we know whether consultants are working more hours than are specified in the contract. For example, for many years there were only two thoracic surgery consultants in Lanarkshire. However, a one-in-two rota is simply unsustainable in the longer term, and the surgeons' job plans show that they work significantly more than 48 hours a week. Of course, we are not blind to the situation. We have recruited an additional consultant, although I have to say that a one-in-three rota is still very tight. Moreover, we have signed up to the west of Scotland cardiothoracic in-patient concentration at the Golden Jubilee national hospital, which will resolve the intense on-call situation by bringing together all thoracic and cardiac surgeons.

One of the contract's advantages is that it is based on individual job plans, which allows us to see whether consultants are working unacceptable hours. Although a solution might not be immediately available, the contract signals to management and staff how the situation might be resolved in the medium to longer term.

Dr Woods: I should also point out that the solution is not always to increase the medical workforce. That is where the connection to redesign becomes important, although I will not go over issues that we have covered before, such as workforce capabilities and extended roles.

Margaret Jamieson: Your comments suggest that the redesign is more focused on consultants. Do you agree that, in the past, some consultants did not really sign up to that process when it was suggested for certain specific areas?

Dr Woods: I am not sure that I entirely recognise your comments about the past. The other week, I attended the launch of our diagnostics collaborative, which is intended to help us to improve access to important diagnostic services, and was struck by the number—and, indeed, the enthusiasm—of senior clinicians leading this work on our behalf. The extent to which the contract supports that work is very important. That said, I have always been impressed by the readiness of some of our consultant leaders to embrace change.

Tim Davison: We now have a far more structured and explicit means of designing and describing that relationship. For example, until recently, gynaecological in-patient services in Lanarkshire were spread over the three main general hospitals. However, the vast majority of gynaecological interventions and treatments are carried out in out-patients departments as day cases, so we concentrated our in-patient services on just one site, which meant that we had a much bigger pool of consultants and were able to provide specialist in-patient services, rather than

gynaecology patients being in general surgical wards. Through the job plan, we were able to describe a much better out-of-hours arrangement for staff, who had only one site to cover from a bigger team, while still having the vast majority of patient contacts on the three sites. We were therefore able to use the job plans to agree with consultants the out-patient sessions and the day-case sessions that they would have on the three sites, as well as their in-patient sessions on the one site. That is the kind of thing that brings the exercise to life. It is not that we did not do such things in the past. We did reorganise services in the past, but the job planning and the new contract arrangement makes the negotiation far more explicit and transparent.

Dr Swainson: The job-planning process and the new contract give us the ability to agree with consultants the changes needed in their working patterns during the process of redesign, as we have already done with nurses, therapists, secretaries and managers, and—as has been the case for some time—for doctors in training. The last leg of the stool gives us all the tools that we require not only to engage people in redesign but to support it contractually.

Julie Burgess: A positive opportunity that comes out of it, and which cannot be understated, is that the job planning year on year gives employers and consultants the chance to refocus on organisational priorities, so if an organisation wishes to change its services or portfolio or to redesign its service it has the opportunity every year to renegotiate the job plan. That is quite a different situation from the one that we had in the past. Also, the new contract can specify that, if someone is working a 40-hour week, 75 per cent of that time should be focused on direct clinical care. The flexibility and focus on the amount of time being spent on direct clinical care present us with real opportunities that we did not have under the old contract.

The Convener: I see that Mary Mulligan and Eleanor Scott have further questions, but I would like to finish our questions on managing costs.

There is scope to reduce costs in some areas of contract spending, such as payments for waiting times. The Health Department expected a reduction in those payments, but they have increased by 34 per cent to £3.4 million. Will that change? Is that part of a national rise that will become a fall?

Dr Woods: That is the point that I was making earlier. The indications are that those figures are now much lower; I gave examples from Lanarkshire and Lothian. We are tracking that and we want that out of the system. We want the work done within the capacity of the new contract, and we now believe that those payments are way below 1 per cent of the consultant pay bill. I cannot recall the figures without looking them up again in my notes, but I think that the figure was about £175,000 in Lanarkshire over the six-month period to the end of December, with a similar figure—I think that it was £137,000—in Lothian for the same period. That gives an indication of the fact that those costs are at the margin. We are determined to meet our waiting times targets through the provisions of the contract and through various measures that I have described to the committee previously. The good news is that we are hitting those waiting times targets; the data published last week show that we have the best waiting times we have ever had in NHS Scotland, and the provisions in the contract will help us to maintain that.

The Convener: You talk about tracking, but we understand that most NHS boards are not monitoring all aspects of the contract costs. I stress the word all. Will that not make it difficult for boards to identify areas for improvement and savings on which you will be able to gather national information?

Dr Woods: I must confess that I was not entirely sure what it was that they were not monitoring, so I am really not able to answer your question.

The Convener: Do you believe that boards are monitoring all aspects of the contract costs?

Dr Woods: My expectation is that they will. It is very much in their interests to ensure that they make the best possible use of the resources that they have.

Mrs Mulligan: I would like to follow up on the contract issue. I understand the need for flexibility, but was it really necessary to have almost individual contracts for consultants?

12:15

Dr Woods: Yes, I think so. Although someone may be described as a general surgeon, what they do in their role as a general surgeon will vary quite a bit, because often they will have a special interest. That means that they will have to devote a proportion of their time to a particular kind of surgery, so the contract had to be sensitive to those specific circumstances.

At a more general level, we have something in excess of 30 recognised medical specialties. We talked about the varied circumstances in Scotland, and when you add all that together and consider the fact that we are trying to connect service objectives to targets through job plans, you can see that we have to have that. It is the only way of doing it. I can see that one or two of my colleagues are desperate to elaborate on that, so I shall let them comment.

Dr Swainson: It is extremely important to have individual contracts, because job planning is moving into a new era. We currently employ team job planning as the first step, which enables us to agree the overall objectives for a department, the volume of activity that staff will be required to undertake and the resources that they will use. We also want to include the amount of teaching that consultants will undertake with medical undergraduates and nursing students, and the number of postgraduates that they will train, what they will train them in and how many sessions or resources that will take.

We then need to take that down into individual job planning, because not everybody is good at everything. We will want some consultants to take on additional teaching and training activity and to do less of something else from the team's overall activity. We might expect younger consultants who have recently joined the team to undertake more of the direct clinical care than older consultants who might be doing some of the other things that we want them to do. Some consultants are recruited because they are gifted at research, and we want to ensure that they have the time and space to do that. Down at the level of individual contributions to the work of the NHS, it becomes important to have 3,500 individual contracts, which local managers are expected to monitor.

Mrs Mulligan: Absolutely. Having convinced me that it was necessary to have 3,500 individual contracts, can you tell me how you monitor that throughout Scotland?

Dr Woods: It is the responsibility of the individual employers, but there is a danger when it comes to considering some of the things that we mentioned earlier. It comes down to the process of annual appraisal, annual review of the job plan and asking questions about whether the objectives have been met and what the new objectives for the forthcoming year should be. That work will, in general, be led by individual clinical directors, in the process that Charles Swainson was trying to describe.

Mrs Mulligan: So the individual clinical directors in each health board will continue to ensure that they are doing what is necessary to fit what is needed in their local areas. How do you then benchmark that between somebody in Shetland and somebody in Glasgow? How do we ensure that we are getting the right balance and that we do not end up in the sort of competitive situation that you said should be avoided?

Dr Woods: On benchmarking, we would be wary of trying to make too many direct comparisons about the content of individual job plans, for all the reasons that we have just described. We are interested in the product of all that activity in terms of benefits, and that is why we are currently analysing the pay modernisation plans that we have received. Of course, the work that we are doing specifically in relation to productivity—on the 1 per cent objective and the balanced score card—will give us some indicators, because it will use data that are generated through the information and statistics division to enable us to see that picture.

We should not lose sight of the fact that we already have a statistical picture of the sessions or, rather, programmed activities—I must use the current terminology—that are being used in different specialties in different boards. That information is all published by the ISD and, if we go to it, we can see what the average number of direct patient care sessions is and what the supporting professional activities and extra programmed activities are. That information can be examined by specialty and by board. It is detailed statistical background material and gives a comprehensive picture.

Mrs Mulligan: Are you confident that that will ensure that patients get the best service, regardless of where they might be or who the clinician might be?

Dr Woods: Yes. We are very clear that that is what the contract is about. It is a means to an end and part of a range of other pay modernisation activities that we are undertaking. For a time, implementing the contract might have become almost an end in itself, but it was always intended to enable the NHS to progress.

I reiterate the point that I made right at the beginning: the previous contract had been around for the best part of 60 years and the new contract represents a sea change. Implementing it has been difficult, but I think that there are few people who would want to turn the clock back, as we have a contract that enables us to construct the kind of discussion that is needed if we are to achieve what is set out in "Delivering for Health".

Tim Davison: The contract might not be benchmarking, but it is sense checking. A consultant's work in Shetland differs greatly from that in Glasgow because the health service differs greatly. The job plan under the contract allows for negotiation with the individual consultant. That might lead to a consultant who works in a small team in a big rural area having more time in their job plan for on-call duties—first because they are on call more frequently because there are fewer consultants, and secondly because they have more travel time because they go from Oban to Fort William to Inverness rather than around the city of Glasgow—and doing less teaching, training and research and development. On the other hand, a consultant in a big teaching centre, where there are much bigger teams and consultants are less frequently on call, might have a job plan with

less travel and less out-of-hours work but more time spent teaching, training and doing research.

The contract enables us to be explicit about such matters. As Kevin Woods said earlier, under the old contract, the understanding was implicit and relied on a lot of good will. Now, we are able to regularise those matters more explicitly through job plans.

Eleanor Scott: I, too, have a question about monitoring. Through job planning and appraisal, we will now know the hours that consultants are actually working. More than half of the respondents to the survey that is referred to in the report said that their contracts did not match their working hours, and a significant number were working over the European working time directive's limits. We should know that. What central monitoring of that is being done with a view to workforce planning for the future?

Dr Woods: We have information on that, which I am trying to locate. I was keen to see what the average working hours were in different specialties and different places. I am not sure that I will be able to locate the data on that quickly enough for you, but we are happy to provide a note on that.

Eleanor Scott: I was not asking for the data; I merely wanted to be reassured that it was being monitored centrally, not being left to individual boards.

Dr Woods: It is being monitored centrally. I seem to recall that the average working hours are about 44 or 45 hours per week.

Tim Davison: Consultants' working hours have peaks and troughs, as do all our working hours. That would become clear if I asked MSPs how many hours they worked on average and then compared it with the hours that they worked each day. We have consultants and managers who work well in excess of 48 hours some weeks and less other weeks. The contract is based on an annualised approach, in which we take the totality of the work and divide it by the number of weeks worked. It is inevitable that there will be peaks and troughs for busy professionals who work in a demand-led service.

Eleanor Scott: I was more concerned to confirm that there was some central monitoring of the overall, collective need for consultant hours in Scotland.

Tim Davison: Yes, there is.

Dr Woods: We might not have time to get into this, but the important connection to make is that the monitoring needs to inform workforce planning. I have outlined to the committee on previous occasions the reforms that we have put in place in that regard.

The Convener: With regard to the information on individual work plans and job plans, the Audit Scotland survey contains evidence that the notion of "service as usual" exists in the minds of some consultants. There seems to be a different approach with respect to the job plans, or a variation in their quality. To what extent can you reassure the committee that their quality will be consistent between health boards?

Dr Woods: I cannot give a categorical assurance that the job plans will be as good everywhere as they are in the best cases. I can, however, tell the committee that we are confident that the medical directors group, which has a key role in leading the work, is working together to ensure that the consistency that you are describing is achieved. There will always be some variability. As I have been pointing out, it cannot be completely removed. It is probably not desirable to remove it entirely, given the different circumstances that will apply. We are confident that we have a group of people who are leading the process in the way that we would want.

The Convener: I am obviously not talking about the variation in what the job plan actually says.

Dr Woods: I understand that.

The Convener: I am focusing on the variation in the quality of the job plan, and in our being confident that the plan will do what it says it will do.

Dr Woods: In practice, there will always be some variability in an organisation as large as NHS Scotland. As Mike Palmer indicated, we are currently in the third year of the contract. We are accumulating experience, and need to learn from it and share it. That is where the medical directors group becomes critically important.

Dr Swainson: As Dr Woods has just said, we are in the third year of what has been a very steep learning curve for some people. Essentially, the detail of job planning depends on the quality of the training and support that is given to clinical directors. They are a group of doctors who fulfil a management role part time, and the individuals change, so there is a constant refreshing of the group, with newcomers requiring to be trained and supported. There will always be some variability, but there is a floor to it. The consultant contract says that if someone has not made a reasonable effort to attain their objectives, if they have not completed a proper job plan, or if they have not had an appraisal, they cannot go forward for pay progression. That is a pretty good floor to use when measuring the system.

The Convener: Thank you. That is useful. It is 12.28 and we still have quite a bit of our agenda to go. Please excuse me if I now call this evidence-taking session to a halt. It has been highly

instructive for us. Thank you, Dr Woods, for coming here today and bringing your team with you, particularly all those who made so much effort. There will be a number of areas that we will wish to tidy up. Your answers have provoked questions in our minds, so we may seek some further information that time limits us from obtaining today. I am sure, therefore, that we will get back to you in writing. I thank you for your time. Your evidence has been very helpful.

Dr Woods: Thank you all very much.

The Convener: Agenda items 5, 6 and 7 are in private.

12:29

Meeting suspended until 12:31 and thereafter continued in private until 12:51.

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