AUDIT COMMITTEE

Monday 5 February 2001
(*Afternoon*)

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AUDIT COMMITTEE
3rd Meeting 2001, Session 1

CONVENER

*Mr Andrew Welsh (Angus) (SNP)

DEPUTY CONVENER

Nick Johnston (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

Scott Barrie (Dunfermline West) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Paul Martin (Glasgow Springburn) (Lab)
Mr Lloyd Quinan (West of Scotland) (SNP)
*Mr Keith Raffan (Mid Scotland and Fife) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Janis Hughes (Glasgow Rutherglen) (Lab)

WITNESSES

Mr Jonathan Best (Yorkhill NHS Trust)
Ms Margaret Boyle (North Glasgow University Hospitals NHS Trust)
Mr Robert Calderwood (South Glasgow University Hospitals NHS Trust)
Mr Tim Davison (Greater Glasgow Primary Care NHS Trust)
Mr Chris Spry (Greater Glasgow Health Board)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Anne Peat

ASSISTANT CLERK

Seán Wixted

LOCATION

Glasgow City Chambers

Scottish Parliament

Audit Committee

Monday 5 February 2001

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:02*]

The Convener (Mr Andrew Welsh): I open the meeting and welcome members of the public. I understand that our colleague, Janis Hughes, will join us today. Although Janis is not a member of the committee, she has an interest in the subject and will be welcome.

I also welcome officials from Audit Scotland to the first meeting of the Audit Committee in Glasgow. As a Glaswegian, I hope that it will not be our last meeting in Glasgow. I remind everybody that all mobile phones and pagers should be switched off.

We have received apologies from Lloyd Quinan. Are there other apologies?

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I have been asked to pass on apologies from Scott Barrie.

The Convener: That is understandable, given the weather conditions.

I seek the approval of members to take agenda items 2, 4, 5 and 6 in private. Are we agreed?

Members *indicated agreement*.

The Convener: We now move into private session.

14:03

Meeting continued in private.

14:15

Meeting continued in public.

National Health Service in Scotland 1999-2000

The Convener: I welcome the witnesses to the Audit Committee. This is our second evidence-taking session on financial stewardship in the NHS in Scotland, based on the Auditor General's 1999-2000 overview report.

Two weeks ago, the committee had a useful and informative meeting, during which we heard evidence from the head of the Scottish Executive health department, Mr Trevor Jones. We also heard evidence on the primary care payment system from the acting chief executive of the Common Services Agency, Mr Eric Harper Gow.

In today's session, we shall follow the same lines of questioning, to establish how the matters that were raised in the Auditor General's report impact at local level—in this case, in the area that is covered by Greater Glasgow Health Board. We shall ask questions on three main topics. The first is the financial performance of NHS trusts in the Glasgow area, including the purpose of financial targets and the overall financial performance of the NHS in the area. Secondly, we will ask about the new system of primary care payments, including the availability of management information and the arrangements for the verification of payments after they have been made. Thirdly, we will ask about the implications for the NHS in the Glasgow area of the implementation of the European Union working time regulations.

I will start with some general questions. We will pose questions to all the witnesses, not just to one individual. The report to which I referred is the first overview report to be published by the Auditor General on the NHS in Scotland. The NHS is a major area of expenditure for which the witnesses have certain responsibilities in the Glasgow area. How satisfied are you with the overall financial performance of the NHS in the Glasgow area? Who would like to respond to my question?

Mr Chris Spry (Greater Glasgow Health Board): I will make a start.

One must take a long view. The NHS in Glasgow went through a period of financial difficulties for a good part of the 1980s and 1990s, as a result of the old Scottish health authorities revenue equalisation formula. A lot of money went out of the NHS in Glasgow and it was extremely difficult for people make adjustments to the pattern of services and so on and to cope with the financial adjustments that were made as a result

of national allocations.

By and large, the system adjusted to those changes painfully but reasonably well. During the 1990s, up to and including the middle of the 1990s, the position continued to be extremely tight. It got a little better towards the end of the 1990s, but it was still tight. Problems of underinvestment in a range of services accumulated and those problems are crying out to be addressed.

Despite those circumstances, one can be reasonably satisfied that the standard of stewardship in the use of resources and the maintenance of financial systems is pretty satisfactory, as far as we are aware and judging from auditors' reports.

The Convener: You said that we should take a long view, but what about immediate needs? Is the overall financial performance good or bad? How would you rank it right now?

Mr Spry: The overall financial performance is pretty good, but there is always room for improvement; one can never be complacent or satisfied that everything is as efficient as it should be. In terms of systems and of people having a responsible approach to financial stewardship, the situation is pretty good.

The Convener: You say that it is pretty good, yet there are continuing deficits.

Mr Spry: That is a different issue. The deficits must be seen in context. In 1999-2000, the North Glasgow University Hospitals NHS Trust deficit was 2.3 per cent of its income, and the South Glasgow University Hospitals NHS Trust deficit was 1.3 per cent of its income. Considering the pattern of turbulence and difficulty that the trusts had experienced over a period of years in handling problems such as inflation, I think that the trusts turned out a pretty creditable performance.

The Convener: We shall return to that later. Do you consider that NHS trusts face significant challenges in meeting their health care commitments within the funds that are available from the health board, while meeting the financial targets that are set for them by the Executive?

Ms Margaret Boyle (North Glasgow University Hospitals NHS Trust): It is fair to say that maintaining the balance is a real challenge. The Auditor General's report clearly identified a number of pressures, particularly in acute services. We continue to strive to meet those challenges, with new financial pressures coming in against a background of a finite allocation of funds. At any time, we are required to do the best that we can to achieve that balance. I do not think that there is an easy answer. We must look at new drug pressures, new technologies, new services that are required and the increase in demand against a background of a specific allocation of money from the public purse for the service.

The Convener: Can the financial targets ever be compatible with ever-changing health care commitments? You say that it is a real challenge maintaining the balance, but how possible is it?

Ms Boyle: The financial targets give us some measure of whether we are running the service within the parameters that the public expects of us. If we have no targets, how can people be assured that we are trying to do the best that we can with the money that is made available to us? I would not say that the targets are necessarily the most sophisticated mechanism for enabling us to do that, but it would be even more difficult for us to be prudent with public money in their absence.

The Convener: Is it a finance-driven system, rather than a service-driven system?

Ms Boyle: I do not think that that is the case. There is a balance. The financial targets are there to give us some indication of whether we are achieving value for money and providing effective services. The counterbalance is that there are continual pressures in terms of new developments, new technologies, and the new drugs and treatments that patients require. Our job is to try and maintain the balance.

Mr Keith Raffan (Mid Scotland and Fife) (LD): You said that the targets may not be the most sophisticated system, but that things would be worse without them. Can you think of a method that would be more sophisticated and better?

Ms Boyle: We have recently given that some thought. It is quite difficult to come up with a method that fits in with a public sector organisation. The difficulty with financial targets is that they were transposed into the health service at a time when there was an internal market, a market economy and a more commercial approach to running health care. We have moved significantly away from that during the past couple of years, but we have not adjusted the financial parameters. I have to be honest and say that, despite having had a number of conversations about that, we have not come up with something that could take the place of the current financial targets.

The Convener: Paul Martin wants to explore why NHS trusts are experiencing difficulties in achieving their financial targets.

Paul Martin (Glasgow Springburn) (Lab): My question is for both Mr Calderwood and Ms Boyle. Paragraph 3.6 of the report tells us that eight of the trusts failed to break even in 1999-2000. Two of those trusts were North Glasgow University Hospitals NHS Trust and South Glasgow

University Hospitals NHS Trust. When did you become aware of the problems?

Mr Robert Calderwood (South Glasgow University Hospitals NHS Trust): In May 1999, the director of finance reported to the trust board in south Glasgow that the level of expenditure in the trust was exceeding the income projections for that fiscal year. The director of finance set about doing an audit of the opening balances of the trust, and identified that we were projecting a £5.8 million imbalance in funds. Those reports were made available to the board every month. We published our first recovery plan in September 1999.

Ms Boyle: That situation was almost exactly mirrored in north Glasgow, because of our programme of reporting. The position became apparent in May, and we followed the same process of taking that information to the trust board, talking to the health board and starting to work on a recovery plan to get us back into financial balance.

Paul Martin: Was that also in May 1999?

Ms Boyle: That is correct.

Paul Martin: What action did the trusts take to deal with those issues?

Mr Calderwood: In 1999-2000, south Glasgow trust's first action was to discuss the income position with the west of Scotland health boards. That resulted in the trust's securing £1.486 million of additional income in the year to 31 March 2000. In addition, the trust identified £2 million of internal efficiencies that could be generated and which would minimise the deficit between income and expenditure in that year. That brought our end-of-year position down broadly to the £2.236 million that we reported.

Margaret Jamieson: The new trusts were set up in April 1999. Were you aware that the amalgamated trust that you now run had hidden deficits?

Mr Calderwood: We were aware that one of the former trusts that makes up the new trust had an in-year difficulty in 1998-99 in achieving the cost improvement programme targets. However, we estimated that challenge to the new trust at about £650,000 and that proved to be something of an understatement.

Margaret Jamieson: How much of an understatement was it?

Mr Calderwood: Eventually, the opening position in May 1999 suggested that, if no action had been taken, the gap between income and expenditure would have been £5.7 million.

Margaret Jamieson: What was the position in the north of Glasgow?

Ms Boyle: We were aware that some difficulties were likely. We thought that the Glasgow royal infirmary would probably be okay. We recognised that there were some difficulties—as there had been in the previous year—in the west of the city. We were aware that there were problems at Stobhill hospital. Therefore, we were aware of some of the deficit. However, some of the pressures in the first two or three months were greater than we expected.

Part of the issue for us was setting up a single control system for the whole of the north Glasgow trust area and bringing together four different financial information systems to try to achieve parity. That was done so that we could see whether we were comparing like with like across the whole of north Glasgow. As we conducted that process, some of the other issues that had to be dealt with were identified.

Margaret Jamieson: Was Greater Glasgow Health Board aware of those issues? What action did the board take to ensure that the new trusts would start with a clean sheet?

Mr Spry: We became aware of the issues pretty quickly, when each trust identified the scale of its problem. In the late spring of 1999, the trusts briefed us about their difficulties. We had already committed ourselves to getting as much as possible of the money that we received out to the trusts, to try to deal with inflation that they were due to experience in that year.

Our uplift at the beginning of that year—1999-2000—was 4.25 per cent, which is about £23 million. We passed about £23 million to the trusts that year to cover inflation. We needed to get as much money as we could out to the trusts to help them with inflation; unfortunately, that meant that very little was left in the larder to give them much more, which is why they had to make savings and have recovery plans. We kept in close touch throughout the year. As we get to the year-end, we get a sense of what the trusts' year-end position is likely to be.

14:30

Greater Glasgow Health Board's year-end position also becomes clearer. For example, something that we were never going to be clear about early in any particular year was how much of the accumulated savings of GP fundholders would be spent by GP fundholders in that year. Similarly, a number of developments were funded—mostly with centrally earmarked funds—during the year. There is sometimes slippage in the start of such developments, so there must be a bit of cash in hand. As the year drew to a close, we worked closely with the trusts to find out the extent to which we could help them with cash.

However, that does not necessarily help their income and expenditure position.

Paul Martin: My question is for Mr Calderwood and Ms Boyle. We spoke about what steps were being taken. Can you take us through the process of reporting to your boards? Was an action plan put in place? You said that you were aware of problems, but you are not being specific about whether you arranged for a recovery plan to be identified. What decisions were taken at the respective boards to deal with what is effectively a serious deficit?

Mr Calderwood: At South Glasgow University Hospitals NHS Trust, the director of finance conducted a retrospective review of the former trust's financial performance in 1997-98 and 1998-99, to track the areas where the level of income and expenditure had got out of balance to the extent that he was reporting in May. That resulted in his report to the board, where he identified a number of areas where renegotiation with west of Scotland health boards on the cost base was necessary. That generated £1.49 million of additional income, including, most notably, £1 million from Greater Glasgow Health Board.

We then considered the fact that one of the drivers for the gap in funding was the failure of the former organisations to deliver the previous two years' cost improvement programmes, which had been a feature of their financial regime. In other words, the trusts had undertaken to deliver certain schemes that subsequently were not actioned or did not generate the level of financial saving that was hoped for.

The board received a report from the executive directors that identified action that could be taken in that year. The action totalled £2 million but was part of a programme that showed how £3.7 million would be recovered over two fiscal years—1999-2000 and 2000-01. That involved income renegotiation with west of Scotland health boards. However, more than £2 million related to changes in the way that we deliver support services in general, for example, estates rationalisation and consideration of the opportunities that the new trust created to bring together some elements of our support staffing. In the clinical areas, we identified opportunities to deliver the service within a different cost envelope, which was agreed with the clinical directors.

In September 1999, the board published the director of finance's audit of the background and steps for the recovery plan, which showed how, over two years, we would—all things being equal—get back into balance.

Ms Boyle: We identified a number of schemes and that process went on to become the recovery plan for North Glasgow University Hospitals NHS Trust. In 50 or 60 different schemes, we looked at possible efficiencies from amalgamating four organisations. One of the drivers for having fewer trusts was that we would benefit from reducing bureaucracy, and therefore costs, within the trusts. We hoped to reduce the costs that are involved in running separate payroll departments, for example. There are 60 or 70 different elements to the schemes. We wanted to identify areas—as Mr Calderwood said—where we could run the service more efficiently and reduce costs. If it would be helpful, I will be happy to make that information available to the committee. There is a huge amount of detail.

We identified the schemes and that information went to our trust board, initially in May. We then had three or four specific sessions—I do not have the dates to hand, but I could find them out—for the trust board to discuss the recovery plan. That allowed the board members to go through the different types of schemes, so that they were clear about the impact of those schemes and so that we could reassure them that we were not going to do things that would compromise services. We were often asked about that, and we were happy to offer reassurance.

The Convener: Thank you. The information on the meetings would be helpful.

Paul Martin: Witnesses from both trusts are saying that they were keen to identify efficiency saving. Do you feel that those efficiency savings could have been carried out prior to the deficits being accumulated?

Ms Boyle: Some of those savings came as a consequence of putting together four organisations and achieving benefits of scale, so I am not sure that all those savings would have been achievable within the individual organisations. The savings came through being able to provide one infrastructure for a service, rather than four. The answer to your question is therefore yes and no. We could have identified some efficiencies in the individual organisations, but other efficiencies were achievable only through putting the four organisations together.

Mr Raffan: I also wanted to ask about efficiency savings or cost-improvement programmes—whatever jargon is used. Other health boards have told me that they have gone beyond efficiency savings and have cut administration and bureaucracy to the bone. You said something different in your previous answer. What is the current position? You are being asked to make efficiency savings of around 2.5 per cent each year. Is it true to say that you have gone beyond that now and that you have almost reached the point where there is health service rationing that affects the service? Is that a fair question?

Mr Calderwood: Every year since 1988, we have subjected support services, administration and the whole gamut of services that we regard as ancillary services to more scrutiny, as we have striven to take money out of those areas of expenditure to maintain or develop clinical services. In 2001, it is fair to say that only structural change will bring further opportunities—albeit limited—for savings in those areas. Since the recovery plans for the trusts were published, we have been considering the opportunities that the new clinical configurations will give us to deliver clinical services differently and within a different cost envelope. Future challenges of dealing with a finite income, but potentially infinite demand, will centre on changes in clinical services. I would not characterise all of those as cuts or restraints; some will allow us to provide a higher quality of service. In future, we will be looking to the restructuring of clinical services. We have not reached the end of that debate yet.

Ms Boyle: Following on from Mr Calderwood's point, I believe that there is sufficient money in the service for us to provide a better service than we do at present. It is the way that we do things that causes the problem. Running a number of services on a number of sites is a major difficulty.

Although individual hospitals or services might find things difficult in the way that Keith Raffan describes, if we combined some services and restructured or radically redesigned the ways in which we provide services, there would be scope to provide better services within the cash envelope that is available at the moment.

The Convener: You are saying that clinical configurations—you began to define that term, but I do not know what it means—and combined sites could deliver savings. Would they deliver substantial amounts? What do you have in mind exactly?

Mr Calderwood: I will offer one example. We have been examining how we deliver laboratory medicine to all our front-line clinical services in Glasgow. We have concluded over the past two years that there are opportunities to enhance the quality of laboratory medicine and increase the proportion of front-line staff by restructuring the physical sites on which we base our laboratories. For example, under a business plan that is being considered by the Scottish Executive, South Glasgow University Hospitals NHS Trust would build new, higher-quality laboratory premises to deal with health and safety and other issues. Doing that would allow us to run the level of service that is needed and reduce by £640,000 the current cost of £7 million a year. Therefore, by structural change in laboratory medicine, we could make efficiency savings of about 10 per cent and invest in better quality infrastructure. There are a series of examples like that in clinical services in Glasgow.

The Convener: So you are saying that capital expenditure will lead to revenue improvements.

Mr Calderwood: It would in that example.

The Convener: Where does the capital come from?

Mr Calderwood: The capital comes from the national capital pool, which is controlled by our colleagues at the Scottish Executive. There is an annual process whereby £196 million a year is allocated for capital expenditure in the national health service. Trusts and health boards put forward to the Executive argued business cases for access to those capital funds. In this case, the bid is for £2.5 million.

Mr Raffan: The main issues are covered in paragraph 3.9 on page 16, which lists about 10 points. Is that list comprehensive? Which of the points are most significant for Glasgow? Perhaps Mr Best and Mr Davison would like to answer—they have been left out on the periphery.

The Convener: No one need feel as if they are on the periphery. If witnesses wish to contribute, they should please do so.

Mr Jonathan Best (Yorkhill NHS Trust): It is heartening and positive that we are beginning to explain some of the difficult areas in the balance between clinical services and maintaining financial control, to which my colleagues alluded earlier. Certainly in my organisation, many of the points that are listed in paragraph 3.9 are familiar in the pressures that we deal with daily.

Mr Raffan: Which are the most significant for you?

Mr Best: We have addressed the use of bank and agency nurses, which was the subject of a value for money study by Audit Scotland, because it is sometimes difficult to attract at short notice staff who have the appropriate skills in paediatrics. The Audit Scotland report has been helpful. We have been working to resolve some of the issues and to reduce expenditure in that area.

14:45

Mr Tim Davison (Greater Glasgow Primary Care NHS Trust): The pressures that are listed are recognisable in the overall health system. However, the position of primary care trusts—such as mine—is different from that of acute trusts in a number of ways. Some of the points in paragraph 3.9 are not so significant for my organisation. For example, we are not the product of a merger of former trusts. We were formed from only one trust that had responsibility for family health services, so we do not have predecessor organisations or

inherited problems.

We do not use bank or agency nurses, so that is not a pressure. Increasing capital charges have tended not to be a problem. Our organisation has been moving from large in-patient services to community-based services, so our overall capital charges have reduced. Factors such as unfunded service developments tend to be less of an issue in the priority service fields. For a number of years, we have, in partnership with local authorities, had very clear strategic development plans for our services. For example, for several years we have had a clearly agreed financial framework with our local authority partner to redesign our mental health and learning disability services.

Mr Raffan: What about increased drug costs?

Mr Davison: We will perhaps address increased drug costs later. The real inflationary pressure on drug costs in primary care has largely been recognised, as there have been inflationary increases of about 10 per cent. Historically in Glasgow—until last year anyway—drug expenditure was contained within income. A lot of hard work goes into trying to improve prescribing practice in primary care. I may address that issue in answer to later questions. The pressure of increased drug costs has been recognised and dealt with in Glasgow, but it has not put us in risk of financial deficit.

Mr Raffan: I will follow that up before I ask questions of Mr Calderwood and Ms Boyle, who have particular pressures. Mr Spry gave evidence on problematic drug misusers to another committee of which I was a member.

His health board area covers roughly a third—between 12,000 and 15,000—of Scotland's 45,000 problematic drug misusers, many of whom have contracted hepatitis C. There is a hepatitis C epidemic in Scotland. The cost of a course of treatment of interferon alpha or ribavirin is between about £5,000 and £10,000. That must be a huge pressure, because your trusts have so many of the drug misusers even taking inflationary pressures into consideration.

Mr Davison: There are very specific pressures.

Mr Raffan: That is why I gave that example—it is rather a good one.

Mr Davison: It is a good example. Also, the increased costs of extending our methadone programme for intravenous drug users are a significant pressure. We are trying to plan a strategic response to such specific pressures, in concert with the health board and our local authority partners. Extending the methadone programme in Glasgow is likely to cost more than £1 million. That will have to be part of a strategic service response. However, the general prescribing pressure that I described earlier is less controllable—there are 626 general practitioners writing prescriptions as we speak—whereas a strategic response to intravenous drug misuse is a little more controllable.

Mr Spry: The health board has consistently allocated more money each year for the methadone programme and for hepatitis C. Although the potential cost of hepatitis C treatment is very high, it is a difficult drug regime for the patient to comply with. Compliance is a key part of the treatment. Sadly, many of the patients have such turbulent existences that they cannot comply, so the actual cost is less than the potential cost. However, we must allocate money to hepatitis C treatment.

Mr Raffan: This is an important area of questioning. Do Ms Boyle and Mr Calderwood wish to respond on reasons for the deficit?

Mr Calderwood: The main reasons are set out in paragraph 3.9. Most of the background to deficits could be explained under those headings. An issue that is not addressed is the impact of payroll inflation in the past two years. The national pay review bodies have set out improvements to terms and conditions of service that have had significant costs above the headline pay inflation. When a pay review body—[*Interruption.*]

The Convener: We will adjourn until the fire alarm, or whatever it is that is ringing, stops.

14:49

Meeting adjourned.

14:50

On resuming—

The Convener: You were stopped in mid flow, Mr Calderwood. Please continue.

Mr Calderwood: There has been a significant inflationary impact on the wage bill over the past two years as a result of national pay settlements that the trusts have funded over and above the high level of inflation. That has created significant pressure on trusts, as the committee will appreciate. Almost 70 per cent of all trust expenditure is on staff salaries; therefore, when there is a movement on the national pay bill above the rate of inflation, an internal challenge is generated.

Over the past two years, there have been improvements in the national terms and conditions of service above the headline rate of inflation. Recent research has suggested that those changes could add as much as 0.8 per cent to the pay bill each year, over and above the published rate of inflation. In a trust with a wage bill of more

than £120 million—and the one for North Glasgow University Hospitals NHS Trust is significantly bigger—significant financial pressure is added through the application of national terms and conditions of service. That point is not identified in paragraph 3.9 of the report.

The Auditor General talks about "increased activity, generally". One of the reasons for that is not just the increase in the total number of patients, but the fact that we are dealing with patients who are much more ill, whose length of stay is significantly shorter than the average in the old days. The acuity of patients' illnesses means that the previous flexibility of colleagues to cover for the odd member of staff who does not attend for their shift is long gone. Now, when nursing staff are unable to attend for shifts, colleagues must cover those duties through working additional hours. That issue has been highlighted in other reports.

Those factors incur significant costs to the health service, which amplify the points that are included in paragraph 3.9 of the report.

Mr Raffan: You have answered in part the question about increased activity generally. We are told that what are called "unfunded service developments"—new services—are

"generally preceded by agreement between the Trust and the Health Board",

although not always. Is that the position? What kinds of new services have you introduced? Why have you introduced them when you are under such financial pressures? Those are easy questions to ask, but I imagine that they could be difficult to answer. Nevertheless, I am asking them.

Mr Calderwood: I will answer while Ms Boyle prepares a more considered answer.

At the moment, three types of unfunded developments are alluded to. First, clinical staff develop new skills constantly. Throughout their working life, they strive to provide a more extensive range of care to their patients. Developments may occur whereby a clinical team learns skills that can be applied to patients presenting, of which the trust or health board might not immediately be aware. Those developments perhaps distort historical referral patterns, as a patient might receive care in institution A where previously they would have been referred on by the consultant. That is a significant feature of the change that occurs.

Secondly, with increasing sophistication we are now able to treat patients who previously did not receive treatment; we can now deal with more complex cases. In the South Glasgow University Hospitals NHS Trust, significant financial pressure has been created in neurosurgery. No more patients have presented over the past five years—the number we treat has remained static, at broadly between 3,100 and 3,200 patients a year—but we have gone from operating on only 30 per cent on whom life-saving intervention is possible to performing clinical intervention on more than 60 per cent. At one level, there is no apparent activity change, but there is a significant movement in costs.

Thirdly, trusts have progressed developments in the expectation of health boards supporting them as good ideas, but in some cases the health boards have not ultimately taken that view. That is a situation that we always allude to.

The Convener: Let us pass from the south to the north for a more considered answer.

Ms Boyle: My colleague did extremely well and I am not sure that I can add much to his answer.

Mr Raffan asked what kind of developments we would initiate, which had not necessarily been agreed. External issues lead us to conclude that, from a service point of view, we should have services in place even if we do not have definitive agreement over them with the health boards. For example, the creation of high-dependency units and beds was an issue in north Glasgow. Two of the predecessor organisations had considered the evidence and various external reports and had concluded that the service that was being provided to patients was not as good as it could have been, as high-dependency beds were not available.

One of the organisations received some funding to develop such a service and was to generate internal savings to pay for it, but those internal savings were not forthcoming and there was a shortfall. The other unit also decided that such a service was a requirement for the best care of patients, but undertook its development without the necessary agreement of the local health board. That specific example might help the committee to understand why we might progress such developments.

Mr Spry: It is worth adding that such developments are not a major problem in Glasgow. The communication between health boards and NHS trusts is sufficient for that to be a pretty unusual circumstance. It is certainly not the way the trusts usually do business.

Ms Boyle: That is true.

The Convener: Paul, do you want to ask about time scales and possibilities?

Paul Martin: Yes. I refer Mr Spry to paragraph 3.14 of the report, which touches on the trusts' financial difficulties and the fact that they have prepared recovery plans. Do you know the time scale over which the trusts' plans project financial

recovery?

Mr Spry: Yes. A date for the trusts to achieve recovery was agreed. The date was different for each trust. Except in the case of North Glasgow University Hospitals NHS Trust, for which the time scale is three years, the time scale is two years, which is acceptable to us and to the trusts. The time scales were agreed in discussion with the NHS management executive. However, we are always looking for opportunities to reduce that time scale, as it is in nobody's interest for a deficit to be extended unnecessarily.

A balance must be struck. If money is allocated for the removal of a deficit, it is not available for the development of services. A judgment has had to be made about how trusts can be helped with cash while their income and expenditure position takes two—or, in the case of north Glasgow, three—years to achieve a balance.

Paul Martin: That is quite a long time, is it not?

Mr Spry: Yes, but doing anything in a shorter period of time would damage patient services and we did not want to contemplate such a situation.

Paul Martin: So if all those issues affect patient care, there is no way of shortening that period. However, if you could reduce that three-year period, that would not affect patient care.

Mr Spry: Did you say that that would not affect patient care?

Paul Martin: Yes.

15:00

Ms Boyle: That is right. We have implemented recovery plan schemes that will not adversely impact on patient care. If we had been required to get back into balance in a much shorter space of time, we would have had either to reduce activity or to remove services. After discussion with the health board and the trust board, we decided that we did not want to do that. Again, we must find a way of getting back into recovery in a shorter time without compromising services. The recovery plan schemes were designed with that in mind, which means that things will take a bit longer.

Paul Martin: Can any of you categorically state that there will be no effect on patient care as a result of the recovery plans? Ms Boyle used the word "adversely" which suggests that patient care might still be affected because of the plans.

Mr Spry: Yes: if the recovery plans mean that a patient will be treated in place A instead of place B, or as a day case instead of as an in-patient, patient care will be affected, but it is a matter of judgment as to whether those would be adverse effects.

Paul Martin: Am I right in suggesting that if we reduced those two-year and three-year periods, we could affect patient care more adversely?

Mr Spry: It is more likely that if one tries to accelerate the recovery period without putting in more income—which is the other device that one can consider—one would have to resort to cruder methods of saving money. The point about making changes that do not have an adverse effect on patient care is that they need a fair bit of careful design and quite a lot of discussion. As a result, the lead time for redesigning services is often quite lengthy. However, as the health board's own income position has improved—which it has—we have invested additional income in the acute trusts to help reduce their deficits.

The Convener: I am interested in your certainty that you will get rid of the deficits in two or three years. I hope that you do, but some of the components of your deficits, such as staff salaries, seem to be long term. You have accumulated deficits; a failure to meet targets; and, in one case, £9.8 million worth of "savings" to make. As miracles are in short supply, how can you pull yourself out of that morass without harming services or doing something that patients would not quite like?

Ms Boyle: With a great deal of difficulty. We must ensure that we discuss with clinical staff how we can best manage this change. There are certain situations in which decisions that we make are constantly under review. If we do not sufficiently review those decisions, there is always the possibility that the situation will continue for slightly longer than we would like, which will have an impact. The continual monitoring and reviewing of what we do is part of the process of managing the recovery.

Furthermore, the recovery plan is not a static document; we did not produce it a year ago and then put it on a shelf and forget about it. Every month, we have to return to the plan and ask ourselves where we thought we would be; what we have done; or whether there are things that we could do that we have not done. Managing the recovery plan essentially means managing the whole business of maintaining services while ensuring that our money is used to best effect.

Mr Spry: We must always scan the horizon ahead. For example, in our conversations with both acute health trusts about whether they are delivering their agreed deficit recovery programme—and what that means as far as this year's and next year's outturns are concerned—we are already considering how much more difficult the situation will become in light of big new issues such as the cost of junior doctors' salaries as a result of the latest pay agreement. The financial effect of that is horrific and it will have

quite a dramatic impact on the finances of health care this year and particularly next year. Just as we are beginning to see the light at the end of the tunnel of these deficits, we must start to think about how we handle junior doctors' hours, the magnitude of which dwarfs the deficits we have been dealing with so far.

The Convener: It bothers me that most of the problems seem to be endemic and on-going. Is the situation cash driven and service poor? Mr Calderwood, how do you get out of mission impossible?

Mr Calderwood: Well, I would like to think that we will.

I should emphasise the comments that my colleagues have already made. The recovery plans reflected only the moment when the new organisations came into existence and some elements of former financial stewardship came to a head.

Every year, there are always areas where the in-year cost of the service moves dramatically from the income that had been agreed as part of the commissioning process. To that extent, each and every year, there is a requirement constantly to review the delivery of the service in the hope that we can find new ways of providing the same service with less cost. The current challenges in the acute sector have come to a head in the past few years. Some of the opportunities to develop new services across Scotland have been delayed as a result of the recognition that the cost base for the current acute services is out of balance. Health boards across Scotland have therefore been putting more money into acute services to recognise the status quo instead of investing new money in those services to recognise developments. That process is not yet complete.

Mr Spry mentioned junior doctors. I have heard of a worst case scenario in which, by December 2002—when the final change to junior doctors' contracts is enacted—the wage bill will increase by approximately £80 million a year unless there is a material change in the distribution of services across Scotland. There will be no improvement in clinical service with that £80 million a year; it is purely a wage bill driven to the individual doctors for the same service. That is completely outwith our control, as it is part of the implementation of national services. Although it is right that junior doctors should work fewer hours, there are a finite number of such doctors. To comply with the rotas, those doctors have to work less. That means that we will have to increase the number of doctors, which is then linked into training programmes. As a result, we could get into a very vicious circle.

The issue of junior doctors is new. Consultants' intensity payments, which were hidden away at the end of last year's pay review, represent another payment to consultants over and above their current wages and terms and conditions of service. Again, those payments will not change the delivery of the service; they will merely increase the cost of the status quo. Later this afternoon, we will discuss the EU working time directive. Although it is eminently reasonable that, for example, staff should not be paid less than their normal entitlement when they go on holiday, the directive has caused major inflationary pressures in the service without any change in the quantity or quality of services. We must address those quite significant issues in the next year or two.

The Convener: The situation that you have just described makes the problem even more intractable, which is why I am interested in your suggestion that you will achieve a balance within two or three years.

Mr Calderwood: We come back to Mr Martin's point about the perspective from which we can describe changes in clinical services. There is a view in the health care community that we can deal with some clinical challenges through restructuring. There is an issue as to whether restructuring proposals in particular communities will be acceptable, but it is fair to say that if nothing changes the known inflationary pressures over the next two years will take away from most health boards the opportunity of gaining material benefits in the range and volume of clinical services that they commission.

The Convener: We are in danger of moving into policy areas, but I know how I feel as a consumer.

Margaret Jamieson: On the changes in clinical services, I get the feeling that you do not import anything from any other service providers. You seem to be implying that you will have your own solutions in your own trusts to the problem of redesigning clinical services, but many trusts in Scotland have won awards for their redesign of services and some of you have specialties in your trusts. Do you examine good practice in other trusts and try to sell that to your clinicians?

Mr Calderwood: One of the most quoted examples of good clinical practice across Scotland is the cataract surgery project in Ayrshire, which has been highly commended. It is fair to say that, within the health service and the medical profession, there is a tendency for people to say that if something has not been invented in their area it is not necessarily the best practice. We have gone through a fairly significant period in that regard. For example, we have worked with the ophthalmologists in Glasgow to examine clinical practice elsewhere in the UK in an attempt to see how their clinical practice can be redesigned to take on board best practice. We are hopeful that recent changes that have been agreed between

the clinicians and the trusts and have been funded by the health board will bring an improvement in ophthalmology services in Glasgow as the city piggy-backs on the ideas of colleagues elsewhere. We do not believe that if a practice has not been invented in Glasgow it is not the best, but we have still some way to go.

Margaret Jamieson: That is heartening.

Janis Hughes (Glasgow Rutherglen) (Lab): I am afraid that I want to return to the financial difficulties. From the answers so far, it is clear that it is a recurring issue. Extra-contractual referrals provide another source of income for you. From speaking to people in Lanarkshire Health Board, I know that to help fund the new services the health board wants to provide, it intends to negotiate with Glasgow on a cost-per-case basis rather than have block contracts. I am sure that other health boards intend to reduce their outgoings in that respect as well. How much more difficult will conducting business that way be, given that it will mean that you have more unplanned income? Obviously, if you have a block contract, you know what money will be available and can include that in your financial plans.

Mr Spry: We have put a lot of work into discussions with the west of Scotland health boards in the past year. It was clear that quite a bit of Glasgow trust income was at risk in terms of that sort of fluctuation and the perfectly reasonable desires of health boards to shift work into new facilities in their areas. We have got agreement that, for the services in Glasgow that are regional or tertiary, we should try to develop west of Scotland consortiums to allow the health boards to pool their resources for those services and spread out risk from one year to another to cope with the fact that the number of patients in some of the specialised areas varies from year to year.

We have made a bit of progress in reducing the amount of risk that Glasgow trusts are exposed to because of some of the cross-boundary flow issues. There are some specific issues related to the fact that Lanarkshire has to move cases away from Glasgow because of the opening of the new hospitals in Lanarkshire. There is no doubt that Greater Glasgow Health Board will have to work with the trusts to pick up the overhead costs that will no longer be covered by Lanarkshire. That is a further difficulty for us but is a perfectly reasonable position for Lanarkshire to take. Jonathan Best might be able to say something about the example of regional working in children's services.

Mr Best: A positive and practical example of that are the arrangements that have been developed during the consortium discussions for in-patient psychiatric services for children at Yorkhill. There is a good agreement with all health boards in the west of Scotland, whereby the health boards and their local communities are guaranteed a service and we are guaranteed a secure income flow on an annual basis. That arrangement allows both sides to experience some stability and allows us to monitor the system, which we do every four months, and plan developments for the future. The work that we are doing in Glasgow with other west of Scotland boards could prove to be as beneficial for other services.

15:15

Janis Hughes: Given that you will be working more on a cost-per-case basis with some health boards, do you think that you have sufficient mechanisms in place to ensure that you will be able to track that kind of financial flow?

Mr Spry: I think that we will be working less on a cost-per-case basis. The use of consortiums reduces the use of cost-per-case financing, which will be replaced with block contracts, to use the old jargon.

Janis Hughes: But there will still be some cost-per-case work.

Mr Spry: Yes, but much less. We have to address precisely what the reduction in the number of patients coming from Lanarkshire to north and south Glasgow will be, specialty by specialty. That will allow us to tell what impact there will be on the cost profile of individual specialties. That is a complicated job and we are not near to finding an answer, but we have been in discussion with Lanarkshire and I am sure that we will come to a fair agreement fairly soon.

The Convener: Which trusts in the Glasgow area expect to achieve their break-even target by the end of the financial year?

Mr Calderwood: South Glasgow University Hospitals NHS Trust does not expect to achieve its financial targets by the end of this financial year.

Ms Boyle: Similarly, North Glasgow University Hospitals NHS Trust does not predict that it will meet its financial targets by the end of this financial year.

Mr Best: Yorkhill NHS Trust predicts that it will meet all its financial targets.

Mr Davison: Greater Glasgow Primary Care NHS Trust also predicts that it will meet its targets.

The Convener: We have spent an hour on this section because we thought it important to do so, but we will now move on to examine why levels of clinical and medical negligence claims are rising and what the consequences of those rises are.

Margaret Jamieson: Mr Spry, how much has

been set aside by health service bodies in the Glasgow area to deal with negligence claims?

Mr Spry: At the end of the financial year 1999-2000, the health board had set aside £6.3 million as a provision for medical negligence claims. The trusts will be able to give you figures for how much has been set aside in their areas.

Mr Calderwood: In the year 1999-2000, the South Glasgow University Hospitals NHS Trust had set aside £1.214 million for medical negligence. In that fiscal year, the trust made payments of £657,000 in settlements of medical negligence claims.

Mr Best: For that year, Yorkhill set aside £79,000 and paid out £9,000.

Mr Davison: Greater Glasgow Primary Care NHS Trust set aside £50,000 and I think we paid out something between £10,000 and £20,000.

Ms Boyle: I am sorry, but I do not have that information with me. I will send it to the committee.

Margaret Jamieson: Why do you think the claims for clinical and medical negligence are rising? Does the fact that they are rising point to problems with the quality of health care that is provided by the national health service in Glasgow?

Mr Spry: I am not sure that the number of claims is rising. I was interested to see the evidence that the committee had from Trevor Jones and his colleagues—that the number of claims appear to be pretty much the same over a period of time. That is similar to our experience, although we log the information in a different way because we look back to see how long the claims have been outstanding and how many we have from different years. I do not have to hand any data on the number of claims that are lodged each year.

Provision has increased partly as a result of an assessment made by the central legal office, which considers each case, judges its risk and the magnitude, and comes to a view about what provision should be made. The CLO carried out a thorough review in 1999-2000, which resulted in an increase in the provision. That was a consequence of how the office assessed the provision and how such provision was required to be treated in the accounts.

Margaret Jamieson: Are you satisfied with the way in which the CLO undertakes that analysis?

Mr Spry: Yes. However, one should remember that lawyers are always cautious.

Margaret Jamieson: The payments for negligence claims must be met from NHS resources, which must detract from health care. What action is the national health service in Glasgow taking to control what seems to be a rising tide of claims?

Mr Calderwood: In Glasgow, in common with trusts elsewhere in Scotland, we are involved in the application of the clinical negligence and other risks indemnity scheme guidelines and regulations, which encourage the trusts to act collaboratively to deal with the financial consequences of claims. More important, the trusts are making a commitment to undertake significant work on risk management, both generally and clinically. The trusts are making a big commitment through the increasing importance of clinical audit and governance to ensure that patients' experience in hospitals or in general health care provision is as good as it can be.

Clinical governance will present challenges to managers and clinicians. At the moment, those processes are being established and we are working through them. There are key milestones in relation to the application of CNORIS and dates by which trusts must have completed certain tasks. There is a financial incentive to ensure that trusts take appropriate action to minimise risk, as that impacts on a trust's contribution to the national fund for clinical negligence. We are committed to going down that road, but it presents another financial challenge—we need to invest in staff and resources to develop clinical audit and risk management. We have yet to assess the full impact of clinical governance and audit in the ability of the staff to perform across a range of tasks.

Margaret Jamieson: Do you think that the sums of money that you are having to put aside might decrease in future because of the sharper delivery of quality clinical services?

Mr Calderwood: I would like to think so. However, one must put that in context. The Scottish courts are still way behind the English courts, which in turn remain way behind the European and north American courts, in the financial value that they place on life and disability. Although Scotland could reduce the number of claims, it is highly possible that, over time, the Scottish courts will place a higher financial value on life or disability. At the moment, the settlements in Scottish courts are significantly lower on a case-by-case basis than are settlements in other legal systems.

Mr Spry: The largest number of unresolved cases on the health board's books—this is going back to before trusts took over the responsibility—relates to obstetrics and gynaecology. The issue is heavily skewed towards the risks associated with childbirth. Those are cases where the potential cost of any settlement is high because of the impact on a child's life.

Mr Raffan: You say that the settlements are way behind those in the rest of the UK, Europe and north America, but what about lawyers' costs? Do lawyers' costs still have to catch up and how big a component are they of the whole cost?

Mr Calderwood: Legal fees in Scotland have continued to rise annually in line with the legal profession's rate of inflation. The number of man hours for which we contract—the number of cases that we defend annually—is fairly static.

The Convener: There is a paradox. Although the annual costs are relatively small, massive amounts of money that could otherwise be spent on services are set aside and the system seeks further cuts to support that. However, further cuts may affect quality, which leaves the service more vulnerable to being sued. That presents an on-going problem. How would you resolve that paradox?

Mr Spry: To some extent, the provision that has to be made, which is for several years ahead, gets built into a deficit position. We have talked about trusts' deficits, which include their provision for clinical negligence requirements, and the same is true of health boards. Greater Glasgow Health Board is currently running a deficit because of clinical negligence. Our financial duty is to break even on cash. However, we are running a deficit on income and expenditure, which—before people start to panic—is somewhat less than our provision for clinical negligence. Nevertheless, one can get too beguiled by the intricacies of accounting convention. The conventions of accounting do not necessarily have a direct impact on clinical services.

The Convener: Quality is the key to avoiding negligence claims. As chief executives now have a legal responsibility for quality, how are the trusts in the Glasgow area addressing their clinical governance responsibilities?

Mr Davison: Although the statutory responsibility of chief executives for clinical governance is relatively new, the approach to improving quality and all the activities that are associated with clinical governance are not. We have for some time been pursuing clinical audit, risk management, research and development and better complaints handling.

In recent times, a far more objective and systematic evaluation of standards of service has been introduced. The Clinical Standards Board for Scotland publishes clear standards against which trusts are to be measured—their performance against those standards will form part of the new performance management arrangements between the Scottish Executive and unified boards. Trusts are now embarking on a sophisticated analysis of how to implement those standards, some of which are fairly specific.

We must consider how to support that implementation, which is an intensive operation. That involves evaluating the standards and carrying out internal audits of our performance against those standards before the Clinical Standards Board for Scotland visit. Where it is found that we are not fully compliant, a series of interventions may be required to bring things up to standard. The question is not just of performing to standard, but of demonstrating that we are performing to standard, which often demands collecting a large amount of clinical information.

That is fairly new. Several trusts in Glasgow—certainly my trust—have been involved in piloting the Clinical Standards Board for Scotland standards before they have been published. We are gaining experience of how to verify our provision against the standards and how to collect data.

Although clinical governance is new, the components of clinical governance are not, and we have experience of those. However, the Clinical Standards Board for Scotland is challenging our systems to be far more detailed in data collection than they were before.

The Convener: I will ask the other witnesses about means and measurement. If there are performance indicators—[*Interruption.*]

We will take a break. We might be in for a series of interruptions, as votes are taking place elsewhere in the building—we will have to thole the bells.

15:30

Meeting adjourned.

15:31

On resuming—

The Convener: I ask my colleagues to speed up the questions and answers. We have dwelt on the first section for a long time, with justification.

What are the means and the measurements? When you set up the performance indicators, how can you tell whether you are succeeding?

Mr Best: I will provide an example. Through the Clinical Standards Board for Scotland, not only have specific standards been developed for schizophrenia and chronic heart disease, for example, but generic standards are being developed, which will be reviewed in all the organisations across Scotland. As Tim Davison alluded to, a self-assessment process has been developed, which will be the subject of review by the Clinical Standards Board for Scotland, so there

is uniformity in some of the generic standards in the service in Scotland. I hope that comparative data will flow from that, so that we can see how we are doing.

The Convener: That applies to the primary care trusts. Does it also apply to the acute trusts?

Ms Boyle: Yes. We have clinical governance committees and we have set out on the track that both Jonathan Best and Tim Davison have described. Given the range and complexity of the services that we run, however, it will take us some years before we have data that will tell us whether the quality of service is all that it should be. The task is a daunting one; we have a lot of work to do, as we must go through each specialty, procedure and clinical condition to get the baseline and then decide what we are comparing it with. We have made a start, but a significant amount of work, time and effort must be put into the process.

The Convener: A local authority parks department said that it used to cut the grass but that now, with performance indicators, all that it seems to do is measure it. Without getting into a morass, does the system work? What is the situation in the south Glasgow acute trust?

Mr Calderwood: As colleagues have pointed out, all our clinical staff are now—because of the external bodies—going through continuing professional development, external accreditation and, for consultants, continuous accreditation and re-accreditation, potentially at intervals of five years. The fitness of an individual to perform their tasks is being examined in a much more systematic way than in the past—as well as the internal mechanisms, that will drive the clinical governance agenda.

I take the convener's point. There will be cases—there have been in the past—when we look at services and see that we are failing to meet the standards for which we strive. A current example is the concept of cancer services. We have done a significant amount of work to study the patient's experience when they are referred from their primary care physician into the secondary care sector with a potential diagnosis of cancer. We have identified bottlenecks and have sought and in many cases, through health boards, secured additional resources to make improvements so that the journey times of patients are speeded up and we meet acceptable targets.

In other areas, the process has led to clinical teams working together. In South Glasgow University Hospitals NHS Trust, breast surgeons were working single-handedly at the Victoria infirmary and the Southern general hospital. If they were not in the hospital, we had no on-site specialist. As a result, not only have we put forward proposals to appoint, as we did the year before last, another breast surgeon—a third one—but we have made the surgeons work as a team, so that they cover each other's area of responsibility when they are away from the hospitals. That gives us an expectation that patients attending either of the hospitals on the south side could be seen by a specialist in 24 hours. That is an example of our examining the outcome of the audit and taking steps to improve the service; some of that is about resource, but much of it is about how we work together and use the current resources differently.

The Convener: I wish you all success in raising quality without getting lost in the paperwork.

I will finish this section by asking you all about the clinical negligence and other risks indemnity scheme. How will the scheme affect the way in which trusts in Glasgow account for negligence? Will the new system present advantages for trusts? If so, what are they?

Mr Davison: It is relatively early days, but the scheme gives a fairly good framework to work within. It is a new approach, which introduces a more unified way of handling clinical negligence and other risks. We will not know for some years whether we are reducing clinical negligence or what the effect of risk management is, but the framework is useful. All the trusts have arrangements to deal with the matter, such as CNORIS committees and designated leads, which seems to be a coherent approach to the problem.

The Convener: Is that a shared feeling?

Ms Boyle: Yes.

The Convener: We will move on to consider whether existing financial targets serve a purpose.

Margaret Jamieson: Paragraph 3.10 on page 16 of the Auditor General's report indicates some areas where trusts were dependent on non-recurring income in 1999-2000 to try to break even. If non-recurring income was available in 1999-2000, what steps have been taken to replace that income or reduce costs in the current financial year? I specifically cite Yorkhill NHS Trust, as it gets a mention in the report for using non-recurring funding—it used capital expenditure to balance its books.

Mr Best: That is correct. The use of receipts from sales of assets is one of a number of methods for satisfying our recovery plan. Yorkhill, like other trusts, is in the middle of managing a recovery plan. We are coming to the end of year 2 of the plan and will be in balance by 31 March in the next financial year. One of the measures that we used to get there was the identification of the sale of surplus assets, which is prudent in any organisation. We requested the use of that money to bridge the gap to get us to financial balance.

That is what has been happening, although we do not intend to prolong the use of that solution.

Margaret Jamieson: How do you compensate for that now? You will have to identify that funding for this year.

Mr Best: That is part of our continuing internal programme of efficiencies and redesign of services to ensure that we utilise income to match expenditure. Fortunately, the additional non-recurring moneys allowed us to bridge the gap to plan and manage properly.

Margaret Jamieson: My next question is for Robert Calderwood. I note that, in order to ensure that the South Glasgow University Hospitals NHS Trust's deficit was not greater than reported, the trust failed to pay other trusts in Glasgow, which caused problems for the North Glasgow University Hospitals NHS Trust. Is that a sensible way of using public funds? You are going to have to pay up sometime, Bob.

Mr Calderwood: The situation in the south Glasgow trust is that a significant day-to-day challenge around cash was identified in 1999 and remains today. To stay within one of the three financial targets—the external financing limit—we had to make a series of payments in March, one of which was of about £4.4 million from the public dividend capital to the management executive. We discussed the trust's inability to make that payment, given its cash position—another difficulty that the trust inherited—with the management executive throughout the second half of 1999. However, the outcome sought by the trust—a forgiveness of PDC payment for 1999-2000—was not forthcoming and we were obliged to make the payment to the management executive on 14 March.

When that decision was conveyed to us, we had £100,000 in the bank; over the following six weeks, we had to generate £4.4 million out of that £100,000. We achieved that by slowing down the rate at which we paid other external creditors, the majority of which were creditors through internal trading with other NHS bodies. Non-payment to other NHS bodies was agreed with the bodies concerned—it was agreed that they did not require payment in that financial year to achieve their targets. To that extent, it was a surprise to note that the external auditors had commented on the non-payment to our colleagues at the north Glasgow trust.

Margaret Jamieson: It would have made better reading if you had paid up on time and if Ms Boyle's figures had been represented as a deficit of £7.6 million, rather than as a deficit of £8.7 million.

Mr Calderwood: My understanding of accounting treatment is that the arrangement would not have made any difference to Ms Boyle's deficit. Her income and expenditure position and her balance sheet would have been dealt with, but not her deficit.

Janis Hughes: My question is for Jonathan Best. Notwithstanding the non-recurring money and capital receipts that Yorkhill used to help the situation in 1999-2000, it is obvious that the trust relies to a great extent on charitable donations. How do those donations help your overall financial situation? I do not mean to suggest that you would not be financially prudent anyway, but are the charitable donations one of the reasons why you will meet your targets for the current financial year? How difficult would it be for you to survive without those donations?

Mr Best: It is fair to say that Yorkhill attracts a greater injection of charitable donations than many other institutions and that those donations have gone some way to helping our financial position.

In or about April 1999, when the extent of the deficit was being uncovered, an attempt was made to reduce the trust's dependence on charitable moneys. Aside from the donations that are received for specific items, we set up a trust equipment group, among other groups, to consider how best to utilise the money with the agreement of those who donate it. Buying medical equipment using moneys from the charitable fund has a significant benefit, in that we do not have to pay VAT on the equipment. However, that does not solve the problem of maintaining the equipment or paying the staff who run it. Those issues must be dealt with internally.

While there has been a reliance on charitable moneys, the system has evolved so that the use of such moneys is in line with the direction in which the trust and its clinical services are going. In addition, the dependency factor has lessened.

Janis Hughes: However, you continue to rely fairly heavily on charitable donations to meet your targets.

Mr Best: We do not rely on donations to meet our targets, as we have changed the system. For example, we set up a scholarship scheme from endowments and undertook a significant clinical audit, which was paid for from legacies that were specifically willed for that purpose. We changed the system to avoid relying on charitable moneys.

The Convener: Understanding comes from information and knowledge. Therefore, can we move on to gaining a more comprehensive picture of overall financial performance in the NHS?

15:45

Paul Martin: Mr Spry, we are aware that the health boards and trusts present their accounts

differently from other organisations. Sometimes, that makes it difficult for us to determine the overall financial position of the NHS in Glasgow. What is the true financial picture?

Mr Spry: The trusts' deficit position is clear and known and their ability to meet their various financial targets is also known. The health board's position is known—it is running a small income and expenditure deficit, but it is delivering on its cash targets. If you were to ask about the overall state of financial health of the NHS in Glasgow, I would go back to my opening remarks. Its state of health is under control, but the position is extremely tight. Simply putting all the accounts together does not give the aspect of the trusts' income that is dependent on other sources. For example, in 1999-2000, the north Glasgow trust's main income was about £220 million from Greater Glasgow Health Board and about £78 million from other health boards. When we consider the overall health of the Glasgow NHS system, we must pay attention to the income that comes from other health boards, as that is a significant element.

There are other elements, such as contracts for national services that are provided in Glasgow and income from teaching and research. All those factors would need to be added together to paint the full picture. However, as I said, if we were to sum up the position, we would say that it is under control but extremely tight and always vulnerable to the sorts of pressures that we discussed earlier.

Paul Martin: My point is that the way in which the accounts are presented makes it difficult to clarify the picture. Is not that correct?

Mr Spry: Yes. That is mainly due to the accounts of other health boards—we cannot determine their accounting arrangements or the way in which their accounts are presented. However, income from other health boards is a significant element for the Glasgow trusts and appears in their accounts.

Paul Martin: So we do not know what the true and comprehensive financial picture is.

Mr Spry: I think that we do. It depends on one's purpose in trying to understand the picture. When the health board talks to the trusts about how it can help them to manage their way out of their deficits, we must think through with them how much of their problem ought to be amenable to some support from neighbouring health boards. Not only do we consider that explicitly, but we discuss it with neighbouring health boards.

Mr Raffan: According to the national health plan, which was announced by the Minister for Health and Community Care in December, trusts will continue to be the major providers of health services. What arrangements will be made for the public reporting of the financial performance of individual trusts? What arrangements are in place now and will those arrangements change?

Mr Calderwood: The trusts publish their annual reports, which contain extracts from the externally audited finance reports. We also make full copies available to the general public. Trust boards now hold all their meetings in public and, to the best of my knowledge, the finance debate is always held during the public part of board meetings. To that extent, there is an on-going understanding of the financial position of the trusts throughout the financial year. In the past year, trusts in Scotland have ensured that a member of the staff partnership forum is in attendance at those board meetings, which means that there is further staff scrutiny of our financial position and the challenges and choices that confront the trust board. Trusts' finances are very much in the public domain. We expect that openness and transparency to be maintained under the health plan.

Mr Raffan: It is easy to talk about public transparency, but transparency depends on whether information is presented in a form that is digestible to laymen such as me, who are not accountants and who are no good at reading balance sheets. How do you put the information truly in the public domain, so that anybody who is picked off the street can understand what you are up to? You do not even have to go out on the street—just pick me.

Mr Calderwood: The way in which our data are presented is understandable to me, as a non-accountant. We focus on the main cost drivers and, on a monthly basis, we consider the issue at clinical directorate level; for example, the level of funding that is made available to run a service for the month and what the actual expenditure is.

The more technical aspects of the accounting treatment are left out of the board report. The report considers expenditure, the target income and the range of clinical services that we provide. Were there more patients or fewer patients? Are patients a driving factor in the financial performance? The report considers staff payroll issues, so that the board can understand what the cost drivers are.

Mr Spry: If I take a bird's eye view of the financial system, it strikes me that there is a lot of movement within the year and from one year to another. Some things that may have been funded centrally in the past are devolved, so that money moves in the system from the centre to, for example, a health board. Sometimes there is a switch of responsibility. A health board might have administered a pot of money in the past, which it has agreed to transfer to a trust. Money can be allocated in-year; sometimes it comes right at the beginning and sometimes at the end. Sometimes

the payments are non-recurrent and sometimes they are recurrent.

If we try to tell the story in numbers, it is incredibly difficult to try to track it from one year to another, because the mechanical task of reconciliation from one year to another is complicated. If we try to tell the story in words that have some credible connection with the numbers, that is also an extremely onerous task. We end up with a statement along the lines of, "The trust has met its financial targets"—or that it has not—or, "The trust has a deficit", or that it has not. We find ourselves falling back on generalisations.

The Convener: The problem of complexity has to be met to ensure clarity—that would help us all.

On the Common Services Agency and the delay in providing important management information on expenditure on primary care services, the CSA

"makes payments to . . . GPs, dentists, opticians and pharmacists . . . on behalf of Primary Care Trusts."

Those payments

"can amount to over 60% of the budget of a Primary Care Trust."

Paragraph 10.6 in the Auditor General's report says that the CSA has had problems in giving timely accurate information on primary care activity levels to primary care trusts and health boards. That is described as a "critical weakness". How far does the Greater Glasgow Primary Care NHS Trust manage its budgets without that information coming to it when it is needed?

Mr Davison: From a Glasgow perspective, the biggest element of cash-limited expenditure for which the delay in information is important is prescribing. The historical position in Glasgow on prescribing has been that, during the 1990s, we lived within our budget, with the exception of 1999-2000, when the prescribing budget was overspent by just over £1 million. Our analysis of that was that it was a peculiar year because of volatility, especially of generic prescribing costs. That has led to a more cautious financial planning system in our trust, because we are more reluctant to make early investment decisions that are based on limited information. In the past year and a half to two years, the delay has not been critical—it has not prevented us from doing anything. The delay is about three months. Prescribing expenditure is fairly non-recurring in nature, in surplus or deficit terms. Last year, for example, we overspent to the tune of more than £1 million. This year, we predict that we will underspend.

We want to be able to forecast, with as much certainty as possible, what the year-end position will be, which means that we have to be more prudent and cautious in how we forecast. We are unable to understand whether predictions have come true until later in the year. That means that if we forecast, for example, a surplus of £1 million in prescribing, the earlier in-year we knew about that, the earlier we could agree with local health care co-operatives and general practices on how we should invest that surplus. The later in the year that we know, the less able we are to make early decisions. Whether that is critical comes down to whether it prevents us from doing anything.

The regulations allow us to carry forward prescribing surpluses into subsequent years. The question is really more about delaying investment decisions than it is about preventing them from happening. If we were to generate a prescribing saving in Glasgow this year of, say, £1 million, we are not confident that that would be a sum that we could apply as a recurring form of expenditure, such as nursing staff recruitment in practices.

We tend to want to agree with co-ops and GP practices on the appropriate, non-recurring application of the surplus on training, audit, premises improvement, organisational development and so on. If we were unable to carry forward surpluses in prescribing, we might have to make rash investment decisions, such as those that the health service used to make 15 or 20 years ago, when people tried to spend money before the year-end and we ended up with lots of typewriters. In summary, a delay in information makes our financial planning more cautious and it delays investment decisions rather than preventing them. In this financial year, we predict a surplus in prescribing, as opposed to a deficit. It will be annoying, but not critical.

The Convener: Prudence in forecasting is one thing, but is it necessary for trusts to challenge GPs to improve their prescribing? I point the witnesses in the direction of the 1999 Accounts Commission report, which recommended a range of improvements in prescribing that could benefit patients and generate savings in the region of £26 million—a large potential amount to be available in the system. Is it necessary to have that information, so that the trusts can challenge GPs to improve their prescribing?

Mr Davison: We have that information; the issue is simply that we receive it three months' later than we would like. We have been challenging GPs about their prescribing decisions for years—that is not new. Our view is that changing prescribing practice is a long-term educational process. The limitation in the availability of the information at the moment—which is a timing issue rather than that the information is not available at all—does not in any way prevent us from challenging GP prescribing practice, and nor should it.

The Convener: Do you expect fully reconciled information to be available for 2000-01 on a time

scale that will allow the audits to be completed in accordance with the deadlines that the department notifies?

Mr Davison: Our feeling is that the information will not be available within the time scales that we would like, by the end of the year. However, by the time that we must close our accounts, we should have about nine months of prescribing information, which should allow us to make a reasonable forecast of prescribing expenditure, which Audit Scotland will accept.

Mr Raffan: In a reply on the hepatitis C drugs, you drew a distinction between relatively stable prescribing and what you called strategic prescribing. Will you clarify that?

16:00

Mr Davison: We have 626 GPs in Glasgow, who spend about £115 million a year in day-to-day prescribing of drugs for patients who present themselves at five or seven minute intervals at the GP's practice. That task is different from that of identifying a client group that has a condition that one drug—for example, methadone—will help to improve. The potential growth in use of that drug can be predicted and is determined by a health board's or trust's decision to expand the service, rather than by 626 individuals who have taken separate decisions for 100 patients a day in their general prescribing practice. That is what I meant. If we decided to extend the prescribing of methadone in Glasgow, we would predict how we would extend it, to what value, at what cost and whether we could afford it.

Mr Raffan: I will describe a less predictable scenario that does not involve a specific client group. New drugs are coming on stream all the time, sometimes with unpredictable costs. For example, Trizivir—a treatment for HIV—became available three weeks ago. The cost per year of that drug is probably £9,600 to £10,000. How much warning do you receive of when such new drugs will come on to the market, so that you can get them to patients without delay?

Mr Davison: We are straying out of family health service prescribing into matters that corporate systems deal with in Glasgow. The licensing authorities make it clear when drugs will become available. We have an area drug and therapeutics committee, which makes judgments about drugs that are coming on to the Glasgow formulary. Some drugs, such as Viagra, are determined by Government policy or guidelines. One of the biggest issues in family health service prescribing is the new anti-smoking drug, Zyban. Its impact on our FHS prescribing budget is unknown. That will depend on prescribing practice and patient take-up and compliance.

I repeat: there is a distinction between the approach that can be taken to some conditions and some new drugs for which a forecast of expenditure can be made, and being able to forecast with reasonable certainty how the larger amount of drugs—which in our case costs about £115 million a year—is performing. The three-month delay means that we are three months behind with our forecasting, compared with a couple of years ago.

The Convener: We will move on to discussing the delay in implementing verification of primary care payments after they have been made.

Margaret Jamieson: Tim Davison said that it was within the hands of another organisation to say whether a significant amount of his budget—I think that it was 61 per cent—should be spent. Why was not a robust system in place from the start for verification checks after payments have been made?

Mr Davison: The picture is a bit confusing. There were 15 fairly robust systems and three regional mechanisms for verification of payment before the system was centralised. It is a fallacy to pretend that nothing happened before the CSA took on overall responsibility. In fact, there was an extensive process of verification.

All the primary care trusts were created less than two years ago. We took over responsibilities with a new organisation. Therefore, 15 new organisations had to work with an organisation that had taken over a newly centralised system. We have been feeling our way towards how much can be done centrally and how much could and should be done locally. We are aware that there will be a national approach to post-payment verification. We are looking forward to that being produced as soon as possible. When it is produced, it will give us more comfort than we have.

Nevertheless, we are in constant dialogue with the CSA on post-payment verification, or PPV. One issue is whether check information should be made available to us. The trust's audit committee has been considering what we should do in advance of receiving the national guidelines on how PPV is handled. For example, we have considered payments for night visits from GPs, which have resulted in our examining outliers for claimants—claims that are outwith the average claim—and the reasons for them. If we are not satisfied with the reasons, we will undertake practice visits to discuss them with GPs.

Margaret Jamieson: The work that your trust is undertaking is commendable, but surely if you are working contractually with the CSA, it should work to your directions. If there is a difficulty in verification of payments that have been made

through the system, and your trust is over budget or cannot break even, your head is on the block.

Mr Davison: That is right. However, the decision to centralise the payments system has been made. It would be folly to reverse that decision when we have started down that path. To my mind, the information services division of the CSA contains the best people to do the job. I have confidence that they will get it right.

In the meantime, what I said remains true. National guidance on PPV will be issued. We will live within that guidance, but we are developing our own PPV. There was always a fairly coherent process of post-payment verification checking. The problem has been to bring together 15 slightly different methods and to report on that timeously.

I do not want to sound complacent. I feel that the information and statistics division is doing everything that it can to improve the information system, the implementation of the new system and the production of information. To some extent, the less harassment that it receives from its customers, the better. It should be left to get on with the job and produce the goods.

Paul Martin: The Auditor General makes it clear that practice visits are an important part of an effective post-payment verification system. Do you agree?

Mr Davison: I am not sure that I do. There are 220 practices in Glasgow. We are trying to do a lot with them on a wide range of issues. Payment is just one small but important part of a practice's considerations.

We talked about standards. One of the standards that will be introduced for general practice is practice accreditation. That will involve a visit to every practice in Glasgow, which will be judged against the clinical standards of the Clinical Standards Board and the Royal College of General Practitioners. We would undertake a visit only for the exception of a horrendous outlier that was brought to our attention.

Instead of routinely visiting practices, we prefer a systematic programme of practice visits to discuss a wide range of issues, including post-payment verification, prescribing practice and clinical standards, to allow us to raise issues about any of them. With the exception of the horrendous outliers that I mentioned being brought to our attention, I think that systematic visiting, as part of a post-payment verification system, is of questionable value, given its cost.

Paul Martin: Do you disagree on that particular point?

Mr Davison: I think that the tenor of what I have said indicates the limited value.

Paul Martin: Yes, but if we get right down to it, you disagree with that particular point.

Mr Davison: To give a black-and-white answer would be to oversimplify what is a very complex issue. I think that the tenor of what I said describes my view.

Paul Martin: How many practice visits have been carried out in the Greater Glasgow Health Board this financial year?

Mr Davison: None has been carried out specifically in relation to post-payment verification. In relation to outlier information on prescribing, 56 visits were undertaken during 1999-2000. Audit Scotland's annual report containing an external audit of our accounts said that we should produce a protocol for practice visits. We will discuss that in our internal audit committee, probably next month. One of the issues the committee will consider is an approach to practice visits that would incorporate a number of issues during visits, and not just post-payment verification.

Paul Martin: Are you not disappointed that no practice visits whatever have been carried out?

Mr Davison: No, I am not disappointed. There have been 56 practice visits in relation to—

Paul Martin: I am sorry—I meant no visits for post-payment verification.

Mr Davison: In relation to post-payment verification, we have done no individual practice visits. We were asked by Audit Scotland to produce a protocol and we are in the process of doing that. In my view, in future we will do things in a way that is more measured and that will add value to the system. It will be less time consuming and resource intensive for those doing the visits, and less time consuming and resource intensive for the general practitioners who are being visited.

What I have said is in relation to the totality of the payments. In Glasgow, if we were given information from the CSA of an extreme position in any individual practice, obviously we would visit that practice quickly. However, I am talking about an overall systematic approach to 220 practices in Glasgow.

Paul Martin: Do you believe that the system is open to abuse, because of the fact that no post-payment verification visits have been made in this financial year?

Mr Davison: Human nature means that any payment system is open to abuse by someone who wants to abuse it. However, the absence of a visit does not mean the absence of post-payment verification. We are given post-payment verification data and the judgment on whether to visit a practice to discuss a particular issue would depend on the seriousness of the information that

we were given. The approach that we have been asked to develop, and that we will develop, will, I hope, incorporate a number of issues when we visit a practice. I hope that that will strengthen the system.

Paul Martin: But do you agree that the fact that there have been no visits means that there could be abuse of the system?

Mr Davison: It is a possibility. However, my understanding is that where there have been post-payment verification visits elsewhere in Scotland, the level of resource recovered has not justified the level of resource involved in making the visits. Obviously, if it costs £1,000 to make some visits that net us £100, we are £900 poorer. That is why we have to give a lot of thought before spending a lot of money visiting practices to discuss just one issue. It would be better to take the time to discuss a number of issues. The exception to that, as I said, would be if something horrendous were brought to our attention, in which case we would react quickly.

Mr Raffan: I think that I have got the picture of what is happening now, so I want to ask about the future. You spoke about incorporating a number of things in the visits—prescribing, post-payment verification and so on. How long will those visits take? Will they be like school inspections and take a few days, or will they take just one day? What will be the cost of the new protocol that you spoke about?

Mr Davison: We have not agreed the new protocol yet, or how it would operate. However, practice accreditation would take a day. That would happen every three years, so we would make a day-long visit to something like 70 practices a year in a three-year cycle. If we add other issues to those visits—issues that may be relatively small—it may still be possible for each visit to take just one day if we increase the number of people involved in each visit. It may be possible to include post-payment verification, staff issues and prescribing, for example, with particular issues being covered in only an hour or so. However, a day will be the minimum, and more time may be required.

Mr Raffan: How much will that cost?

Mr Davison: We do not know yet. It will depend on who is involved in the visit. We talked earlier about our response to clinical governance. One of the costs of clinical governance is the cost of lots of clinical staff running around assessing other clinical staff. That has a cost. If clinical staff who would otherwise be treating patients are going off to assess the performance of other clinical staff, that has a cost. We are investigating what that cost is, but I do not have a feel for it at the moment.

16:15

The Convener: Margaret Jamieson will ask about European Union working time regulations.

Margaret Jamieson: I am sure that some chief executives will not have forgotten that, in a previous life, I took great pleasure in talking about some of the regulations that came out of Europe. I recall the introduction—not in Glasgow but in another part of Scotland—of the working time regulations in October 1998. It was a considerable time before the NHS heard the wake-up call. Why did the NHS not accept that it was legally required to observe the regulations?

Mr Calderwood: Trusts in Scotland first took reports on the European working time directive to their boards around October or November 1998. In south Glasgow, a paper went to the board meeting in November 1998. It set out the issues as they were understood at that time. The issues centred on ancillary staff, bank and agency nurses, and staff whose conditions at that time either did not recognise annual leave at all or did not recognise the minimum periods of annual leave. Subsequently, the management executive issued a letter on 14 January 1999. The letter set out the basis on which trusts should implement the working time regulations.

In some areas of the regulations, there was no ambiguity and work began—certainly on the south side of Glasgow—from February 1999. In other areas there was ambiguity. The directors of human resources in the NHS trusts met to discuss how to deal with ambiguities. In particular, they sought the view of the central legal office on what were then the vexed questions of averaging, of earnings and of how averaging applied to the implementation of the working time regulations.

Those discussions were fairly protracted, much to everyone's frustration. Ultimately, in December 1999, the central legal office produced a bulletin addressing its interpretation of the application of averaging to the NHS. Staff representatives did not agree with that interpretation. The matter was discussed in the Scottish partnership forum and, at its meeting on 10 February, it was agreed to set up a joint group with representatives of staff and employers. They were charged with resolving the outstanding issues—including, specifically, the averaging method of payment. That group met for the first time at the end of March 2000 and subsequently produced a report that resulted in a standard agreement across the NHS in Scotland. Staff and employers supported the agreement and that was reflected in a letter from the management executive dated 29 August 2000.

That letter confirmed the basis for the payment and, for the first time, intimated that the management executive would—in recognition of

the basis on which the agreement was to be implemented—make available an additional £20 million to the NHS in Scotland to meet costs associated with implementing the agreement. That subsequently resulted in an agreement, dated 9 November 2000, being signed by the parties. Payments backdated to October 1998 to 31 March 2000 were included in staff pay at the end of December 2000; the backdated payments that were due from 1 April 2000 to January 2001 were paid at the end of January.

That is the background to the situation. Trusts were aware of the issues in October and November 1998 and started dealing with them locally. However, there was a difference of interpretation about the way in which other elements of the EU working time directive would apply to national health service staff who were perceived as having better terms and conditions of service than the de minimis level that the directive set out to establish.

Margaret Jamieson: I shall not ask who won.

Mr Calderwood: If you looked at the costs, you would conclude that the staff side's opinion was ultimately the view that was taken.

Margaret Jamieson: You were right again, Robert.

The Convener: For the record, I am told that there is a potential liability of more than £15 million for the whole of Scotland, regarding annual leave payments that have been forgone since the EU regulations came into force. Can you tell us what the final cost will be for Glasgow and how much of it has been paid out so far? Is that figure available for each trust?

Mr Calderwood: The corporate figure for Glasgow suggests that retrospective and current year costs will total some £5.589 million by 31 March.

Ms Boyle: That will be the cost through the Glasgow health care system. The cost for the trusts—returning to the point that was made earlier—will be nearer £7 million, not taking account of some outstanding issues. That is our current estimate, based on what we know about the application.

The Convener: Thank you. This market day is wearing late. We have had a very good session, and I thank all our witnesses for coming to give evidence. I thank everyone for giving me a good excuse to return to my native city.

I now draw the public meeting to a close.

16:22

Meeting continued in private until 16:37.

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