AUDIT COMMITTEE

Tuesday 16 March 2004
(*Morning*)

Session 2

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AUDIT COMMITTEE
5th Meeting 2004, Session 2

CONVENER

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

DEPUTY CONVENER

*Mr Kenny MacAskill (Lothians) (SNP)

COMMITTEE MEMBERS

*Rhona Brankin (Midlothian) (Lab)
*Susan Deacon (Edinburgh East and Musselburgh) (Lab)
*Robin Harper (Lothians) (Green)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*George Lyon (Argyll and Bute) (LD)

COMMITTEE SUBSTITUTES

Chris Ballance (South of Scotland) (Green)
Mr Ted Brocklebank (Mid Scotland and Fife) (Con)
Marlyn Glen (North East Scotland) (Lab)
Mr Andrew Welsh (Angus) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)

THE FOLLOWING GAVE EVIDENCE:

Mr David Bolton (NHS Lothian)
Professor James Barbour (NHS Lothian)
Mr John Matheson (NHS Lothian)
Mr Stuart Smith (NHS Lothian)
Dr Charles Swainson (NHS Lothian)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Christine Lambourne

LOCATION

Committee Room 1

Scottish Parliament

Audit Committee

Tuesday 16 March 2004

(*Morning*)

[THE CONVENER *opened the meeting at 09:34*]

Items in Private

The Convener (Mr Brian Monteith): I declare this meeting of the Audit Committee open and welcome members of the committee and Audit Scotland.

Item 1 on the agenda is to seek the committee's agreement to take items 2 and 7 in private. Item 2 is to consider lines of questioning for witnesses on the Auditor General for Scotland's overview of the national health service. Item 7 is to allow the committee to consider its approach to the Auditor General's report on medical equipment. Do members agree to take items 2 and 7 in private?

Members *indicated agreement*.

09:35

Meeting continued in private.

10:04

Meeting continued in public.

"Overview of the National Health Service in Scotland 2002/03"

The Convener: I welcome Professor Barbour and his team and members of the press and the public who have just joined us. I ask visitors to switch off their mobile phones and pagers, as they interfere with our intercom system.

While the witnesses get ready, I mention that, following the Audit Committee's visit to the National Assembly for Wales last week and our meeting with the Assembly's Audit Committee, a paper on the visit and the lessons that we might learn from it will be prepared for discussion at a future meeting.

Before I ask Professor Barbour to introduce the members of his team, to explain their different roles and to make an opening statement, it is worth explaining for the record the purpose of taking evidence on the matter. We are carrying out an inquiry into Audit Scotland's "Overview of the National Health Service in Scotland 2002/03". The committee felt that it would be particularly useful to consider the pressures on health boards rather than simply those on the Scottish Executive Health Department. During the inquiry, the committee will take evidence from a variety of health boards.

Today, we have representatives of Lothian NHS Board. We aim to examine the financial performance of Lothian University Hospitals NHS Trust in 2002-03 and earlier years; the key risks to NHS Lothian in meeting its financial plans for 2003-04; the extent to which the cost pressures that are highlighted in the Auditor General's report apply to NHS Lothian; and how NHS Lothian is planning for the integration of its trusts.

The purpose of having representatives of NHS Lothian before us is to get a broad feel for the pressures on different types of health board. The aim is not so much to put them through the mill and to hold them to account for decisions, but to try to tease out the particular pressures at board level. We want to get a clearer picture of the situation throughout Scotland.

Professor James Barbour (NHS Lothian): I will begin by introducing my colleagues. On my far right is Charles Swainson, who is the medical director for Lothian university hospitals operating division, as it now is. He is also the medical director for Lothian NHS Board. To my immediate right is Stuart Smith, who since January has been the acting chair of the operating division. On my immediate left is David Bolton, who since October

has been the acting chief executive of what was then the Lothian University Hospitals NHS Trust, which is now the division. On my far left is John Matheson, who is the finance director for Lothian NHS Board. I hope that my colleagues and I will be able to contribute using our base of knowledge. I thank the committee for inviting us today. After my short opening statement, we will be happy to take questions.

As somebody whose career since 1977 has been spent in the national health service, I am entirely committed to transparency, openness and accountability. As I spent most of that career in the major teaching centres of Aberdeen, London, Manchester and Sheffield prior to coming to Edinburgh, I hope that I can give some insights into the issues. I am passionate about the health service, particularly the inequalities issues, and I hope that we can reassure the committee on our stewardship.

I am sure that the committee will want to speak about issues that are raised in the Auditor General's report. It is worth pointing out that when that report was produced, NHS Lothian comprised four separate statutory organisations under a unified board of governance. It might be helpful to set out the actions that we have taken and continue to take in response to the financial issues under the broad headings identified for the unified board's functions, which are strategic direction, resource allocation, development of local health plans and performance management.

I hope that my colleagues, particularly the divisional colleagues, will tell members about the progress that they are making within the clarity and unambiguous accountability of the divisional structure. I remind members that when Malcolm Chisholm announced the white paper "Partnership for Care", he said:

> "The existence of separate NHS trusts covering the same areas as NHS boards has not yielded clear benefits, but has confused accountability and obstructed the integration of services."

I hope that our submission and the evidence that we will give today will demonstrate the benefits that are already being achieved through single-system working.

To take a line from the committee's questions, I point out that this year NHS Lothian will meet our financial targets, as we have done every year since the inception of the unified board. I take my responsibilities in that area extremely seriously and will take them even more seriously when, after 1 April, I am the sole accountable officer for the NHS Lothian system, supported by divisional chief executives.

With regard to a strategic direction, we believe that our work in setting up our pan-Lothian review—which was agreed at our first board meeting—was an inclusive and strategic response to the financial pressures that we face. The review covered six themes, but I will simply highlight three of them: the management of demand; fair funding of tertiary services; and the groundbreaking work that Charles Swainson and David Bolton are leading on the provision of acute services throughout Lothian. That work is bearing fruit and savings of some £14 million out of our original £24 million target have been achieved. When we took the pan-Lothian review to our board in January 2002, our external adviser stated that the financial shortfall that we faced then reflected assumptions made in the business cases for the new royal infirmary and the publicly funded Anne Ferguson building. The adviser pointed out that either the savings targets, which may have been set at that time to meet the costs of the new and—it must be remembered—excellent facilities, were not met or the money was used to meet other day-to-day pressures.

With regard to how we have allocated resources, we recognised from the beginning that the underlying financial pressures that the trust faced would take time to resolve. We sought to give colleagues the necessary turning room by the responsible and prudent provision of non-recurrent support. I hope that our written submission addresses that matter. My colleague John Matheson can give members the detail. It is also important to remember that we sought and obtained brokerage support of £20 million from the Scottish Executive. However, in seeking that support, we were mindful of the Executive's requirement that it could offer the support only on receipt of a robust financial recovery plan that was accompanied by the trust's achievement of an in-year income and expenditure balance. We tried to take a collegiate approach across NHS Lothian to the problems that the trust faced. We did so not only through the pan-Lothian review, but by other NHS Lothian trusts voluntarily giving up £2 million of their income, by taking a partnership approach to obtaining contributions from other boards of £3 million to support our tertiary activity, and by making internal efficiencies within NHS Lothian to the value of £1 million.

We hope that our local health plan, which has been praised, demonstrates our openness and transparency—particularly through the use of the traffic-light system—and highlights our commitment to tackling the financial challenges and closing the health gap and inequalities, which we have seen so graphically illustrated in the past few days.

It is probably fair to say that performance management has been challenging, given the confused accountabilities to which Malcolm Chisholm referred and what our chairman calls the

last vestiges of the internal market of the mind. As the Auditor General commented, our approach to the use of the performance assessment framework, which has been copied elsewhere, our use of bilateral performance management meetings and the attendance of the chairman and me at trust management team meetings show that we have tried to create a performance culture across NHS Lothian. Generally, our achievements have been considerable. Performance on waiting times, the overall meeting of financial targets, the achievement of general practitioner 48-hour targets, the fact that the other two trusts met their financial targets and our work in public consultation and involvement are all testament to that.

With regard to prescribing costs, work by colleagues in the primary care trust and local GPs means that we have achieved 80 per cent performance in the use of generic drugs. That figure has not been bettered in Scotland. Of particular interest is our current work in trying to link money and outcomes, which is timely in the context and pattern emerging locally and nationally. Our work supports a trend that shows that while expenditure on acute hospitals has grown, activity is not always keeping pace. Some of that is attributable to the effects of the new quality standards, new working arrangements for junior doctors and complex case mix, but it underlines a fundamental performance management issue for the public services with respect to how outcomes, quality and efficiency are to be managed.

What is certainly clear to us is that the continuing delivery of the board's strategy through operating divisions must lead to improved efficiency, reduced unit costs and even greater benefit for patients. That is at the heart of the management challenge that we face. Our service redesign committee and our work on the pan-Lothian project—better acute care in Lothian—accompanied by continuing investment and innovation in the use of information technology, are examples of the strategic focus that we are trying to bring to the improved use of our capital assets, thereby enabling improved outcomes to be achieved by our work force. The new contracts for GPs and consultants are important levers for that.

10:15

Finally, it is important to tell the committee that my colleagues who are here at the meeting and their support team, which has been in place since October last year, are beginning to see results. The year-end projection that was produced for KPMG by the Auditor General in February showed a projected outturn for the division of £11.1 million. The division is now projecting a year-end position of £9.1 million. Last year, it had a monthly deficit that reached a peak of £1.1 million a month, but that has been reduced to a running rate of £400,000 a month.

There is more to be done, but I hope that the committee gets a sense of NHS Lothian's long-term commitment to tackling the issues, and a sense of the leadership that has been shown, particularly by Stuart Smith and David Bolton. They have taken over operational responsibility for an organisation that has had four chairs, five chief executives, four finance directors and two human resources directors in the past five years. As "Partnership for Care" says, we are interested not in blame but in achievement. I thank the committee for the opportunity to make this statement. We are happy to take questions.

The Convener: Thank you, Professor Barbour. Over the past two years, Lothian University Hospitals NHS Trust has acquired significant injections of non-recurrent funding in order to balance its books. What are the key cost pressures behind the need for non-recurrent funding? What were the sources of such funding in 2002-03 and how was the funding used?

Professor Barbour: John Matheson will answer the detailed financial questions and I am happy to deal with the broader issues.

Mr John Matheson (NHS Lothian): My first point on the sources and application of non-recurrent funding is that it is important to differentiate between the use of non-recurrent funding for non-recurrent purposes and its use to underpin the recurrent base, which includes the payment of staff and expenditure on drugs. The Auditor General's report for 2002-03 identified that just over £64 million of non-recurrent support was put into Lothian University Hospitals NHS Trust. On the constituent elements of that, £16 million was for the double-running costs that related to the physical move from the old Edinburgh royal infirmary to the new royal infirmary at Little France; and £14 million related to capital-to-revenue movement, which happens in any NHS organisation and which relates to the accounting rules that underpin the fact that assets of less than £5,000 are not capitalised. Some elements of capital expenditure are deemed not to add value but to be maintenance-type expenditure—the repair and maintenance of flat roofs is a classic example of that. Funding for waiting-list initiatives and funding for winter pressures are exposures that involve projects that are being evaluated, and money is given on a non-recurrent basis until the evaluation takes place. To return to my first point about non-recurrent support for recurrent expenditure, the core element in the £64 million is the £8 million that NHS Lothian gave the trust to

give it turning space and the opportunity to produce recovery plans.

The first part of the question was about the causes of the requirement for non-recurrent support, and I will highlight three factors. First, in 2002-03, significant pressure arose throughout Scotland in respect of the new deal for junior doctors, and Lothian University Hospitals NHS Trust, as a major acute teaching trust, was no exception. Funding compliant rotas and non-compliant rotas throughout NHS Lothian will cost in the region of £17 million, so there is a requirement for non-recurrent support. As part of our future planning, we have set aside some recurrent support to cover that cost; we are also trying to ensure that the exposure is minimised. By the end of the next financial year, 2004-05, we will have set aside £12 million for the new deal for junior doctors. The funding also links closely with the project to review acute services throughout NHS Lothian—we might touch on that later.

Secondly, some of the assumptions in respect of the business cases for the Anne Ferguson development at the Western general hospital and the new Edinburgh royal infirmary had to be revisited, and there was some non-recurrent exposure there. Thirdly, there was some slippage in respect of the continuing target for local efficiency savings. I hope that my answer covers the reasons for the non-recurrent exposure and the sources that were used.

The Convener: Thank you. To pick up on the double-running costs, it appears that some of those costs were unforeseen. Will you explain how that came about and what lessons might be learned for other health boards?

Professor Barbour: I will deal with the general point and John Matheson will deal with the detail. It is quite understandable that double-running costs arose because of the phased transition from the old royal infirmary to the new royal infirmary. Given the logistics of that move, it would not have been possible to move every service on day one. Fixed costs were still being incurred at the old royal infirmary while the new royal infirmary came into being. That was a perfectly legitimate use of non-recurrent money, which was agreed and supported by NHS Lothian and the Executive.

On the unforeseen double-running costs, there is a general issue that the Auditor General mentions as it affects all of Scotland, which we certainly saw locally. Some of our work on financial projections and financial modelling was not as robust as we would have liked it to be. John Matheson's mention of the original business cases showed the extent to which assumptions that were made back in the mid-1990s turned out not to have borne fruit. It was certainly clear from the trust's financial modelling that some of its projections—particularly those on double-running costs—proved not to be entirely correct. John Matheson can give you the detail on precisely where they fell down.

Mr Matheson: The quantum of movement is an important point to consider. I have mentioned the figure of £16 million in relation to the double-running costs, which were incurred primarily in 2002-03, but another element of those costs—a further £4 million—arose in the early part of 2003-04, so the anticipated level was £20 million. The actual cost was about £20.8 million, so there was a movement of about £800,000.

George Lyon (Argyll and Bute) (LD): How did that differ from what was projected in the original business case? Surely there should have been a line in the forward budgets that said that a certain amount of money would be needed to cover the period during which the double-running costs were going to take effect. What was the difference between the original projected figure and that of £20.8 million, which you have given us today?

Professor Barbour: Again, I will answer the general question.

George Lyon: I would rather have a specific answer, if that is possible.

Professor Barbour: You will get a specific answer as well. The original business cases assumed that the costs of the new royal infirmary would be met, essentially, by savings that would be made across the system. Some of the assumptions in that area involved manpower planning—in particular, changes to rates of pay and consultant manpower levels. Those assumptions turned out not to be viable—that is why we ended up with a £24 million shortfall that the pan-Lothian review tackled. That gives the general context; John Matheson will give a more specific answer.

Mr Matheson: The assumption was always that the double-running costs would amount to about £20 million, which was to be funded from non-recurrent sources. The only movement was the additional £800,000, which has occurred in year. Again, that has been sourced from within the total £800 million that is available to NHS Lothian. The original estimate of £20 million for the double-running costs, which formed part of the business case assumptions and the assumptions that underpinned the move, was sourced in that way and we were left with the marginal movement of £800,000.

George Lyon: Double-running costs of £20 million were planned for.

Mr Matheson: Yes.

George Lyon: But you are saying that meeting those costs was not taken account of in your

budget, so you had to source the money from non-recurring funds.

Mr Matheson: The money was sourced from non-recurring funds because the exposure was non-recurring; we are talking about a transient cost that arose during the period of the move. Because the move happened in two phases—in February 2002 and May 2003—we had double-running costs during that period. The exposure was non-recurrent and was sourced on a non-recurrent basis.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): If £20 million out of that non-recurrent funding was earmarked to shore up the double-running costs, what did NHS Lothian in its totality not provide to the users of the service?

Mr Matheson: The prime source of that non-recurrent income was the use of capital receipts. Every item of expenditure has an opportunity cost, but the capital receipts were generated from the sale of the old royal infirmary. That was the prime source of funding for the double-running costs.

Margaret Jamieson: Surely, moving to a new hospital meant a reduced number of acute care beds being available to the population of Lothian. The design of that hospital was predicated on strengthening support in the community. Can you give us an assurance that that support was there and that you are on target to ensure that that support—whether it is community hospitals, more GPs, more nurses in the community, or whatever—is in place for the population of Lothian?

Professor Barbour: The planning process always assumed that there would be an investment in community-based treatment centres and facilities. However, it is fair to say that the assumptions on which the business cases were based, particularly with regard to the timing of delivery, were perhaps over-optimistic. That said, we have just seen the completion of the work on Leith community treatment centre. We have also, I hope, sorted out any blockages that we might have had with regard to Musselburgh community treatment centre and plans are well advanced for a community treatment centre in Midlothian. We are proceeding in accordance with those plans.

With regard to the point about bed numbers, I can say that an exhaustive inquiry was undertaken at that time. All the indications are that the bed numbers have come out right. Charles Swainson can confirm that. It is important to note that, notwithstanding some of the pressures that we face around delayed discharge—which we might touch on later—not only do we have no evidence that demand for acute services in Lothian is being in any way suppressed through a lack of beds, but we have strong evidence to show that, through our achieving our waiting list targets, there is a match between the number of beds and demand. Charles Swainson might want to comment on the clinical changes that have accompanied that.

Dr Charles Swainson (NHS Lothian): There is no disadvantage to patients in the restructuring of the acute services bed provision in Lothian. Indeed, NHS Lothian has achieved its targets for waiting times in each of the years since such things have been measured. Records show that the growth of hospital activity between the period when the planning started, in 1995-96, and the last year in which it was measured, in 2002-03, was absolutely on track to meet predictions. There were no surprises. The demographic growth model that was adopted by the NHS board at that time proved to be correct. If it were not for the number of delayed discharges currently in the hospitals in Lothian and throughout Scotland—which was not a factor in the original planning, but which has grown since then—we would be using fewer beds than we are using now. We would be using the beds that we have in Lothian rather differently.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): I have a couple of supplementary questions that follow Margaret Jamieson's questions directly. I am interested in the balance between acute and primary care or, more generally, support within the community.

I note that the community treatment centres that were referred to are several years from delivery. We are talking about slippage not of months but of several years. My interest in the subject is well known. What has happened over the years and what will happen in the years to come—we are talking about facilities for which there is not a brick on the ground—will not be resolved tomorrow. That must have a knock-on effect for patient care in the area, so what is its impact on the acute service sector and what are its financial implications? It strikes me that, if the original plans for the balance of care are so significantly off track in time terms, the impact cannot be quite as neutral as you suggest.

In answering that question, will you tell us how confident you are—notwithstanding the bricks-and-mortar questions—about some of the other capacity issues that Margaret Jamieson raised about staff in the community and what monitoring is taking place of changes in the patterns of hospital stay, for example, in areas such as orthopaedics and maternity services? As I understand the general situation in Lothian, the plans and assumptions are predicated on the notion that hospital stays will be shorter. However, I also understand that substantial additional support will be provided in the community and at

home. How confident are you that a shift has taken place and that community provision exists?

10:30

Professor Barbour: There was a bundle of questions there; Charles Swainson may comment on the clinical side. Susan Deacon asked about delays in delivering community treatment centres: I am sure that you understand the frustrations that we have all felt, and that you understand how much work has gone into translating into reality commitments that were made on where centres would be developed, even though the wherewithal in terms of land and capital investment had not necessarily been secured. I hope that all those frustrations are behind us now.

In my opening statement, I said that there was local and national evidence that activity has dropped off—notwithstanding the considerable financial investment that has gone into acute services in particular over the past few years. That drop-off is, on the face of it, considerable. It is a United Kingdom trend that was picked up in the Wanless report and a number of other places. A number of possible explanations exist: one is that we do not count as well as we used to, and another is that the lack of activity is more than compensated for by an increased and complicated case mix. A partial explanation may lie in the effects of junior doctors and new quality standards. However, whichever way we look at it, there has been a drop-off in activity. That may partially explain why the pressures that were expected to require community investment may not have impinged in quite the way that Susan Deacon describes.

If we consider the level of delayed discharges and some other quality indicators such as readmission rates, it is clear that if we had more community based, step-down or intermediate care facilities, that would obviate—we like to think—the need for people to come into acute hospitals in the first place. It would also help to reduce some people's length of stay in hospital, which would have a corresponding efficiency benefit, if not a direct financial benefit. We regard the onset of community health partnerships as helpful in that regard.

Susan Deacon asked how we monitor any changes in manpower. That is a difficult question because the health service throughout Scotland has not been as successful in work-force development as it might have been. We are trying to strengthen our capabilities in such development. We want to strengthen our human resource function and to create regional work-force development posts. The job of the people in those posts will be to model the work-force needs for Lothian and across into Fife and the other boards that are part of our regional consortium.

If we consider the levers for change in the new consultant contract and the new general medical services contract, it is obvious that they are intended to help us to secure a greater preponderance of service in the community, and better management of the nature and level of activity that is undertaken in acute hospitals.

Charles Swainson: I will try to give some helpful examples. Lengths of stay in acute hospitals in Lothian are no longer as exceptional as they once looked; everybody has moved in similar directions, although perhaps not in the same way or at the same speed. If we wanted to challenge lengths of stay now, and to shift the balance radically between acute hospitals and primary care, the numbers would be very different.

There has been a shift in practice over the years, which we have deliberately supported because we had a model in our heads of where we wanted to go. Over the years, NHS Lothian has invested in certain types of community support. I will give the committee some examples, including some that involve new money and some that involve existing money in the system.

We have, for example, developed personal medical services pilots in general practice. That was a direct investment by the Executive. That strengthened GP, nursing and other resources in general practice with the specific intent of being able to look after a greater proportion of patients who would otherwise go to hospital. It has been extremely successful in respect of looking after patients with chronic heart disease, chronic chest disease and diabetes. We wanted to encourage such developments to make the health service in Lothian less dependent on its hospitals.

Another example is the investment in community midwives, which is on-going. There has been steady investment from 1998-1999, which has enabled us to achieve different lengths of stay for women before and after labour because a team of community midwives can provide better support in the community, which allows earlier discharge from hospital.

There has also been a general shift towards out-patient settings. In the early 1990s, we admitted people to hospital for certain kinds of investigation and they would typically stay for one or two days, but patients are no longer admitted to hospital for such investigations. People come into the hospital, have an investigation in an X-ray department during the day and then leave. Similarly, we used to admit patients to hospital for one or two days prior to their having an operation, but that practice has almost disappeared. Patients are now assessed in clinics or, indeed, often in general

practice before they come for operations, so all the information is available to the surgeon and the anaesthetist prior to the patient's arrival. Therefore, many patients for surgery are admitted on the day of surgery rather than one or two days beforehand.

I hope that those examples are helpful.

Professor Barbour: Convener, if you do not mind, can David Bolton give the committee a perspective from the primary care end?

The Convener: Certainly.

Mr David Bolton (NHS Lothian): Thank you. I will give some background. Before I came to the acute trusts in November, all of my track record was in primary care—I was very involved in primary care and community development throughout Lothian.

To answer the question directly, we have invested significantly in community rehabilitation services jointly with local authorities in the past two or three years, which means that we have had facilities to manage the care of patients who have been discharged from hospital. We also now have rapid-response teams in our local health care co-operatives, which have taken responsibility for managing people at home rather than bringing them into hospital. Those have been quite fundamental in allowing earlier discharge and in maintaining in their own homes patients who would previously have gone to hospital.

However, the big winner for us has been personal medical services, which has come in advance of the general medical services contract. Around 25 per cent of our practices in Lothian were in the PMS scheme. I suppose that the focus was on nurse practitioners who saw, and managed the care of, people who in part came into hospital either as out-patients or in-patients, which does not happen any more. Thereafter, the big focus has been on chronic disease management, which Charles Swainson mentioned. In some practices now, the number of patients with chronic respiratory disease who are admitted to hospital has fallen from around 20 a year to virtually zero. That has made a huge difference in respect of 25 per cent or so of our practices and what comes through the front door of our acute hospitals. Therefore, there have been many positive changes in primary care in the community. I also believe that the new GMS contract will, when it starts to bite—which will probably be next year, rather than this year—take those changes forward.

The Convener: I am conscious that we have questions on recurrent funding to which we must return, but I would prefer us to exhaust the current line of questioning before we return to them, otherwise we will go backward and forward.

Rhona Brankin (Midlothian) (Lab): My question is not specifically on the current line of questioning—it is about capital revenue transfer.

The Convener: We will return to that issue.

Rhona Brankin: I am happy to wait.

The Convener: No other member seems to have a question on service delivery.

Mr Kenny MacAskill (Lothians) (SNP): I have a number of questions to ask. How do you try to identify the need for non-recurrent funding and to make it available? Do you have any reserve or contingency funds, or does the system not allow any such flexibility?

Professor Barbour: The straight answer to the question is that, if the system worked properly, if financial projections were accurate and if doctors and clinicians interacted in a way that would prevent unforeseen and unpredicted developments, the use of non-recurrent funding would be restricted, as my colleague John Matheson said, to legitimate non-recurrent purposes, one-off expenditures relating to waiting lists, winter expenditure or unforeseen areas of capital expenditure.

We have, because of imperfections in the system, developed some reliance on non-recurrent funding, which we have sought to cap. We agreed last year that we would try to develop a financial regime that would cap that and reduce it progressively—John Matheson can give you the numbers. I hope that the reduction from last year through this year into next year will show that that is happening.

It is also important to recognise that there is an expectation that competent managers—Malcolm Chisholm made this point in announcing last year's allocation—will balance the books. We will balance the books by ensuring that there are no unforeseen developments that miss the local planning system, which is what hospitals have in the past called "creeping" developments. The reality of that is that in teaching hospitals—which, lest we forget, are bastions of excellence; the one in Edinburgh is among the finest in Europe—we employ people whose job it is to test the boundaries of medicine and to make clinical advances. That is what we want them to do. However, very little of that happens suddenly. If the planning system is working properly, that should be predicted and funding provision can be made through the local health planning process, which is what we have tried to do. The plan that we have sent the committee shows how we have allocated funding to developments.

The imperfection in the situation that we face was worsened by the fact that efficiency savings, which were part of our overall financial equation,

were either not made or were made late. There are a number of references to late planning of efficiency savings. Typically, if the efficiency savings programme is being carried out properly, it is planned a year in advance of the year in which we expect it to impact. All that suggests a situation in which, in the best of all possible worlds, reliance on non-recurrent funding would be relatively limited. John Matheson can answer the part of your question on the numbers.

Mr Matheson: We are an £800 million organisation; within an organisation of that size there will always be in-year flexibility. The position in respect of 2003-04—I echo James Barbour's point that we will achieve financial balance at the end of that year—is that as part of the initial discussions with the NHS Lothian university hospitals division around the five-year plan projection, we agreed that, given where the trust was in terms of its modelling, we required to give it non-recurrent support in year to the tune of £11.9 million. That was a combination of brokerage support, support from capital and support from the other parts of NHS Lothian, which emphasises the single-system approach. That brought us back to an anticipated break-even position for 2003-04.

In-year financial pressures in relation to junior doctors, the pace of savings, and drug and other clinical pressures have resulted in an in-year deficit which, at the end of September, was £6.6 million and will be just over £9 million at the end of the year. You can see that the level of month-on-month overspend has reduced significantly. It is still not back to zero, which is our aim to take forward into next year, but it has reduced significantly.

Kenny MacAskill asked specifically about contingency funds. Given the complexity of the organisation, it is inevitable that there will be development pressures both locally and nationally. We have ensured that there is flexibility in our overall envelope. We have a contingency reserve, which is about 0.5 per cent of our total available funding. One of the areas in which that is being utilised in-year is funding of the consultant contract, which has been back-dated to 1 April 2003. We made an initial assessment of the anticipated cost of the consultant contract; the actual cost will be in excess of that anticipated cost and we have used the contingency reserve in that context.

10:45

Mr MacAskill: There is an underlying recurrent financial deficit of £8.2 million in 2002-03. Some of the factors may overlap, but why is that the situation? To what extent has the role as a university teaching hospital been a factor?

Mr Matheson: I will deal with the financial issue; Charles Swainson may want to discuss the teaching component.

The £8.2 million requirement for non-recurrent support in 2002-03 was centred primarily on the pace of delivery of efficiency savings and the additional cost of junior doctors. In that year there was a prioritised sum of money—£3 million—for junior doctors, but the actual costs exceeded that. We continue year on year to invest additional money to cover junior doctors, but that requires some non-recurrent support. Charles Swainson can give the committee details of the level of compliance that we have reached for junior doctors and how that compares with the position in the rest of Scotland.

Professor Barbour: The published numbers for January have us at 72 per cent compliance, which is slightly better than the Scottish average. It is worth pausing to consider that the funding regime that was set up to ensure compliance on junior doctors' hours of work was intended to be punitive and to levy fines on individual organisations that were failing to achieve compliance. The difficulty that we faced was how to impose a punitive fine on an organisation of that magnitude without impinging on its ability to deliver clinical services. The fine came back and in some sense bit us in the context of the requirement for the system to meet its financial targets. Considerable work has gone into the matter. Charles Swainson can speak about that and can express more cautious optimism for the future about the effects of the work that we are doing, especially on the better acute care project.

Charles Swainson: To achieve compliance for junior doctors is hugely challenging for busy hospitals, primarily because of the need to provide services during the night, at weekends and on public holidays as well as during the day. That is the issue that drives the process. It is extremely expensive to maintain compliance. Many 24-hour services are compliant when doctors are paid at what are called bands 2A and 2B. That enables us to provide round-the-clock services for patients, with doctors getting reasonable time off, and it generally involves the majority of doctors working in patterns of shifts that vary between eight and 11 hours. With that level of compliance, doctors' salaries attract an 80 per cent premium, which represents almost a doubling in salary costs. In a sense, we are getting less benefit than we got a few years previously—when we were non-compliant and doctors were working longer hours—but we are spending more money.

The challenge this year and in future years is progressively to bring doctors' hours into line with the European working time directive, which will be very difficult. As members are aware, there has

been a derogation from the directive for this group of staff. If we are to comply fully, shift lengths for 24-hour services will have to be reduced to eight hours or, perhaps, less. Patterns of employment will dictate that we employ doctors either in shifts or as resident on call from home. In effect, that means that the intensity of work that doctors are expected to undertake is fairly low.

Modelling in NHS Lothian has shown that we cannot continue to deliver acute services—especially 24-hour, seven-days-a-week services—on three hospital sites precisely as we do currently. The way forward is to concentrate in fewer places the services that demand the expertise and skills of junior and senior doctors: that is an argument for centralisation. We must also take the opportunity to decentralise and to provide in different ways services that have been traditionally delivered by junior doctors, but which can be delivered well, safely and with benefits to patients by other kinds of staff.

With the redesign of services, we are trying to centralise services that must be centralised because of costs and scarce manpower, and to decentralise and provide differently other services, to which people rightly expect easy local access.

Mr MacAskill: The working time directive appears to be having a significant impact. I appreciate that it is a European Union directive, but it is open to interpretation. Is the interpretation of the directive's impact on medical matters different in the Irish Republic? If so, what do you have to do that your counterparts in Dublin, for example, do not have to do?

Professor Barbour: I say truthfully that I was not aware that a different interpretation was being used in Dublin. I know that, nationally in Scotland, we have been much exercised by the matter. I understand that the UK Government has taken a particular stance on doctors. Charles Swainson might know about an exemption in Dublin.

Mr MacAskill: I am not aware of an exemption in Dublin, but I know that the haulage sector there has a different interpretation of when hours start. That interpretation might not apply to the health sector, but it certainly applies to other aspects of life.

Charles Swainson: I do not have the data with me, but different European Union countries have different interpretations of the extent to which regulations are enforced and of whether some groups of staff have derogations. The situation is highly varied. In the United Kingdom, we are obliged to follow the agreement that the United Kingdom has made.

Rhona Brankin: As the Treasury is clamping down on capital revenue transfer, to what extent are you taking that into consideration in planning? How will you ensure that the funding that is set aside for service development goes into service development?

Mr Matheson: We have used capital-to-revenue flexibility in previous financial years to support achievement of the revenue balance. I emphasise that some of that capital-to-revenue movement recognises non-capitalisable expenditure, but some of it has been used to support revenue balance.

We have also used the profit on the sale of assets to give us some non-recurrent support. I am aware that the rules on capital-to-revenue flexibility, which allow a 20 per cent transfer from capital to revenue, are under discussion between the Scottish Executive and the Treasury. We are keeping close to Executive colleagues while those discussions develop.

Professor Barbour: We tackle service development through the local health plan process, which is inclusive and comprehensive. We target our development moneys against a hierarchy of priorities. That starts with national priorities as set out in the various national planning documents, which are followed by local priorities that we have garnered through extensive discussion with stakeholders. That is expressed in the local health plan, which the committee received, and in the breakdown of the uplift for 2003-04 in the papers that we sent to the committee, which shows how that money is apportioned. Members will see that once we had met the cost of the must-be-dones and the imperatives, we had about £8.5 million for service development available from £48 million.

Rhona Brankin: I suppose that I seek reassurance that that money will be available. How will you ensure that the money is available?

Professor Barbour: You are right to press the point. I will return to the discussion about how we support the division non-recurrently as efficiency measures in the division and throughout NHS Lothian bite. We have been mindful that we also have an obligation to make the money go as far as it can to secure service development. We have tried to strike that balance.

We have resisted easily the temptation that has been accepted in the past in the health service—in which I have worked in England as well as Scotland—that, when we are faced with a financial crisis, the answer is to stop doing everything. In my judgment, that becomes an indiscriminate slash-and-burn approach that does not pay proper attention to the added value that should come from good management, and does not keep faith with promises to the local population in our health plan. We have resisted that and have tried to strike a balance that will give people turning room to allow them to get their house in order.

Robin Harper (Lothians) (Green): I would like to pursue efficiency savings a little further. You mentioned earlier that work on financial modelling was not robust and that certain non-viable assumptions had been made about costs' being met by efficiency savings. Will you expand on the problems and why they arose and, if possible, give us a hint about what is being done to ensure that they do not arise again?

Professor Barbour: There are three strands to the situation. The underlying financial problem, which stemmed from the business cases for the new royal infirmary and the Anne Ferguson building, arose because assumptions were made in relation to those business cases about how savings could be made to meet the costs of the royal infirmary's private finance initiative or the publicly funded Anne Ferguson building's capital charges.

At that time—the mid-1990s, when the internal market was at its most virulent—it was assumed that savings could be made through changes in the terms and conditions of staff. Given that one of the priorities that were dealt with as soon as the unified health board came into being in Lothian was the question of low pay, you can imagine that that assumption, if it was ever valid, was certainly not valid in the economic conditions that we faced in the early years this decade.

A second assumption was made, which was that savings could be generated by a reduction by 19 of the number of medical consultants. Again, that is an example of something that might have seemed, at the time, to be a reasonable assumption. However, any familiarity with medical work-force planning would have suggested that, as we move towards a consultant-led service, we will need more hospital consultants, rather than fewer.

Those examples should give you an idea of how assumptions that were based on the best available knowledge, as advisers said at the time, turned out to be incorrect as the implementation cycle moved on. Perhaps there is a lesson to be learned in relation to the gap between the business-case preparation process—bearing it in mind that those business cases were prepared in the isolation of the internal market—and the lead time for delivering the aims, by which time certain assumptions might have become out of date.

In our contemporary situation, there is a legitimate expectation that the activities of NHS Lothian university hospitals division—and those of all divisions—will generate year-on-year efficiency savings. The Auditor General makes the point that there might be a view that the scope for those efficiency savings, on a salami-slice basis, is finite. That might be true, but the counter-argument might be that, given that Lothian University Hospitals NHS Trust generally did not meet its efficiency-savings target in the previous five years, we have not yet reached the end of the salami-slicing process. A more constructive point, however, is that, in any area of public activity, it is reasonable to expect that there will be a productivity gain each year as a result of the onset of new technology, the effects of changing the profile of the work force and, in the case of the health service, the substitution possibilities that will arise around primary and secondary care. Derek Wanless supported that idea; he said that that gain could typically be expected to be 1.5 per cent. That is higher than Lothian University Hospitals NHS Trust ever achieved.

11:00

Earlier, I made a point that the Auditor General has also picked up on: if you were dealing with a hospital trust that was run in the best of all possible worlds, you would identify proactively the efficiency savings in advance of the year in which you were going to undertake them, and you would identify them on a partnership basis with senior professional staff and trade union colleagues. I am not sure that that always happened in the case of Lothian University Hospitals NHS Trust.

The evidence for where the comfort may lie in our avoiding the sins of the past haunting us in the future is in the numbers that Stuart Smith and David Bolton are producing. By taking a rigorous and inclusive approach to the matter and by working in partnership to ensure that a hierarchy of objectives runs all the way down the division, those numbers are beginning to be met. That is how the £1.1 million run rate has reduced to £400,000. We are not complacent: we recognise that we need to take a strategic approach, which is why the work in better acute care, the new consultant contract—once we get through the initial bulge when there will be additional expenditure—and the new GMS contract will help us to drive the productivity cycle. Management is supposed to add value in all those cases.

The Convener: We need to consider 2003-04 and future pressures, but before we do that, I will play the role of Franz Beckenbauer and sweep up a number of points from your answers that still need to be teased out—I am being Frank McAveety now.

John Matheson mentioned the phrase "opportunity cost". You will recognise why committee members are so interested in using non-recurrent funding to help to deal with recurrent funding problems. If receipts were being used to deal with a deficit or a gap and they were above and beyond the anticipated costs, there would be no opportunity cost because, in a sense, one would have received a windfall—perhaps because

property values in Edinburgh had gone up, for example. However, if the capital receipts were as expected, I presume that there would be other commitments that you might have been planning to use the money for. If there were an overrun, an opportunity cost would be incurred in that you would have to delay or reconfigure what you were going to deliver. What are the opportunity costs to NHS Lothian?

The fact that there are transfers from one trust to another or from some trusts to a general pool was mentioned. Has that upset service delivery and to what extent? If it has, financial pressures must be generated in turn. That is a depressing cycle, but it must be managed. I would welcome your views on the transfer of funds from one trust to another—or from what will be one division to another.

There is an underlying recurrent financial deficit—or there has been in Lothian University Hospitals NHS Trust—which has not been covered in every case by recurrent funding. Given what the Treasury says about access to non-recurrent funding, and given NHS Lothian's dependency on such funding in the past, that must be a worry for us and for you. Why has there been such a problem for NHS Lothian?

Professor Barbour: I will try to play Franco Baresi to the convener's sweeper.

It is important to bear it in mind that part of NHS Lothian's legacy of having the new Edinburgh royal infirmary is the fact that, to the great credit of those involved at the time, a very hard-nosed approach was taken to disposing of the old royal infirmary, although it was also seen as a source of financial problems. Colleagues will correct me, but I think that I am right in saying that the original business plan suggested that the old royal infirmary would be a negative asset and that we would have to give people money to take it off our hands. A very hard-nosed approach was taken—in fairness, that was due to the trust's chairman at the time, Barry Sealey—and I think that we finally disposed of the old infirmary for around £40 million. Colleagues will keep me right, but it was certainly a substantial amount of money. Therefore, it was always the case that a benefit came from the sale that was seen to be able to support taking forward the new royal infirmary.

However, your underlying point is absolutely correct: of course, there is an opportunity cost. Through close co-operative working with the Executive, which has been a feature of our discussions throughout, we were able to negotiate a brokerage advance of £20 million, which we must start to repay in 2007-08 and finish repaying in 2011-12—I think that that is what the letter says. The advance was interest free, so the opportunity cost was limited, at least as far as NHS Lothian was concerned.

In particular in the coming year, subject to the comments about Treasury rules, we will be looking to slow down our capital programme to provide the necessary bridging fund. That will inevitably mean that some schemes that should otherwise have started will take a bit longer—I guess that that is the inevitable feature of capital-to-revenue transfers and it highlights precisely their opportunity cost.

On our position next year, we are mindful of the overdependence on non-recurrent money. Our trajectory shows that that overdependence is being reduced and I guess that we can take some comfort from the work that Stuart Smith and David Bolton have done, which shows that the run rate and, therefore, the accumulating deficit are ceasing. We very much hope that over the next couple of years we will drive out the underlying income and expenditure deficit and that, through the strategic approach that we have shown in the pan-Lothian review, we will be able to take care with the accumulated past deficit.

John Matheson might want to touch on the specifics of the numbers and the capital-to-revenue issue.

Mr Matheson: The convener made the point about windfall, but I would counter-argue that there is an opportunity cost even in respect of windfall, because we do not get the benefit of accelerating the capital programme.

I made the point that we are in active discussion with the Scottish Executive about how the issue of capital-to-revenue transfer is moving forward. An element of our anticipated non-recurrent support will come from profit on disposal next year, so it will not come directly from capital-to-revenue transfer but will already be in the revenue account. However, we still have a residual element, about which we need clarification from the Scottish Executive.

The Convener: Did you have a comment on the cross-transfer from trusts?

Professor Barbour: The £2 million that we cross-transferred was what is called deferred income. Basically, those trusts had not used all the money that they had in that year, so they used their potential to have a slight surplus to aid trusts that did not have such a surplus. That was a non-recurrent position in that year; we are not depending on that for future years.

Mr Matheson: To follow that, one of the areas on which we are really focused is the need with single-system working to avoid compartmentalising budgets on the basis of organisational structure and instead to try to allocate budgets on the basis of service delivery. We are considering managed clinical networks and how, for example, the cancer pathway might

sit not within the physical environment but within the provision of services to patients. That flexibility within the totality of the £800 million is very important as we move forward.

Rhona Brankin: That business of money being used to plug the acute services gap is a big issue in the Lothians and I seek reassurance that that practice will not continue in the future.

Professor Barbour: David Bolton and Stuart Smith might want to comment on that. David Bolton and Charles Swainson were at a meeting with Lothian university hospitals NHS division medical staff last night and I think that they were choosing words that would make it plain to colleagues that there is no pot of gold at the end of the rainbow. There is no facility for constant bail-outs and—without mixing my clichés too much—charity will have to begin at home. I would like to think—and my discussions with clinical colleagues bear this out—that there is a willingness on the part of clinical colleagues to put their shoulders behind the wheel and to find ways of helping the trust—or, in this case, the division—to recover financial control of its own destiny.

My chairman has commented that there is a perception in other parts of Lothian that over-generous support has been given to Lothian University Hospitals NHS Trust during its period of difficulty. I think that that was the correct choice, but it has had to be accompanied by some tough love, whereby people have control of their own financial matters.

Mr Bolton: As the committee heard earlier, over a three or four-month period, we have reduced the on-going overspend that is filled by non-recurrent money from about £1.1 million per month to less than half of that. We need to balance income and expenditure as soon as we reasonably can, so that we do not have to rely on non-recurrent funding to any significant extent. We expect that we will be well down that road by this time next year, but it takes time to make that happen because NHS Lothian is a huge organisation.

I agree with Professor Barbour's comments about the commitment of management and the clinical staff. Hospitals suffer as a result of the inappropriate use of non-recurrent money—the convener referred earlier to the opportunity cost in that regard. When we balance income and expenditure, we will be able to use non-recurrent money for other purposes, such as services, development and equipment.

The clinical staff do not doubt the value to them of moving as swiftly as we can. We have introduced a number of basic housekeeping controls that have made a big difference. We know that they will bear further fruit for us next year. I expect that if we are not there within 12 months, we will be very close to being there. I feel quite confident that we can do that.

The Convener: I think that we can move on to consider 2003-04 and the future.

George Lyon: The witnesses have spoken about restoring financial control of NHS Lothian's destiny. If one examines some of the predictions that were made, one would think that no financial controls were in place. In May 2002, the trust forecast a cumulative deficit of £11.7 million over the period up to 2006-07. When the plan was updated in March 2003, the trust predicted a projected cumulative shortfall of £180 million over the five years to 2007-08. In March 2003, the plan indicated a deficit of £37.1 million for the current financial year. However, after a further discussion with the board of NHS Lothian, a balanced financial budget for 2003-04 was approved in June 2003.

The figures that I have outlined point to a problem, which is that NHS Lothian does not have a sound financial base to start from. Given that the baseline seems to be less than robust, how can we have confidence in NHS Lothian's financial planning and in the assurances that it has given us today?

Professor Barbour: At the time to which George Lyon refers, NHS Lothian comprised four independent legal organisations, which had four accountable officers. Three of the four organisations have rigorous financial controls and have met their financial targets. The financial performance of NHS Lothian as a whole, for which I am accountable, has been such that it has met its financial targets since the inception of the unified board. That needs to be made clear at the outset.

The point made by George Lyon about changes in the financial projections is a fair one. I think that the Auditor General will confirm that the cumulative figure of £180 million is an expression of £37 million over five years. The two numbers refer to the same projection. The underlying question is how the trust could have moved within a year from a projected annual overspend of approximately £6 million to a projected annual overspend of £37 million. I can give a number of responses to that.

The Auditor General made an important behavioural point when he said that we should not continue to base financial projections on worst-case scenarios. We pointed out in our submission that a newly appointed chief executive carried out an internal risk assessment at the time under discussion. The problematic figure of £37 million was produced during that assessment. When one strips away the money that we knew we were going to give and some of the more heroic

assumptions, which included a whole set of aspirations around service developments, there was an underlying discrepancy of approximately £11 million between the plan from the previous year and the plan produced that year. Therefore, you might say that there must have been a flaw in the financial projections in that year or in the previous year—indeed, I think that you would be correct in doing so. If you were to say that, I think that we would accept fully that that was the case.

We would also say that the behavioural aspects, which I referred to as the last vestiges of the internal market, have been such that it is probably the case in Lothian and—I speculate—in other parts of Scotland that people have seen the financial planning process as a means of gaming the system. People are listing all of the pressures on a worst-case basis to secure additional money.

That said, we have now rigorously tightened the process. We have direct management accountability, which we did not have at the time. David Bolton is directly accountable to me for performance and the finance director will be directly accountable to John Matheson for performance. I guess that that tightening of the process, coupled with the common financial reporting process that we now go through, gives us faith in a combination of the activity that is being taken at local level and our ability to manage the macro financial position. Although the numbers that we have rehearsed with the committee over the past three or four months give cautious ground for optimism, we are by no means out of the woods.

11:15

George Lyon: I take it that that is what you referred to in one of your submissions as the benefits that will be delivered by a single system.

Professor Barbour: Absolutely.

George Lyon: Under a single system, you will be able to shift money from the primary system into the acute system to plug the black holes. Is not that one of the more sceptical interpretations that could be made of the single system?

Professor Barbour: John Matheson made the point that, as I think the committee would expect, we regard the £800 million plus that comes into NHS Lothian as a sum that must be used in the way that is most flexible and that gives the most benefit to patients and communities. The fact that the money is currently allocated on the basis of institutions that are centred on buildings is a budgetary illogicality. The sooner we get to programme budgeting, whereby we can talk about the amount of money that we spend on cancer and diabetes as opposed to the global sum that we give to a hospital that happens to house those services, the more we will be able to see the kind of transparency that the committee and NHS Lothian want to see.

We have not raided primary care to do that. As David Bolton will confirm, we have an active body of local general practitioners who watch this stuff like a hawk and who would be very conscious of any suggestion that we might have raided primary care.

What we will try to do is to reduce the amount of money that is spent on corporate overheads, both within NHS Lothian and across Scotland. The committee will be familiar with the work around shared services and the potential that that brings. A couple of years ago, we analysed some of our services. The analysis suggested, for example, that in orthopaedic services in Lothian University Hospitals NHS Trust, 30p in every £1 that was being spent was loaded against a corporate overhead. We will certainly bring transparency of that kind to accounting.

George Lyon: I have a follow-up question on the point about regaining financial control and establishing a rigorous financial management system. Does that mean that the promises that were made under the old system will no longer be delivered?

Professor Barbour: We made very public commitments in our local health plan and we delivered on our promises last year. Our draft plan is out to consultation and the results are due to be reported to our next board meeting. We are absolutely committed to meeting those promises. For us to do so, colleagues across the system will have to meet their promises, particularly in respect of the individual financial accountabilities of each of the constituent parts of NHS Lothian.

George Lyon: How will Lothian University Hospitals NHS Trust be able to move from a projected financial deficit of £37.1 million to a planned balanced financial position for 2003-04? Will you detail exactly how that will be achieved and where the savings will be made?

Professor Barbour: John Matheson will take you through what I guess are the line-by-line discussions that went on over many days and weeks to come away from a position of £37 million.

Mr Matheson: There are five figures which, hopefully, total £37 million. As Professor Barbour indicated, the trust submitted its five-year plan in March 2003. There was no detailed discussion with NHS Lothian. If there had been, I think that the figure would not have started at £37 million, £10 million of which was funding that NHS Lothian had ring fenced to give to the trust in respect of waiting list initiatives, delayed discharge and modernisation moneys.

Slightly less than £2.5 million related to the fact that the trust also provides tertiary services outwith the Lothian area to colleagues in Fife, the Borders, the Forth valley, Dumfries and Galloway and elsewhere. Specific pressures existed and were resolved through discussions with colleagues outwith NHS Lothian. James Barbour mentioned the efficiency target of 1.5 per cent that was identified in the Wanless report as being a reasonable target for NHS organisations. That target was agreed by Lothian University Hospitals NHS Trust.

George Lyon: How much money does that target amount to?

Mr Matheson: It amounts to £4 million.

We had detailed discussions with trust colleagues about some of the development pressures that the trust had included but which did not sit with a national priority or a priority within our local health plan. That accounted for slightly less than £8 million. The trust identified internal non-recurrent support of £1.5 million, which left us with a residual balance of £12 million to cover on a non-recurrent basis. That was covered from brokered support from the Scottish Executive of slightly less than £6 million; from capital-to-revenue virement of slightly more than £4 million; and from deferred income from throughout NHS Lothian, which reflected collegiate support from colleagues in West Lothian Healthcare NHS Trust and Lothian Primary Care NHS Trust. That is how the figure of £37 million was brought down to zero.

George Lyon: What are the key risks to achieving financial balance this year? How do you view the 2004-05 year? One of the most surprising comments that I have heard today, which I think was in answer to Brian Monteith's question, was your point about the fact that you did not predict that the new deal for junior doctors would cost £8 million a year. Is that an accurate reflection of your comment, or have I misinterpreted it? Why was the impact of that deal not planned for, given that the new contracts and the European working time directive will have a big impact on your budget? What are you doing to plan for the new contracts and to build them into the budget at the beginning of the year so that the pressure does not suddenly build up three quarters of the way through the year?

Mr Matheson: That is a fair challenge. The figure of £8 million relates to the consultant contract.

George Lyon: Right, but was it unplanned?

Mr Matheson: I will take you through the iterations during 2003-04. When we set the budget at the start of the financial year, we were aware of the offer that had been made to consultant colleagues in relation to their contract. The offer was around 8 per cent and was to cost around £2.8 million or £2.9 million. From informal indications, we became aware that it was likely that the offer would not be accepted, which is why we allowed the slightly higher figure of £4 million in our budgeting plan. After discussions were concluded and a second UK-wide ballot was carried out among consultant colleagues in the autumn, we found out that the cost of the consultant contract was to be around £8 million—the figure that we have been discussing—and that the contract was to be backdated to 1 April 2003.

George Lyon: To be clear, the original figure in the budget was £2.9 million, but after the final agreement was reached, the resulting figure was £8 million.

Mr Matheson: That is the present figure. Detailed discussions are taking place with consultant colleagues to agree job plans, which will reflect what NHS Lothian wants consultant colleagues to deliver. As those plans have not been finalised, I give the health warning that the figure of £8 million may move slightly.

George Lyon: I assume that you mean that it may move up the way.

Mr Matheson: I most certainly hope that it will not move significantly, or up the way.

Professor Barbour: To spare John Matheson's blushes, I point out that the provision of £2.9 million and £4 million was at the high end of prudence in the NHS in Scotland at the time.

George Lyon: I understand that point, but it is not what I was driving at.

Professor Barbour: I know.

Susan Deacon: I have a point for clarification. Can you say more about the impact of the backdating element and the extent to which that might not have been expected?

Mr Matheson: We had to accommodate the backdating element in our mid-year review to ensure that we achieved financial balance. I re-emphasise Charles Swainson's earlier point that the critical factor is to ensure that we get service enhancement and improvement from what is a significant investment. That is our clear focus in agreeing job plans with consultant colleagues.

George Lyon: Can you address my wider question, which was on the cost pressures in coming in on target this year and your view on next year's cost pressures? Will you detail exactly which areas you believe will be the most difficult to deal with and that have not been planned for?

Mr Matheson: As a health system, we have received an uplift of 6.75 per cent for next year, which comes to about £47 million. Our clear focus is to consider not only the uplift element, but the

total £800 million figure, in terms of the services that we can provide. There are three key cost pressures next year. One is the continuing cost of consultant contracts. Over the next month we will firm up the actual figure, for which we will need to budget and plan.

The second cost pressure arises from the GMS contract. There has been significant additional funding investment in GMS as part of the contractual arrangements, but we have to accommodate some knock-on costs. One is the additional cost of out-of-hours services in the evenings and weekends. Our assessment is that that will cost around £1 million. The second one is the additional cost of prescribing in the Lothian area. The current assessment is that that will be between £4 and £5 million, which reflects quality indicators in the GMS contract for cholesterol measures and so on.

The third key element that we will have to accommodate is the fact that our asset base is revalued every five years within the NHS Scotland system. The revaluation within Lothian, which partly reflects land and property prices, is expected to give us additional exposure. Therefore, those three additional elements must be accommodated within the planning for 2004-05 and beyond.

Susan Deacon: As a follow-up to that, will you comment on the extent to which the three cost pressures that you have identified are unique to Lothian and are different within Lothian or are cost pressures that you believe will be shared across NHS Scotland in the year to come?

Mr Matheson: All three of those cost pressures have a clear NHS Scotland focus. One could argue that, because of the complexity of NHS Lothian as a teaching health board, the consultant contract involves additional exposure. We would look to recover an element of the £8 million from colleagues outwith Lothian through tertiary services costs. On the GMS contract, Audit Scotland's work shows that Lothian is a cost-effective GMS prescriber. For example, we use a clinical lipid audit mechanism to ensure that our expenditure on statins is focused and directed. Because of that we may incur additional expenditure on statins.

Our cost profile on out-of-hours services is probably slightly less than that in the rest of Scotland. I know from discussions with colleagues elsewhere that there is a higher pro-rata cost in some more rural areas than there is in Lothian. Therefore, some Scotland-wide generic issues have a higher profile in Lothian and some have a slightly lower profile.

11:30

Margaret Jamieson: I want to take you back to your comments to my colleague George Lyon on the projected £37.1 million financial deficit and the appropriateness of the current base budget. Given all that has been said since you gave that response, can you assure me that you have reassessed your base budget to take into account the different contracts, different property costs and so on? How confident are you that you now have, on a system-wide basis, an appropriate and robust base budget?

Professor Barbour: I have three responses to that, the first of which is that a piece of work that is being taken forward nationally is intended to benchmark NHS performance in Scotland against that in England and against international comparators. That will give us a broader dimension on whether the efficiency of the health spend in Scotland is all that we would like it to be. We read the headline numbers on the extent to which we in Scotland are seen to have a higher rate of investment per head, but we need to get below those headline numbers.

Earlier, I made a point about the relationship with activity, and it is important to say—to some extent, I say this with a heavy heart—that with the flowering of the internal market, base budgets were generally set for deliverable amounts of activity. Trusts were expected to deliver improved levels of activity year on year, and the only proxy of measurement was the number of finished consultant episodes. It seems to me that when the internal market was jettisoned in Scotland, some of the counting rigour of that process was thrown out. We have tried to reinstate it; we have done analytical work in Lothian to plot the level of expenditure and the level of activity during the past five years. With our divisional colleagues, we are setting indicative activity targets for the coming year, and we expect them to meet those targets.

With regard to the other aspect of your question, which was about what gives us confidence that the budgets are correct, we are undertaking reviews of the big-ticket, volatile budget items with divisional colleagues, if not to zero base them—I am in the company of an accountant, who tells me about all the difficulties that exist with that—then to go back to first principles and see to what extent the items are historical artefacts. I will give you an example that troubles us greatly. The average daily spend in NHS Lothian last year on agency nurse costs was £26,000. That money was spent against nursing budgets, which are historical artefacts—they might have been quality related or activity related, and they might have been revisited annually, but I suspect that the answer in both cases is that they were not. We are determined to get to the bottom of that and to ensure that we

have proper budgets in place that will do that—we have been rigorously prodded on that by our employee director.

I hope that the transparency that comes through single-system working, through our relationships, and through the relationship that John Matheson will have with his finance colleagues, will mean that we will not see any of the black arts that we have seen in the past in Lothian, in terms of the way in which money is moved around to cover overheads and the like.

Margaret Jamieson: Is it only since you started operating as a single system that you have managed to drill down into some of the information that was provided by the previous three operating units? Were the problems related to one unit in particular or to all three? It is obvious that Lothian University Hospitals NHS Trust was the one that gave you the most problems with financial balance for several years.

Professor Barbour: I will not say that we have not been able to drill down. We have tried to do that; for the reasons that you mention, we produced some benchmarking analysis of Lothian University Hospitals NHS Trust's financial and activity performance and we hoped that that would underpin its savings plan. On the positive side—if I look forward rather than backwards—it will be much easier to ensure that thorough and rigorous drilling down takes place under single-system working with direct lines of accountability between me and David Bolton, and between John Matheson and the finance director.

As I said a few minutes ago, the other trusts in NHS Lothian met their financial targets, with greater or lesser degrees of difficulty. They have not had the degree of yawing around that George Lyon explored, and they have not had malfunctions in respect of their financial performance. Generally, it is true to say that there is greater volatility in teaching hospitals. However, it is also fair to say that one would expect that to be dealt with by the higher quality of management that is usually employed in such hospitals, because of levels of remuneration and seniority.

Margaret Jamieson: Under the Arbuthnott formula, having a teaching element is a plus for NHS Lothian. Teaching hospitals have an opportunity to engage with companies and universities on income generation. As someone from an area that, to ensure financial balance, is innovative in service redesign, patient journey pathways and so on, I get the distinct impression from what we have heard today and from the Auditor General's report that in NHS Lothian part of the system is managing very well, but there is also a loose cannon. It reminds me of the saying that the child that cries loudest gets the most attention—in this case, more money. Given that your head will be on block in respect of how the system performs, are you confident that the Auditor General will not identify you as the accountable officer for problems that you will inherit? Are you confident that you have stripped out all those problems?

Professor Barbour: Let me put it this way—I am not in a hurry to repeat today's experience, stimulating though it has been. If I am to repeat it, I want to have much greater control of my destiny in doing so.

Margaret Jamieson makes an entirely fair point. The major risk that we identified at the inception of the unified board was the financial management of an organisation that historically was not directly accountable. What do I bet against the likelihood of being back before the committee next year under the scrutiny of the Auditor General? I bet my experience of running teaching hospitals and, more particularly, the experience of David Bolton and Stuart Smith, who are showing that within four months it is possible to reduce the run rate from £1.1 million to £400,000 and to ensure that the underlying deficit is driven out next year and in the following year. There is evidence that that can be done.

Margaret Jamieson's analogy of the child that cries loudest is apposite. Charles Swainson will confirm that there has been an underlying cultural imprint in Lothian that someone will come along to bail us out. People believed that sufficient adverse publicity would ensure that that happened at an early opportunity. We are saying that, mindful in a responsible way of what our needs are in terms of service delivery, we can no longer take that approach. We must stand on our own two feet. Given the numbers that I have seen and the team that we have, I think that we will do that.

Susan Deacon: I am interested to hear many of the comments that have been made. I welcome the tone and substance of what has been said about seeking to change both the culture and many of the systems and practices of the past.

This morning, in some of your most recent responses, we have heard a great deal about the improved information flow and transparency that will accompany the changes that are being made. On a number of occasions, you spoke about being able to drill down into some of the issues. You gave the example of the costs of agency nursing. I recall that the Auditor General produced a not insignificant report on that matter in 1999-2000 and that there was subsequent follow-up work. In other words, this information is not new. The detail of accounting may have been refined, but the fact that substantial NHS resources—notably in areas such as Lothian—are spent on agency nursing has been known for a considerable number of years. I welcome the fact that the data will be

improved, refined, made more transparent and so on, but what will you do with that information?

What are you doing to ensure that managerial performance is improved to deliver changes in these areas? We have talked a great deal this morning—it is perhaps more correct to say that you have alluded to it in your answers—about management practice at a very senior level. However, delivering improvements in areas such as agency nursing requires improvements and changes to practice at a number of different levels. Can you tell us what is being done in that regard?

Professor Barbour: I will answer on the generality and my colleagues will speak about the specifics. If one takes the challenge head on, the response is that, if the Auditor General had been producing reports since 1999, what did anybody do with them? They went to NHS trusts and assurances were given that action was being taken, I guess, in the follow-up audits. The figure of £26,000 came from an analysis that we undertook at unified board level. That was the first time that we had seen the consolidated numbers for NHS Lothian. It was also the first time that we had been able to tease out what was happening around the reasons for agency nursing spend throughout NHS Lothian. We actively embraced the issue.

In terms of the managerial change that comes with that work, a question about delivery and implementation arises. One of the fundamental differences that the white paper talks about is a position whereby the board's strategic intentions will be carried out through divisional units of management, rather than through independent statutory organisations. That is a profound difference because, for the first time, we have a complete alignment of the board's overall objectives running all the way down through the division and the individuals. Stuart Smith and David Bolton can speak on a practical level about precisely what they are doing with ward sisters and divisional managers to ensure that a different approach is being taken.

Mr Stuart Smith (NHS Lothian): Specifically, I have the pleasure—the honour—of being the chair of the West Lothian Healthcare NHS Trust and of the Lothian NHS university hospitals division. I am, therefore, well placed to see both sides of the coin. Since joining the division at the beginning of the year, I have seen an improvement in communications. There is definitely streamlined reporting between the division and the health board. There are clearer lines for responsibilities and roles and there has been a reduction in duplication. Along with the chief executive, David Bolton, we have set in motion project groups to address some of the issues that we have touched on, such as agency nursing, delayed discharges, zero-based budgeting—which James Barbour referred to—procurement, those who do not attend appointments, and so on. There are many projects that require to be driven forward, and there is determination among the senior management team to do that.

Mr Bolton: The issue of agency nurses is not a single issue: a range of issues contribute to it, among which are recruitment and retention. We have about 400 nurse vacancies in the NHS trusts at present, and Edinburgh royal infirmary has not been regarded as a good place to work recently when people have had a choice. We are setting about fixing that. We are introducing flexibility in shift patterns, which did not exist before, and we have a number of other initiatives that we will run forward. Some of those have started and some will be introduced fairly soon. It is important to us that we can recruit staff and keep them. They have to want to work for us when there is a choice, and we have set about ensuring that they do.

We have also started to examine the real need for agency nurses when there is a vacancy. We are looking at the establishment levels to which nurses or charge nurses are being recruited, which are historical rather than real time. By August—or perhaps a wee bit earlier—we will know exactly what the real-time establishment should be for every ward and theatre. We are also taking a broader view, when we are down a nurse or two, about whether adjacent wards or the whole hospital—for example, the whole Western general hospital—can come together to provide support for a ward that is understaffed. The culture in the past has been focused on individual wards: one ward could be overstaffed while, a little further down the road, another ward could be understaffed. Wards have not worked well together; however, that has now been stopped, and we have ways of sorting it out, especially in the evenings.

With colleagues throughout Lothian, we are now reconsidering what we pay when we need to use an agency, and we are driving the costs down. One of the real benefits of pan-Lothian working is that we can do that in a joined-up way. The fact that we are a bigger market means that we can be quite aggressive; indeed, we are being quite aggressive in the costs that we are paying for agency staff.

In the past few months, a very real benefit that has been strongly evident to me in the acute division is the ability, through a single-system working arrangement, to ask for and receive—rapidly—input and expertise from other parts of the system and from other trusts. It is arguable that one should always have been able to do that, but the culture was not right for it. It has been a real treat to work with people from West Lothian Healthcare NHS Trust and from Lothian Primary

Care NHS Trust, all of whom have been able to give bits and pieces of information and direction that have helped us to solve our problems. The traffic has not been one way: some of our clinicians have identified areas in primary care in which improvements could be made over the next year. That is a facet of the single system that one could argue was not there before but which is very evident now and is making a difference.

11:45

Margaret Jamieson: I want to pick up the point about agency nurses, on which the Auditor General produced a substantial piece of work. Am I right in getting back from you the feeling that the issue was never tackled in Lothian University Hospitals NHS Trust? Agency nurses are usually used for full shifts, even though someone might be needed only for three hours. Does providing what is, in effect, an in-house agency from among your work-force pool give you greater flexibility?

Mr Bolton: That is absolutely right—I support all of that. We have been growing our number of bank staff and we are rewarding them properly financially. That means that our need for agency staff will reduce. You are right that it is critical to have the staff available in-house, to provide the training in-house and to know that the staff on the wards are trained and competent. We have made significant progress on that.

On your first point, there were plans to manage agency controls in the trust, but the level of management and control was quite low in the organisation and people were changing jobs and so on. To be honest, I think that that was a failure. Control is now at a much higher level and, although it takes a wee bit longer to get authorisation, it is worth it.

George Lyon: Until now, we have dealt with the input side of health care in Lothian. I want to turn to the demand and activity sides, because they are what patients and ordinary men and women in the street are interested in. As well as wanting the service to meet their demands, they have the expectation that the substantial uplift in funding for the health service will produce extra activity and outcomes. I was deeply worried by one of your comments. You said that you have done some work in that area and have found that activity levels are decreasing, in spite of a substantial—probably record—increase in the money that is being put into the system.

First, I would like Professor Barbour to deal with the demand side. Is demand for your services rising rapidly each year? Do you measure that and have a good handle on it? It is clear that that has a big impact on the supply side and the number of services that you have to provide. Secondly, I would like you to deal with the activity issue, which, it seems to me, is crucial. If activity levels are going down, there is something fundamentally wrong with the whole system.

Professor Barbour: Right. I will deal with the demand management part of your question first. As part of our pan-Lothian projects, we set up a demand management group. I want to make a general point, lest I forget it. It would be fair to say that a study of health policy over the past 20 years would show that almost all the health policy initiatives that have taken place in the United Kingdom and beyond have been supply-side driven. People have fooled with reorganising the supply end without tackling the demand end. That is a general statement.

We set up the demand management project, which was intended, as David Bolton described, to bring general practitioners alongside hospital consultants to consider ways of keeping people out of expensive acute hospitals. There were a number of reasons for wanting to do that, not least because it was desirable from the patients' standpoint. All the evidence shows that patients want to get treatment as near their home as possible and preferably in their home. The new GMS contract offers us a way into that discussion. David Bolton has talked about the investment that we have made in a variety of community teams and community-based services. We know that we have more to do and, as Susan Deacon has reminded us, we need to pick up the pace of that work. The plans to do that are under way, and the GMS contract will help.

I turn to evidence of demand. Measuring demand in the health service is complicated—we can do it through waiting-list figures. NHS Lothian met the nine-month guarantee a year earlier than did the rest of Scotland. We managed the demand and responded by ensuring that there were shorter waiting times. The drivers under Arbuthnott are population, poverty, age and demographics. The population of Lothian is increasing, which might drive aspects of demand for the services, of which maternity services are a good example. The West Lothian population is burgeoning and the opening of the first new GP practice there for 30 or 40 years was possible precisely because of our response.

On care of the elderly, our demand figures are skewed by the imbalance that exists in the care-home sector. The number of delayed discharges that we have in NHS Lothian, which, as of today, is about 440, means that many elderly people who are in hospital beds should not be there. That skews our ability to respond productively.

I have not seen evidence—although Charles Swainson might have—that referral patterns have changed substantially over the past 10 years. I have seen a headline analysis that suggests that

there is a drop-off in activity that can be counted, such as in-patient episodes, day-case episodes and out-patient episodes. That might be explained by artefacts of the counting system. In other words, in the days of the internal market, when people were paid according to activity, there might have been some inflation of the numbers, and we might have gone back to the original numbers. There is a quality dimension to the issue. Hospital consultants would argue that there is a case-mix complexity and that complying, in GP-practice terms, with guidelines from the National Institute for Clinical Excellence and NHS Quality Improvement Scotland on spending the desired amount of time with patients has been at the expense of productivity. We are still bottoming out that work, but it is fair to say that the trend is probably replicated at national and UK level. To that extent, the real challenge for us is how to translate the new GMS contract and the new consultant contract into improved productivity, which is not about slavish counting of finished consultant episodes but is discernible in terms of quality benefit for individual patients.

My colleagues referred earlier to managed clinical networks. One of the chinks of light in that discussion is the work that we are seeing in our managed clinical network in cancer services, which is showing that, through better co-ordination of the system and better matching of inputs and outputs, we are getting better outcomes for patients in terms of cancer survival rates.

I have said a lot and I am happy to go back to any points if you want, but I hope that that has given you an overview.

George Lyon: It is clear that there is still a lot of drilling down to be done to find out whether better quality is being delivered in each episode or whether the productivity levels are dropping off. When will you have that information? It seems fundamental to the understanding of the ordinary person on the street of what the health service is delivering.

Professor Barbour: We piloted the work that we are doing locally with the information services division of the Common Services Agency, which has given us a preliminary report. However, that report has to be health-checked and gone through in detail for all the reasons that you set out. We have discussed the report nationally, because it might have broader applicability once we have bought into it. It is important that the report has clinical credibility. We do not want to get stuck with a headline number and then have Charles Swainson and his colleagues tell us that we have totally ignored clinical and other outcome dimensions.

Mr Bolton: I want to make a brief point on the care of people in our hospitals and the fact that so many more older people are now getting interventions and are being cured, which would not have been the case 10 years ago, or even less. For example, significant intervention is made in the care of cardiology patients, which gives them a long and high-quality life. That is expensive and means that those people are in hospital beds for longer, but such treatment was not available 10 years ago. Activity does not look as if it has shot away, but morbidity and the kind of patient who is seen are different. That involves cost and bed occupancy issues.

In orthopaedics, we see older people who might not have withstood the surgery that was available 10 years ago come in for their second or third knee or hip replacement. That is new and expensive treatment that keeps people in beds for a long time.

I will finish with the point that James Barbour made. A complication is the fact that we have quite a high number of delayed discharges in the system.

George Lyon: Should any system not be able to separate out that information, deal with it and—

Mr Bolton: With respect, we have the information. It tells us that morbidity in hospital is much higher, particularly for older people. We plan for that.

George Lyon: Convener, could we request further written information on what is being done, as we do not have much time left for questions?

The Convener: The session is proving very useful and I am of the view that we should continue our current line of questioning until we have exhausted everything that we wanted to deal with today. The rest of today's agenda depends on when we finish this item, but we will probably put the remaining items on the agenda for our 30 March meeting, if that is fine with the committee. That will affect the briefing on the medical equipment report. Will that cause the Auditor General any problems?

Mr Robert Black (Auditor General for Scotland): Not at all. That proposal would be entirely acceptable.

The Convener: I propose that we carry on with questions. I still intend to fit in a 10 to 15-minute discussion of the evidence after this item, but I hope to have a comfort break before that. If we need more written evidence, we will be in touch with the witnesses after the meeting.

I will develop George Lyon's line of questioning about the cost pressures that will be faced in the next few years. NHS Lothian provided a helpful paper, some of the issues in which have been touched on in other questions, such as the consultant contract initial offer, how that offer is

changing because of a further review and ballot, and the fact that the offer was backdated. Considering the other pressures on you leads me to ask whether other backdated settlements were not backdated initially or were not expected to be backdated. If so, to what extent do they have an impact on your budget?

The consultant contract is a UK national agreement, as other agreements may be. Do aspects such as different working practices or staffing levels in Scotland have an impact on the demands that you face, with the result that although an uplift is provided throughout the UK to meet the costs of the contract, the pressure is more severe in Lothian or the rest of Scotland? Will the uplift, as budgeted for, be sufficient?

12:00

Professor Barbour: Charles Swainson will deal with questions about the new consultant contract and its UK and Scottish dimensions. It is important to say that the final number, as John Matheson said, will be the expression of 3,000 individual conversations about job plans with hospital consultants and their managers throughout Scotland. The final number will not be known for a while.

You asked whether any more such agreements exist. I do not think that there are any more retrospective agreements, but we have not touched on agenda for change, which has the same fundamental significance for every other member of staff as the new consultant contract has for hospital consultants. We have a pilot site for agenda for change in West Lothian, which is beginning to generate potentially significant financial implications. The unions that are involved, particularly Unison, are due to hold a ballot on the matter and my understanding is that there is an expectation that payments will be retrospective. Therefore, another pilot could be coming down the track for us.

Dr Swainson: Two aspects of the consultant contract in Scotland are different from the contract in the rest of the UK. That position is true of the negotiations in each of the devolved countries. The first unique feature of the contract in Scotland is that the working week is slightly different because it includes Saturday mornings and because we have a 12-hour timespan. Secondly, it has been agreed that consultants can take sabbatical leave after seven or 10 years of their working lives. On the particular pressures in Scotland and in Lothian, there are more consultants per head of the population in Scotland than there are in England and Wales. We have more consultants overall, so the overall costs are likely to be higher in Scotland, on a pro rata basis, than they are in other countries in the UK.

Working practices are at the heart of the matter, because the new contract, in effect, does two things. First, it brings consultants into the same kind of framework as that of other health service employees; that change involved a difficult professional discussion for consultants. Secondly, the contract gives NHS employers the ability to manage consultants in a way that they have never had since the inception of the NHS in 1948. The principal aim of that measure is to ensure that the objectives to which consultants work are the same as those of the local NHS system and the NHS in Scotland. It might be surprising that there has previously been no such alignment of objectives, but that has always been the case. To achieve that major cultural change in working practice, the contract has been priced accordingly and consultants gain considerable individual benefit compared with the uplift for all other NHS staff throughout the UK.

It must be ensured that the contract is used for the benefit of people in Scotland and that the significant up-front investment brings tangible benefits within the next few years. For example, there will probably be shorter hospital waiting times, which is a key objective. We should also achieve better access to specialist care throughout Scotland, with reduced inequalities. We will get better-rested and better-supported doctors, working in larger teams, and such arrangements will provide continuity of care.

George Lyon: I have a supplementary question on the consultant contract. Are the agenda for change costs factored into next year's budget, or do they start to have an impact this year?

Mr Matheson: The current starting date for full implementation of the new system is 1 October 2004 and the costs have been factored into projections for 2004-05 and beyond.

George Lyon: What is the likely impact of that on your budget? What have you factored in as the cost?

Mr Matheson: The cost will be an average increase of 5 per cent over and above the core pay award of 3.2 per cent.

George Lyon: So it is 9 per cent in total.

Mr Matheson: It is 8 per cent.

George Lyon: Sorry—I meant 8 per cent.

Susan Deacon: Will Charles Swainson or the other panel members comment on the extent to which the Scotland-level variation or regional variation in the new consultant or GMS contracts will enable the variations that panel members want to make in response to their local situation? Charles Swainson touched on some of the differences, such as the number of GPs and consultants per head of population and the lower level of private sector activity.

I make no apology for asking about rurality. We are often in danger of perceiving NHS Lothian as an urban board, but, as members of the committee are aware, the needs of many rural communities in all parts of Lothian need to be met. To what extent will the new contracts allow for variations in local needs?

Dr Swainson: There are tremendous opportunities in Scotland for doing things differently and better to meet our health needs. The first aspect that I wish to discuss is the managed clinical networks. The regional cancer networks have started to achieve real improvements in access to specialist care and in waiting times for patients accessing services.

The new contract gives us an opportunity to work on a bigger canvas, rather than concentrating on the local canvas. I was delighted that Dr Anna Gregor, who is the lead cancer clinician for the region and the leader of the south east Scotland cancer network, wanted to pick up the discussions with local consultants about the contract. There will be a network discussion, as well as a regional discussion, to seek to ascertain the contribution to be made by consultants working in Lothian to the network's work outside Lothian, for example in Fife and the Borders. Attempts will be made to secure the contribution for the future, to get consultants to work in more flexible ways and to improve services in the way that they have sought.

There is a lot to play for. Imaginative management can gain a great deal from all the contracts. The relationship between the consultant contract and the GMS contract will be fully explored by the CHPs—the committee may be aware that I am involved in some of that work. I am delighted that the guidance that has been published makes that point strongly. The guidance suggests ways in which the two contracts, in particular, can be used to improve services for patients near their homes. That will have the effect of reducing patients' reliance on hospitals and improving the local nature of services available to patients.

Professor Barbour: I will pick up on two other aspects of Susan Deacon's questions, the first of which is the regional dimension of this debate. NHS Lothian is part of the regional consortium of south-east and Tayside boards, which I chair. NHS Lothian is mindful of the fact that decisions on its consultant work pattern impinge on what happens in other board areas and vice versa. We are working with NHS Fife on some of the consultant staffing pressures that it faces. We will have a session with our colleagues from NHS Borders, who are in the public gallery, to discuss with them how we calibrate our services on an integrated basis.

Charles Swainson and David Bolton have been working on better acute care, and the acute care steering group has received representations from the other boards, which are keen to ensure that the repercussive effects of changes that we make in Edinburgh-based services are translated sensibly to other parts of Lothian and beyond.

Susan Deacon spoke about rurality. It is important to emphasise that NHS Lothian is continuing to invest heavily in West Lothian. There has been investment in accident and emergency services and renal dialysis services, and ground-breaking work has been done at the Strathbrock partnership centre. We are getting ready to finalise the business case for the Midlothian community treatment centre and we hope that that can be brought to fruition without further undue delay. Work has taken place in Musselburgh in East Lothian. As Charles Swainson said, we are mindful of the importance of transferring services to such places as Haddington and St John's hospital in Livingston. There needs to be a sensible balance between services that need to be provided acutely in Edinburgh and those that have to be provided locally. We are mindful of the fact that Edinburgh does not constitute all of Lothian. We have responsibilities in other areas.

Mr Bolton: I will touch briefly on the GMS contract, because there are opportunities in that that will be evident quite soon. One of those benefits is the opportunity for the skill mix of practice staff to shift radically as a result of new funding and sensible changes in the regulations. Young doctors who do not want to be a partner in a practice will be able to go in as a salaried doctor and have flexible hours. That will be a big win in terms of the recruitment and retention of GPs and it will happen immediately.

In addition, there will be scope to have fewer doctors in practices. For example, a six-man practice might end up with five doctors, not all of whom are full-time, and a number of nurse practitioners who are skilled in the diagnosis and treatment of certain diseases. Nurses are now getting prescribing rights as well. The skill mix will differ, but it should speed up access to treatment in the practice. That will be a benefit and we will be able to retain doctors who are unhappy about getting into the system only if they are principals.

The other change will come through enhanced services. The new GMS contracts will be with local, rather than national, boards, which will mean that if there is particular pressure in an area, some of the new money for enhanced services could be used to create a new service. An obvious example of a new service would be care for the homeless. In the past, establishing proper care for that group of patients has been incredibly bureaucratic; in the future, with the new contracts, it will be much easier to do that.

The Convener: I want to move to planning for the integration of trusts. I need clarification on two points in the questions that we have gone through.

First, your paper outlines the uplift of 7 per cent, which amounts to £48 million, and shows how you break that down. A sum of £4 million is set aside under the heading of "Consultant Contract Initial Offer". From the evidence that we have heard today, I presume that that figure is now expected to be £8 million. Is that correct?

George Lyon also has a question on that point.

George Lyon: In your budget figures for the uplift, there is a figure of £8.5 million for service developments; some 16 per cent of the total uplift has been earmarked for that. Has that sum been spent on service developments or has it been plundered to plug gaps in other areas? That question is crucial in showing what impact the uplift is having on improved services for patients.

Mr Matheson: Yes, it certainly has. In the submission, I indicate some of the areas in which we have used that sum of money. The money has gone into service enhancements.

George Lyon: You have managed to use it in that way.

Mr Matheson: In the schedule, there is a figure of £14 million for prescribing. Within that figure, there was a ring-fenced sum of £1.5 million to deal with the recommendations that arose from the Scottish medicines consortium and ensure that they were implemented timeously in NHS Lothian.

The Convener: We will move on to discuss the integration of trusts. I am conscious that the witnesses have been sitting here throughout the meeting, as have I. However, they seem to be keen to answer our questions so it would be better if we were to try to finish the final section. We can then take a break.

Rhona Brankin: I am conscious of the amount of time that has passed and I wonder whether we ought to offer the witnesses a break.

The Convener: If we have a break now, the chances are that we will overrun the time that you told me you were keen to keep to. Given the pressures, I am sure that we can finish this quickly.

Professor Barbour: We are okay with that, convener.

Rhona Brankin: What management structure is being proposed for the new NHS in Lothian? How are you planning the integration of trusts in NHS Lothian? What progress can you report? What key issues and challenges do you face in planning the integration?

Professor Barbour: Like every other health system, we undertook public consultation on the dissolution of our trusts. The configuration that we are going for reflects the guidance that was contained in the relevant Health Department letter. Therefore, in the first instance, we have gone for a straightforward translation of our three existing trusts into operating divisions. We will have an operating division for West Lothian, one at primary care level and one for Lothian university hospitals.

Because of the departure of the previous chief executive and as a result of the particular financial pressures that we faced, which have been mentioned in our discussion this morning, we opted for early dissolution of the Lothian University Hospitals NHS Trust, which ceased to be on 1 January. You have heard about the progress that colleagues have made since that date. Our other two trusts will cease to be on 1 April.

12:15

It is fair to say that we would apply the principle that the managerial form should follow the clinical function. Therefore, as we undertake further work on providing better acute care—our review of acute services throughout Lothian—and as we see the onset of community health partnerships, to which I will return, it is possible that the movement of the trust configuration into the operating division configuration could change. If CHPs deliver their full potential, they cast a long shadow over the continuation of primary care divisions.

With regard to the balance of care between Edinburgh and West Lothian, we are seeing an increasing convergence between those two parts of our health system—to their mutual benefit, one would like to think—and a movement out to West Lothian of senior clinical expertise to provide support for services there. We anticipate that, over time, that clinical movement will be reflected by further changes in our management structure.

As far as the integrative process is concerned, we will have a management team that will meet under my chairmanship; that team will include the divisional chief executives and existing directors such as John Matheson and Charles Swainson. We are strengthening that team with the addition of a human resources director, who will have responsibility not just for communication aspects, but for the culture change dimensions.

We have just received the CHP guidance, which raises interesting challenges for us especially in Edinburgh. In Midlothian, East Lothian and West Lothian, there is a straightforward mapping of existing local health care co-operatives on to CHPs. Good discussions are under way with each of those local authorities on how that can be taken forward. The issue that remains for us is in Edinburgh, where we have five LHCCs. If each LHCC became a committee of the board, that

would give us eight operating committees and would make my line of direct reporting some 17 strong. I am not enthusiastic about that. We are in discussion with colleagues from the City of Edinburgh Council, and we will have an away day next month to consider how we can reach the full potential of the community health partnerships in Edinburgh and what work we can do with them on pooled budgets and shared services, particularly in the context of recent changes in the social work department.

Work is under way—it was reinforced by a management team away day two weeks ago—to look at integrating all the services that we can, reasonably and functionally, across Lothian. Finance, HR, nursing and all the support services are areas in which we are looking for integration. That is coupled with the work on shared services, to which I referred earlier, in regard to which we are looking to dovetail with the national work in that area to avoid duplication of the administrative costs for four finance departments, four invoicing departments, four estates departments, and the like.

I hope that that gives you a flavour of what is happening. I suppose that the cultural question in all that is what David Bolton referred to. The progress that we are showing in getting the agendas aligned is such that, when we meet as a unified board, the cascade effects of that business go all the way down through divisional management team meetings and into individual objectives. At our board meeting in March, we will discuss a paper that sets out some ground rules and rules of engagement on how we expect divisional management teams to work. I hope that you will get the sense that we have a collegiate, open and transparent approach to all that.

Rhona Brankin: You talk about integration. The question is how you can ensure transparency and accountability. In the light of the reasons that you have given for underlying recurring deficits in particular services, how can you reassure us that accountability for the financial performance of the former trusts will be maintained and the results reported?

Professor Barbour: Earlier, you tested me on the question of how I see my own situation in 12 months' time. I guess that the accountability position is now much clearer and more straightforward than it was: I will be the single accountable officer for NHS Lothian and an unambiguous line of accountability will run all the way from national level through the unified boards into the system itself.

The Auditor General's report raised a question of transparency. The history that was rehearsed at that time was about what happened in a number of trusts during the previous round of reorganisation when deficits got mixed up, confused or otherwise moved around. Our position is that, because of the financial pressures that we faced, we now have absolute transparency. The finance and performance review committee that we set up and which is now being replicated across the rest of Scotland crawls over everyone's numbers in a very transparent and rigorous manner. That line of accountability has also been carried through at board level. Moreover, the addition of single-system financial reporting, under which John Matheson will produce a consolidated report for the whole of NHS Lothian, should provide some comfort that we will neither be able to nor want to move around or mix up deficits.

Susan Deacon: I suppose that I am encouraged by your enthusiasm for the changes to the service's decision-making processes and systems of governance. I hope that you are right to be confident that the approach will remove much of the previous ambiguity and lack of clarity.

I note that, alongside those changes to the health service's systems of governance, we are now in a period in which—not for the first time in its history—the NHS's structure is being quite substantially reorganised. What steps are you taking to ensure that that structural reorganisation does not sap either resources or enthusiasm—which can often be the case in such circumstances—or that it does not lead to a hiatus in some of the developments that you have been detailing this morning? After all, there is some evidence that that has happened in previous reorganisations.

Professor Barbour: In anticipating members' questions, I was trying to work out the number of health service reorganisations that I had been through since I joined in 1977—I kind of lost count at eight or nine. The trend is for the health service to be subject to frequent reorganisation; Susan Deacon's point about not taking our eye off the ball is highly relevant in that respect.

The vast majority of the 26,000 health service employees will probably say that they have seen no difference in their working lives. Indeed, that view is perfectly correct and was certainly borne out by the local consultation that we undertook. This reorganisation has been characterised by the strapline "Minimum change—maximum impact" and the Health Department letter that accompanied it was at pains to try to reassure senior managers in particular that, although some of their accountability arrangements would change, other arrangements including salary, terms and conditions and so on would be unaltered. As a result, it is important to emphasise that we do not foresee the possibility that nervous managers in NHS Lothian will take their eyes off the ball of delivering improved services for patients

because they are looking worriedly at their contracts.

As for the steps that we are taking to change the culture, we are ensuring that the implementation of the changes that are set out in "Partnership for Care" is led by a steering group that is chaired by our chairman and which currently comprises all the divisional and trust chairmen, the chief executives and our employee director. Moreover, I hope that our recruitment of a new HR director will provide the underpinnings for cultural and organisational development.

We are not going for a big bang and we do not expect people's eyes to be taken off the ball. The performance culture that we have tried to inculcate in NHS Lothian through the performance assessment framework will mean that we can continue to focus on actual delivery rather than simply move the deckchairs around.

George Lyon: Following Rhona Brankin's question, I want to highlight the Auditor General's fundamental point that the previous system at least allowed those of us who are on the outside looking in to see where the problems were. In most NHS set-ups in Scotland, the problems clearly lie in the acute trusts. From the point of view of auditors and the Audit Committee, the previous system at least allowed us to identify where the problems lay.

The question that arises about the new system is whether, given that each health board area will have only one accountable officer, budgeting will be transparently devolved to division managers. When auditors examine the delivery of a health-care system, will the system be transparent so that people from outside it will be able to see where things are going wrong? In the big world of the new health boards, it will be easy enough for accountable officers to say that everything is fine, even when there have been major problems that have had to be sorted out by switching around moneys internally from, say, primary care to acute services.

Fundamentally, we would like to be able to look into the system a bit deeper to find out in which areas specific problems arise. We want to be able to hear from accountable officers about the adjustments that they have had to make. We do not want a seamless exercise in which all those issues are hidden below the big numbers that are presented to us.

Professor Barbour: That question requires a number of levels of response. Perhaps John Matheson will comment on some of the technical aspects.

All systems are required to produce a scheme of delegation that shows how they will delegate the maximum amount of operating authority such that individual divisions do not have to keep cross-checking with NHS board officers or the board itself. We are absolutely committed to that, not least because it is important that we delegate not just to operating divisions but below that level right down to the front line. In the NHS, we have perhaps not engaged clinical staff and partnership colleagues in the way that we might have done by involving them in tackling some of the underlying financial problems that we face. The scheme of delegation will be a formal requirement on NHS boards. It will be incorporated in boards' standing financial orders and standing financial instructions and it will be written into the remits for the individual operating division subcommittees.

On transparency, unlike meetings of the trust management teams, all our board meetings will be in public. All the numbers will be reported in public at our board meetings. Also—I think that I am right in saying this; John Matheson will confirm whether or not I am—although we are expected to produce consolidated accounts, that consolidation will be of the individual reporting linkages from each of the operating divisions. Those linkages will be featured in the report that goes to the Executive.

John Matheson will confirm whether what I have said is correct, and expand on it.

Mr Matheson: I can confirm that our monthly submissions to the Scottish Executive will contain that level of detail.

So far, we have focused on the importance of the finance and performance review committee, but there will also be an audit committee, which will examine governance controls across NHS Lothian. In each division, there will be a dedicated audit committee. It is also important to remember, particularly as the Auditor General is present, that external audit will play an important role. The external audit report will take an overview of NHS Lothian, but it will also undoubtedly get into the detail at divisional level.

George Lyon: Does that mean that financial budgets will be devolved to division managers, who will report each month on how their spending is performing?

Mr Matheson: That is absolutely the case.

George Lyon: Will that be transparent? Will everyone be able to see what the year's budget is and the targets that they have to meet?

Mr Matheson: Absolutely. Within the scheme of delegation, that responsibility will be delegated to individual divisions. Let me be clear: the divisions will be accountable for delivering from a fiscal perspective and an activity perspective. They will need to provide quantity and quality within the resource that is available.

12:30

Professor Barbour: The interesting thing about where the service might go is the possibility that we will be able to move away from setting budgets at institutional level towards setting them at a disease or care-programme level, as Charles Swainson mentioned earlier. The extent to which that is done—it is a desirable thing in my view—raises interesting questions about where the level of accountability will sit, because there will be a spend that straddles a number of institutions.

One of the challenges around developing managed clinical networks is how to complete that next strand of accountability. Our managed clinical network with Anna Gregor has done a lot of work on how it will go to the next stage, which is to take accountability for the money and the people who work in the network. That is scary for some managers because it takes away from the traditional managerial power base that people have inhabited, but it is probably correct from the standpoint of engaging clinical professionals and getting the best bang for the buck.

Susan Deacon: I am conscious of the time, and I am aware that I am about to introduce an issue to which we could probably devote an entire meeting. In closing, will you comment on the relationship between your unified NHS board and the Scottish Executive, in particular in relation to various methods of performance management? Because of time, I will roll the subjects together. I would like you to comment specifically on the accountability review process and on the performance assessment framework.

I note that the letter from the chief executive of NHS Scotland, which you received at the end of the accountability review, is rightly heavy on comments on and praise for the inputs to the system to deliver improvements, but is a deal lighter in comment on some of the outputs and outcomes, particularly for the local population. For example, there is a great deal of comment on your inputs to address delayed discharge, but no reference to the extent to which that continues to be a profound problem in the area. The same applies to waiting for audiology services, which is recognised as being particularly problematic. Would you take those comments and observations into account and comment on the nature of that accountability process and how it could be improved from your point of view and from the public's point of view?

On the performance assessment framework—I know that I am living dangerously, but I have said this previously at this committee—I had some responsibility for introducing that system. I have been supportive of there being a means of allowing benchmarking between different boards, but I am conscious that it is now a large system with a considerable number of indicators. Concerns have been expressed in a number of places that that is leading to a lot of ticking of boxes, but that it is not necessarily the aid to monitoring and improving performance that some of us hoped it would be.

I know that those are big questions, and that we are into minus three minutes to answer them, but I would be grateful if you could comment upon them.

Professor Barbour: I am happy to have a go and to provide responses on a number of levels. At a mechanistic level, our accountability review letter is published in our annual report, so whatever we might think about it, in so far as it is the process by which we are held to account, it is published and made available.

The accountability review process has improved a lot in recent years. I have been exposed to it in England as well as in Scotland, and in the past few years Scotland has done a lot of work to make that process more meaningful. I was involved with it in England and my experience is that the discussion centres all too often only on the big-ticket items such as money and waiting lists. At least in our accountability review process we are beginning to see on the horizon discussions about health inequality and some of the joint future and partnership working issues.

My view, which I have rehearsed in other places, is that if the maxim is that joined-up problems require joined-up solutions, the English accountability review process would now typically involve the director of social services. At the other end of the process is the chief inspector of social services, or his or her agent in regional terms. I know that the structures are different, but if we consider the delayed discharges example or the joint future work, increasingly we can perform only to the extent that health services and local authorities are in strategic alignment. Therefore, in the case of delayed discharges, holding us to account on a joint basis for a spend that is in excess of £12 million does not seem to me to be unreasonable. It would be useful to make such a modification to the process.

We have already rehearsed the arguments on outcomes. To the extent to which developmental work in that area is possible, I think that the accountability review process should be enhanced by it, because it is needed.

As someone who has worked for the health service for a long time—rather than as someone who holds the position of chief executive of NHS Lothian—my personal view is that there is scope for much better stakeholder involvement—to use the jargon—in the accountability review process. Although there is an effort to ensure that local

partnership organisations are involved—the chief executive of NHS Scotland has a separate meeting with those organisations to test the water—I think that, when we are being held to account, there is an opportunity for public involvement and public engagement in that process, which I would not shy away from. I have given you some observations on the process.

We have been fans of the performance assessment framework, not because we believe that it is the be-all and end-all, but because we believe that it at least brings structure and rigour to the process. At organisation level, we have an excellent relationship at which we work very hard with the people at the Executive who undertake the performance management work with us. We work in a mutually supportive manner, which we hope means that we avoid giving one another surprises. To that degree, we are fans of the PAF, even though it could be refined.

The Convener: Professor Barbour, I thank you and your team very much. This has been an extensive evidence session not only for you but for the committee—we have taken longer than we normally take. I thank you for your patience and for answering our questions so fully. Once we have contemplated and read through what you have said in the *Official Report*, further points on which we seek clarification may well arise. Given the length of time that you have spent with us today, I expect that we will be able to pursue any such matters through an exchange of letters.

That ends that item, so I propose that we bring the meeting to an end. We will consider dealing at a future meeting with the other items on the agenda. I thank the Auditor General and his team for sitting through the session. I am, however, sorry that we were unable to deal with the later items on the agenda. It is important that I say to the committee that, given our experience today, we might need to consider the agenda for the next evidence session with a view to building in an additional meeting at a later date, in order to cater for the items that we have not been able to deal with. I will be in touch by e-mail on that issue. I thank members for their time.

Meeting closed at 12:38.

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