AUDIT COMMITTEE

Tuesday 30 March 2004
(*Morning*)

Session 2

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by The Stationery Office Ltd.

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AUDIT COMMITTEE
6th 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)
Caroline Gardner (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

Dr Ross Cameron (NHS Borders)
Mr John Glennie (NHS Borders)
Dr Alan Green (NHS Ayrshire and Arran)
Mrs Wai-yin Hatton (NHS Ayrshire and Arran)
Mr Robert Kemp (NHS Borders)
Mr Derek Lindsay (NHS Ayrshire and Arran)
Mr Derek Yuille (Ayrshire and Arran Primary Care NHS Trust)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Christine Lambourne

LOCATION

The Chamber

Scottish Parliament

Audit Committee

Tuesday 30 March 2004

(*Morning*)

[THE CONVENER *opened the meeting at 09:10*]

Items in Private

The Convener (Mr Brian Monteith): As we are quorate, I bring to order the sixth meeting of the Audit Committee in 2004. Two more members are coming in, so I will go through the preamble. I welcome the Auditor General for Scotland and his team. I remind people, including myself, to switch off their mobile phones and pagers.

The first item on the agenda is to seek the committee's agreement to take agenda items 2 and 7 in private. Item 2 is consideration of lines of questioning on the Auditor General's report "Overview of the National Health Service in Scotland 2002/03". Item 7 is the committee's consideration of its approach to the Audit Scotland report on medical equipment. Are we agreed that we should take agenda items 2 and 7 in private?

Members *indicated agreement*.

The Convener: We have an additional meeting tomorrow, and I seek the committee's agreement to that meeting being held in private. Are we agreed that we should meet in private on Wednesday 31 March to consider the draft annual report, the draft report on Scottish Enterprise and further written evidence and possible findings and recommendations on the Scottish Parliamentary Corporate Body accounts?

Members *indicated agreement*.

The Convener: We have organised a meeting on 27 April 2004 to take further evidence on the NHS overview report. On that occasion, we will take evidence from Trevor Jones. For administrative ease, it would be helpful for us to agree today that we should consider the lines of questioning for that meeting in private. Is it agreed that we should do so?

Members *indicated agreement*.

The Convener: We move into private session for agenda item 2. We will take a few minutes to let the public gallery clear.

09:12

Meeting continued in private.

09:33

Meeting continued in public.

"Better equipped to care?"

The Convener: I welcome back the press and the public to the sixth meeting of the Audit Committee in 2004 and remind everyone to turn off their mobile phones and pagers.

Agenda item 3 is consideration of Audit Scotland's report "Better equipped to care? Follow-up report on managing medical equipment". I invite the Auditor General for Scotland to brief the committee on the report.

Mr Robert Black (Auditor General for Scotland): Thank you, convener. I invite Caroline Gardner, who is the deputy auditor general, to brief the committee.

Caroline Gardner (Audit Scotland): I will give a brief introduction to the report.

The report follows a baseline report that the Auditor General published in 2001, which made a number of recommendations aimed at improving the management of medical equipment. The area is important for two reasons. First, medical equipment is critical to the care of most patients in the national health service and, secondly, a lot of money is tied up in it. We estimate that the value of medical equipment in the NHS at the moment is more than £600 million and that around £130 million a year is spent on replacing and maintaining equipment. Therefore, the issue matters to the NHS in many ways.

The follow-up report addresses the areas of concern that we identified back in 2001. We think that there is still substantial room for improvement throughout the NHS in Scotland in respect of how medical equipment is dealt with. There are three main areas in which there could be improvement. First, medical equipment needs to be given a higher profile. NHS operating divisions must have a clearer picture of what information they currently have, including the age of equipment. They need to plan for its replacement and keep an eye on developments that might mean that better equipment is available to improve the care that patients receive.

To ensure that that happens on the ground, we think that there is a case for the Scottish Executive Health Department to take a clearer lead on medical equipment. In the report, we have recommended that the department might consider putting in place a specific standard for managing medical equipment within the controls assurance statement that health boards are required to complete each year. That would provide

assurances that proper management arrangements are in place to manage the risks relating to equipment.

Secondly, we think that more could be done to manage the risks relating to operator error in using medical equipment. We found that only half of the trusts that we looked at had comprehensive systems for planning and recording staff training. Of course, that does not necessarily mean that staff are not being trained, but it means that there are risks in respect of managing the risks relating to equipment and ensuring that staff are properly placed to use the equipment that they need to use.

Finally, we think that there is a risk related to over-reliance on aging equipment. Such equipment might work well at the moment, but the risk that it will need to be replaced quickly increases with the equipment's age. That risks service continuity—being able to deliver services as planned—and financial problems, if planning for replacing the equipment has not been done. In the 15 categories of equipment that we considered, a quarter of the equipment was beyond its standard life at the time of the audit.

Those are the three areas in which we think that there is room for improvement. We will be more than happy to answer any questions that members have about medical equipment or the report. As I said, the report is a follow-up report and the areas that I have mentioned are the continuing areas of weakness in which we think that there is room for improvement.

The Convener: Thank you for that briefing. The committee will discuss its response to the report under agenda item 7, but we have an opportunity now in public to ask Caroline Gardner any questions or for any clarifications. Do members want to raise any issues?

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Some equipment in hospitals is provided by donation. It would be interesting to find out how many pieces of equipment in Scotland were provided by donation, what proportion of the total amount of equipment that represents and about the planning process that is involved. I know that some gifts are well intentioned, but they might be a gift of a particular piece of equipment and a replacement for something older or more prone to breakdown might have been better. Was that matter considered?

Caroline Gardner: You are quite right. Donated equipment can be a difficult issue for the reasons that you have given and because the purchase costs are often covered, but not the maintenance costs thereafter. I am not sure how closely we considered the area—I will check with the team behind me.

Mr Black: I will say something about that, as I was speaking to the team when Caroline Gardner was speaking. Rhona Jack has reminded me that we mentioned the matter in the first report, but did not follow it up in the report that we are discussing, because donated items are a very small part of the stock of medical equipment.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): I would like to pick up from where Margaret Jamieson left off. In the past, there have been contentious and well-publicised cases of local fundraising for particular pieces of equipment that local health services said they did not want or need as a priority and for which there was no money for maintenance. There is an interesting issue about the degree of planning that we ought to expect from the service at a local or national level. Would you like to elaborate on that? In simpler—or even simplistic—terms, it is sometimes suggested that there should be a national planned replacement list, which is dealt with year on year. Will you give us more of a sense of the level at which you think such detailed planning should take place and whether an explicit, itemised list ought to exist? Should such planning be a more integral part of working year on year?

You said that 15 different categories of equipment are covered in the report, but is there a distinction in the planning approaches for different types of equipment? No one would advocate having people sitting in St Andrew's House planning where every X-ray machine in the country should go. However, there are interesting debates to be had about some of the bigger items of equipment, such as magnetic resonance imaging scanners, which are used on a more regional basis.

Caroline Gardner: I will start by dealing with the last question and will then work backwards.

We distinguished between two broad categories of equipment: high-value, low-volume pieces of equipment that need very long-term planning, probably on a national basis; and low-value, high-volume pieces such as infusion kits that are on every ward and are used every day, planning for which is likely to be managed much better at local level. We were concerned that such planning in NHS boards tends to be managed too far down in the organisation, so that in many cases it is not visible to the board as part of its strategic planning for delivering future health care. The records and information that are available at operational level are not really good enough to support planning and management. We are not suggesting that there should be a list in St Andrew's House that indicates when every infusion kit should be replaced. However, if the question is asked, information about how the process is managed

should be readily available to the health boards and the department.

Understandably, the Health Department would argue that its focus is on high-value pieces of equipment and those that are related to service change. For example, it thinks about the provision of new cancer services as part of the cancer strategy. That approach is absolutely necessary. However, we are concerned that insufficient attention is being paid to more everyday pieces of equipment that still account for a great deal of money and involvement in patient care. The information is not available to ensure that provision of such equipment is being planned and managed as effectively as it could be. We are not saying that equipment is not being managed effectively in all cases, but people do not have readily available the information about what they have, what they are spending and how old equipment is that would assure us that the system is working well in practice and that we should leave well enough alone.

Margaret Jamieson: When faced with clinical negligence claims, surely it would be to the benefit of the NHS if it could demonstrate that there was planned maintenance, renewal and so on. A significant amount of money is going into the pot to defend the NHS against such claims. Did you consider that issue?

Caroline Gardner: We have not examined directly the number of clinical negligence claims that arise from problems with the use or availability of medical equipment. However, the member is absolutely right—all the research that has been done suggests that such problems are a significant source of negligence claims. That is why we are suggesting that this issue should be included in the controls assurance statements that health boards have to make each year, to ensure that the matter gets the right attention at national level and to enable health boards to demonstrate that they are doing the right things day by day.

Margaret Jamieson: We could include it as a tick box in the performance assessment framework.

Caroline Gardner: We did not recommend that.

The Convener: As there are no further questions, I thank Caroline Gardner for her briefing. We will discuss the matter further under agenda item 7.

"Individual Learning Accounts in Scotland"

09:43

The Convener: Item 4 on the agenda is consideration of the Executive response to the committee's report on individual learning accounts in Scotland. Members should have the appropriate document, which was sent to us by Eddie Frizzell. I invite the Auditor General to comment on the Executive response.

Mr Black: We have nothing to add at this stage.

The Convener: While members examine the response, it is worth my reflecting on the extent to which the Executive has noted and accepted our recommendations. The main difference is to be found in relation to our recommendation that

"the Chief Executives of SAAS and SUfI and the Head of ETLLD should write to the Audit and Enterprise and Culture Committees to state that they are content"

that there are adequate checks to provide an assurance of accountability. In the main, the rest of the response seems to be favourable.

Margaret Jamieson: Is it not for us, rather than an official, to determine what we think is in the best interests of the Parliament and the people of Scotland? Eddie Frizzell has totally missed the point that we were trying to make about quality issues. He says:

"the Education Department's focus is solely on schools".

The issues of how services are delivered and added value appear to have been lost in the Executive response.

George Lyon (Argyll and Bute) (LD): I agree with Margaret Jamieson. I am concerned about the reaction of the Department of Enterprise, Transport and Lifelong Learning to the two issues that she has raised.

The Convener: I, too, agree that it is for us to say what we feel. The committee has no difficulty in making suggestions. The Executive is saying that it thinks that relevant lines of accountability exist, but it is right and proper that we suggest additional checks, given that we are in an evolving situation and that devolution must be tried and tested so that we find new ways of having accountability. We are not in a static institutional situation. Our suggestion has merit.

Margaret Jamieson: Eddie Frizzell misses the point totally that we were examining the issue because the system failed. We are saying that we want to ensure that there are proper systems in place for the new scheme and that if the Executive adopts our recommendation, that will deal with

some of the problems that were experienced. It is right for us to point out to Eddie Frizzell that he may be leaving himself wide open to something happening.

The Convener: In the committee's view, would it be helpful if I drafted a letter to the department, setting out why we came to the conclusions that we reached, as a way of seeking closure on the matter?

Robin Harper (Lothians) (Green): This is a small point, but it is unfortunate for

"ILA-funded learners who would probably have undertaken learning without ILA support"

to be described as "deadweight".

The Convener: That is an economic term that is often used, but I appreciate the point that Robin Harper makes about the use of the term with reference to groups of people.

With the committee's agreement, I will draft and circulate a letter setting out the points that members have made.

Agenda item 5 is an evidence-taking session on "Overview of the National Health Service in Scotland 2002/03". Before we start, we will have a short comfort break of five minutes.

09:48

Meeting suspended.

09:56

On resuming—

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

The Convener: Agenda item 5 is our second evidence-taking session on the Auditor General's report "Overview of the National Health Service in Scotland 2002/03".

I welcome the witnesses to this meeting of the Audit Committee. We have with us representatives of NHS Borders, NHS Ayrshire and Arran, and Ayrshire and Arran Primary Care NHS Trust. I understand that the facts contained in the Auditor General's report pertaining to those NHS institutions have already been agreed. In today's session, we will ask questions on financial and service planning, the benefits of trust integration and the lessons that can be learned, and performance management and accountability in the NHS organisational structure.

We are undertaking an overview of the NHS, but it is worth pointing out, as I did when we took evidence from NHS Lothian, that our intention in taking evidence from NHS boards and primary care trusts is to establish what the local pressures and issues are before we take further evidence at a national level. That is why we welcome the witnesses today. Our intention is not to look over past difficulties for the sake of examining your organisations' troubles or successes, but to try to tease out the important and influential pressures that need to be resolved throughout Scotland.

I ask Mrs Hatton, who is the chief executive of NHS Ayrshire and Arran, and Mr Glennie, who is the chief executive of NHS Borders, to introduce their teams.

Mrs Wai-yin Hatton (NHS Ayrshire and Arran): Thank you very much for inviting us to give evidence. Dr Alan Green is the medical director for NHS Ayrshire and Arran, as well as being the medical director of the primary care trust, which, in a couple of days' time, will be the community health division. Derek Lindsay is the finance director for NHS Ayrshire and Arran, and Derek Yuille will be the divisional director of finance for both divisions in NHS Ayrshire and Arran.

Mr John Glennie (NHS Borders): Good morning. I introduce Dr Ross Cameron, who is our medical director and chairman of our clinical executive, and Robert Kemp, who is our finance director.

10:00

The Convener: Would you like to make brief opening statements?

Mrs Hatton: Yes. The three main areas that I will cover are our financial position; health and health care improvements in Ayrshire and Arran; and challenges.

The board and the trust have always hit their financial targets and achieved income and expenditure balance. However, that has not been easy, because of the finite allocations, the pressures that we are under, the service developments and a raft of service pressures.

We have a track record of deliberately taking a strategic approach to financial planning. As far back as 1996, we were preparing the ground for an anticipated levelling of funding allocation from the national review and as a result of the Arbuthnott inquiry. We have also had a policy of restricting the use of non-recurring funding as far as possible, so that we do not build up potential difficulties in later years. A third area of our deliberate approach is that we have always ensured that we set ourselves realistic efficiency savings targets that have always been achieved. Perhaps much more important, in the current climate of single-system working, is the fact that the single-system approach and culture has helped us to get to our current position. We have learned from the past in this different era of working.

I will not go into detail about health and health care improvements, because I do not want to pre-empt your questions. Much of our effort has been made not only in the acute sector, where the results are much more visible, but in community developments. I am sure that my colleagues will be able to give you examples of work that we have done with the local health care co-operatives.

We have been doing our utmost to achieve our waiting times targets, not because they are targets but because doing so is good for the patients and helps them to get access to health services. Single-system working is a clear area in which we can see how the synergy of cross-system working has begun to help some of our capacity and pressure problems.

On challenges, we in Ayrshire and Arran share practically all the risks and pressures of our colleague areas in the rest of Scotland. However, Ayrshire has areas of deprivation—the recent statistics have confirmed our hunches about certain pockets of deprivation—and an aging population. Those two factors pose particular challenges in our area.

Over the past two or three years, we have been working hard to build a cross-team culture across the board and the trust before 1 April 2004, which is in just a couple of days' time. That team working has helped us to understand our previous behaviour and what we needed to change. Over the past two years, we have been able to share and understand each others' problems and come up with shared solutions based on the three sectors helping each other as opposed to one sector being left alone to deal with its difficulties. That has set a strong foundation for future working. We are continuing to work towards system-wide solutions.

I hope that that sets the scene. I am happy to elaborate on any of our systems, processes or plans for the future.

Mr Glennie: First, I will talk about organisational integration. For a number of reasons, we chose proactively to seek permission to change our structure. Principal among those reasons was a recognition that the delivery of health care was about to change radically and that we needed to have an organisation that could provide the necessary leadership. We have an ambition to achieve truly integrated care and we believe that we can more easily realise that with an integrated management structure that reflects that ambition and pulls together acute services, primary care, mental health and health improvement into one management entity. We want to create an organisation that has clearer clinical priorities and a clearer clinical view. We felt that we needed to be more coherent partners externally. For us, in the Borders, the external partnership with Scottish Borders Council and the Lothian councils is important. We felt that, if we were a single entity, we could be a better partner. Importantly, we recognised that, as a small NHS system with three organisations, we were carrying a large management overhead.

For those reasons, we have concentrated this year on setting up our clinical executive, which is a form of single operating division and is led by Dr Ross Cameron. The clinical executive concentrates on giving a clear clinical lead to the board on priorities, integrating the clinical and managerial agendas, ensuring clinical ownership of our key result areas and providing a focused lead for the redesign, which will be a major issue in the years ahead. To pick up on the Auditor General's point, all of that has been done with clear delegation to clinical boards and with the clinical executive concentrating on those areas in which it can add value.

The second issue that we have concentrated on is our culture. We have tried to improve our openness, transparency and communication processes so that the agenda is signed up to by all and everyone feels that they can make an input.

We have also concentrated on setting up Borders-wide support functions such as finance, human resources and estates. In doing that, we have saved £500,000, which we have ploughed back into front-line services, and created support services that are more fit for purpose.

We believe that we now have a clear vision and agreed strategies and priorities that are signed up to by all the clinical boards and leaders and, importantly, by the staff partnership forum. We are on target to deliver on our key result areas this year: finance, although there will be a significant amount of non-recurring expenditure to support us in that regard; waiting times; and delayed discharges.

There are major challenges around the issues relating to sustaining local services. That is a key issue in a rural area such as the Borders. Many of the clinical and staffing drivers can be seen as leading towards centralisation, and we are working on solving problems in that regard. The second key issue is pay and modernisation, which we believe will impact particularly hard on us. Factors relating to general medical services, general practitioners and out-of-hours cover cost more in a rural area. The consultant contract has implications in that regard as well, because, in a small district general hospital with small rotas, rationalisation is more difficult.

We believe that the clinical executive, which encompasses both our LHCCs, will provide a strong foundation on which to build a single community health partnership to go beside our coterminosity with Scottish Borders Council.

The Convener: The Auditor General's report indicates that NHS Ayrshire and Arran and NHS Borders will face significant financial challenges in 2003-04 and beyond. You alluded to some of those challenges in your opening statements. What is the expected financial performance of NHS Ayrshire and Arran and NHS Borders in 2003-04?

Mrs Hatton: We are on target to achieve year-end balance, as in previous years. However, we face certain challenges in the coming year. The balanced position that we are in will ensure that we have a good foundation to allow us to deal with those challenges.

Mr Glennie: I will ask Mr Kemp to answer in detail. In principle, we expect to achieve our financial targets. As I said, that will be done with a significant amount of non-recurring support.

Mr Robert Kemp (NHS Borders): We expect to achieve our targets for the coming year. The Scottish Executive has provided us with additional funding, which has been helpful, and the clinical executive and clinical boards have worked hard to keep spending within budgets.

We have about £3.6 million-worth of non-recurring money this year. Some £2.2 million of that sum was borrowing that was agreed with the Scottish Executive as part of our five-year recovery plan.

Margaret Jamieson: The Auditor General's report highlights a number of cost pressures that the NHS will face over the next few years. It is obvious that the pressures will be different in each of the NHS areas, so I will ask about the Borders first. What are the pressures in your area and how will you address them?

Mr Glennie: Robert Kemp can best answer on what the pressures are.

Mr Kemp: One of the main pressures that we will face next year will arise from the consultant contract, which we estimate will cost £2 million. We are still working through the detailed job plans and diaries, so it will be another eight or so weeks until we know the actual cost. We believe that we will be at the high end of costs in Scotland, because of cost issues that relate to the limited ability to rationalise services in a small district general hospital. John Glennie referred to that in his opening statement.

One of the other pressures that we believe will have a significant impact on NHS Borders is the transfer of responsibility for out-of-hours services to health boards. We believe that that will cost NHS Borders about £1 million extra, but that is only an estimate. We are only just taking our options for the reprovision of services through our board and out to consultation, and it will be another three or four months until we have a firm costing. We think that the £1 million estimate might be a little bit light, but we might be able to pull back the consultant contract a wee bit over the next few weeks.

Those are some of the main pressures in addition to the usual pay inflation, general inflation and the impact of capital charges. The final pressure is the increase in drug costs. In our financial plan, we have set aside 10 per cent a year for that. For NHS Borders, that equates to £2 million a year, which is a similar figure to what we put aside every year for pay inflation and is one of the biggest uses of new money that comes into NHS Borders.

Mr Glennie: We have set up a leadership group, which comprises the clinical executive and the board management team, to address the pressures. We have an agreed agenda, and there has been an open sharing and ownership of the financial position. The group's health plan indicates that the main drivers in addressing the pressures will be a clinical redesign process, which we envisage will entail fewer in-patient beds in fewer locations; a major drive to improve

efficiency; an examination of our high-cost areas; and an attempt to ensure that support service overheads are kept to a minimum. We will work with the Scottish Executive Finance and Central Services Department to ensure that we have a robust five-year plan that brings us back into balance and a timescale that allows us to balance the needs of the clinical services alongside the need to meet our financial targets.

Margaret Jamieson: What about NHS Ayrshire and Arran?

Mr Derek Lindsay (NHS Ayrshire and Arran): The main financial pressures this year and next year include the consultant contract, which Robert Kemp has mentioned. The agenda for change, which will be implemented from 1 October, is a new pressure for 2004-05. The costs of that will exceed those of the consultant contract, because it applies to most staff in the NHS, whereas the consultant contract applies to only a proportion of staff.

Out-of-hours services have been mentioned. In Ayrshire, the changes will take effect from 1 April, and an additional cost will be associated with the provision of those services under the new GMS contract. Capital charges are also an issue for us. As yet, we do not know the full extent of the additional costs for 2004-05, because a revaluation of all the NHS estate is going on, the outcome of which we will not know until the end of April. The likelihood is that there will be an increase of in excess of 10 per cent in our asset values, which will also mean a 10 per cent increase in capital charges. All those cost pressures will be significant.

Margaret Jamieson asked how we would manage the cost pressures. We have a number of mechanisms for doing that. Over the past few months, we have been working in a cross-system manner to identify all the cost pressures for 2004-05 and have undertaken prioritisation via expert groups. One group has considered waiting times and the associated pressures; another group has considered health and safety issues; and a further group has considered prescribing cost pressures. The medicines resource group that we have in Ayrshire is effective in considering all of those. We have also had a group that has tried to make a best estimate of pay increases and supplies inflation, and a clinical group, which is led by Dr Alan Green, has considered a number of our clinical governance and service issues.

We have engaged with a lot of people to try to get a handle on the cost pressures for 2004-05, and we therefore hope that all parties will sign up to the solution and the budget that will be presented to our next board meeting. The work that has been done is reinforced by our finance committee, which met on Friday last week and is meeting again later this week; it keeps a close eye on our priorities and on whether we are progressing down the right road.

10:15

Mrs Hatton: Perhaps Dr Green can elaborate on the change in out-of-hours services and the pressures arising from that.

Dr Alan Green (NHS Ayrshire and Arran): In Ayrshire, we are fairly fortunate in that we already have in place a well-subscribed out-of-hours service that covers the mainland practices; the service is provided by an organisation known as Ayrshire doctors on call, or ADOC. We propose to bring that service into the NHS from 1 April this year. That will mean a significant increase in cost to the NHS, because we have had to transfer all the staff to NHS contracts under the Transfer of Undertakings (Protection of Employment) Regulations and we have had to make up the shortfall that the general practitioners previously paid out of their own pockets to provide the service.

The major issue that I have will be a major cost pressure for the whole system in Scotland. We have agreed with the GPs that, for the first three months of the new arrangements, they will continue on their present rate of pay plus 3.25 per cent inflation. My problem is that there is no national agreement on hourly pay for out-of-hours services and market forces are beginning to take over, with areas such as NHS Tayside offering far greater amounts of money. If that happens, we too will be subject to those forces and we could end up having to pay a further £600,000 to £700,000 per year for GPs' pay to cover out-of-hours services. It is obvious that that will become unviable, so we view ADOC as a short-term to medium-term solution and we are considering redesigning the out-of-hours services over the long term.

George Lyon: I presume that NHS Borders and NHS Ayrshire and Arran have specific problems because of their rural geography—they have lots of single-handed doctors and small practices. The chief executive of NHS Argyll and Clyde explained to me that one of the ways in which that board would cope with out-of-hours cover was that the GPs would give up the service and hand back £6,000 and, in return, the board would probably have to pay them £60,000 to cover exactly the same hours again. Is that your experience in trying to deal with the problem?

Dr Green: It is similar, but NHS Ayrshire and Arran is slightly different, in that all our mainland practices are covered by ADOC. At present, the doctors pay on average £8,500 to £9,000 into ADOC, then work for it and get paid for doing so.

The global sum equivalent is about £5,500, so the difference between that and £8,500 is £3,000 per GP, or in total, as there are 250 GPs in Ayrshire, £750,000.

Dr Ross Cameron (NHS Borders): To help the committee understand the pressures that we face, I will go into the geographic factors, which are particularly important, in some detail. NHS Borders has no large conurbation in its area; we have about 100,000 people spread over 2,000 square miles in a variety of small towns and villages. At the moment, we have a cell network of GPs on call with a minimum of five GPs on call overnight and more than that at weekends. Under the national standards of work load for out-of-hours medicine, if the population is concentrated, one doctor can normally deal with up to 120,000 people. In urban areas, that work load can be coped with, and that would be true in our area were it not for the geography. We get an average of five or six calls after midnight and up to 8 am; it is clear that one doctor could deal with that, but not if he had to travel from Peebles to Eyemouth to Hawick.

The same financial pressures apply and the pro-rata rate that the GPs have given up applies to our 87 principals, but to replace that, we will have to cover the national rate. If we were working on an equivalent pro-rata basis to NHS Ayrshire and Arran, we would have one doctor on call, but one doctor is physically unable to deliver care over 2,000 square miles. The relative impact in cost and for attracting doctors to the out-of-hours service—we have a much smaller pool of doctors—presents considerable difficulty.

George Lyon: How much will the changes cost?

Dr Cameron: The board has been discussing several options, but the net cost to the board is expected to be around £1 million, taking into account the clawback from GPs and the money that we spend on out-of-hours services at present.

George Lyon: Will the sum be greater than the cost of the consultant contract?

Dr Cameron: Not in absolute terms. Robert Kemp will give you the details.

Mr Kemp: We estimate that the consultant contract will cost NHS Borders £2 million and that the excess cost of the out-of-hours service will be £1 million.

George Lyon: I ask the same question of NHS Ayrshire and Arran.

Mr Lindsay: The additional cost of the out-of-hours service is likely to be £1.5 million, while the cost of the consultant contract will be roughly double that.

Margaret Jamieson: I want to return to cost pressures. The underlying recurrent deficits are £2.5 million for NHS Borders and £4.5 million for NHS Ayrshire and Arran, but when the witnesses answered my question about cost pressures, none of them said that the deficit was a pressure that would have to be dealt with in the next few years. Why does NHS Borders have a five-year recovery plan for the £2.5 million, while NHS Ayrshire and Arran does not have an agreed recovery plan for the £4.5 million? What action have the boards taken to ensure that the base budget with which they operate is appropriate and correct?

Mr Kemp: NHS Borders has a history of achieving its financial targets and achieving savings. However, from about 2000, that situation was underpinned by an increasing reliance on non-recurring money and a growing recurring deficit. It is hard to say exactly what caused the deficit to grow, given that spending is around £100 million and that many items change within that. However, the three pressures that we found to be impacting significantly in NHS Borders were the working time directive, the new deal for junior doctors and prescribing costs. Those pressures resulted in a cumulative recurring deficit of £3 million.

In establishing the new organisation, we worked closely with the Scottish Executive because we recognised that we had to stop the growth in recurring deficit and halt our reliance on non-recurring funding. In partnership with the Executive, we have worked out a five-year recovery plan that is predicated on our borrowing money in 2003-04 and 2004-05 and repaying it by the end of year 5 of the plan. In this year, we are on target with the recovery plan. We have made savings of £800,000, £500,000 of which have come from savings in management costs resulting from integration. That has reduced our deficit to the amount to which Margaret Jamieson referred. We estimate that the impact of the new pressures that have hit the service will increase our deficit by around £3 million.

Many of the steps that we have taken were aimed at empowering the clinical executive and, within that, the clinical board structure so that there is ownership of the financial situation in NHS Borders and a realisation that we have to take control of our destiny. We have spent a lot of time giving presentations to clinical boards, departments and the staff partnership forum to create a collective understanding of and a consistent message about our situation and the pressures. That process has been successful. Ross Cameron might want to comment on it from the service perspective.

We have built on our financial reporting. There is now consistent reporting of the in-year financial situation from individual departments through clinical boards to the clinical executive to the

board. That system is consistent and ties clearly into the recurring deficit situation. Through achieving ownership and providing the information that people need to make decisions, we will achieve the best basis on which to move forward and reduce our recurring deficit.

Dr Cameron: In the clinical executive that we have created, which brings together the clinical chairs of the LHCCs, the board of Borders general hospital and the mental health network with the managers of the service, we have clinical decision-making ability and managerial ability in one room. We can consider the financial problems and the priorities without having to cross borders in the same organisation. That system has helped us to achieve an overview and a shared understanding of problems and difficulties, as a result of which we feel that we are giving a more unified response to the difficulties. The new system certainly feels different.

Margaret Jamieson: How is that reflected in your base budget?

Mr Glennie: NHS Ayrshire and Arran described a process whereby a number of groups dealt with the key issues. We have a similar process. One of those groups is a value-for-money benchmarking cost-reduction group, which considers a series of savings targets and savings measures. That work is backed up by a benchmarking process that takes into account value for money and the situation with Arbuthnott for each service. We are trying to develop a robust process in which we work with clinical and support services to establish a reasonable budget and cost targets.

Margaret Jamieson: I ask the same question of NHS Ayrshire and Arran.

Mr Lindsay: The yearly increase in prescribing costs tends to be around 10 per cent, but in 2002-03 it was particularly high—about 12 per cent. When we went into 2003-04, we projected that if the increase in prescribing costs continued at that rate, we would face a recurring deficit of around £4.5 million in that year. However, we had non-recurring ways in which to cover that deficit in-year and we could therefore achieve our financial targets. However, the prescribing costs increase has not been as high as we anticipated at the beginning of 2003-04, and the figure is not 12 per cent, but closer to 8 per cent. A number of drugs became generic, which helped our in-year financial position and has meant that we are only £1.25 million out of recurring balance going into 2004-05.

We have a plan in place to achieve a saving of £1.25 million through a number of specific plans, one of which is for agency nursing. During 2003-04, we have already seen a significant movement in the cost of agency nursing. We also anticipate savings in procurement costs. The introduction of e-procurement in the forthcoming year will also yield savings. We will move to a recurring balance through those specific plans. We do not have a formal recovery plan, because the Scottish Executive did not require us to submit one. We discussed our financial situation at our accountability review. The Scottish Executive was satisfied that we have robust measures in place to achieve financial balance and that we are not significantly far away from doing so. We were not required to submit a formal recovery plan, but we have internal plans to achieve a recurring balance. We will achieve a base budget that is in line with that through those measures.

Margaret Jamieson: One measure that is identified for NHS Ayrshire and Arran in reducing the £4.5 million deficit is the sale of surplus assets. How is that sale progressing and what is the anticipated receipt?

10:30

Mr Lindsay: As we went into 2003-04, we identified a number of measures through which we might cover the anticipated deficit of £4.5 million. One such measure was to carry forward non-recurring money from the previous year, which covered around £2 million. We also anticipated some capital receipts that we were able to transfer to revenue. We have sold a number of assets including Ravenspark hospital, the former headquarters of Ayrshire and Arran Primary Care NHS Trust at Hunters Avenue, and the former financial services building. We have made progress there and we have been able not only to achieve our financial targets this year, but to carry forward significant non-recurring resources into 2004-05, most of which are related to earmarked funding for specific purposes such as cancer and coronary heart disease. However, some of the non-recurring resources will also be available to help us with considerable cost pressures in 2004-05.

Margaret Jamieson: As a local member, I welcome the significant amount of money that will be carried forward, but we will debate that matter in another forum.

How do you match up the expectations of the public and what has been identified in the health plan with what you must achieve to break even? I do not suggest that that is an easy task, but there will be differences between the two health boards in how they deliver their health plans. What innovative things have you done to ensure that you are drilling down into the areas of significant deprivation? I ask the representatives from NHS Borders to forgive me if I give this example from Ayrshire and Arran, but there is a huge difference between the deprivation facing my constituents in

Altonhill and that facing Cathy Jamieson's constituents in Alloway. How do you address that problem, bearing in mind the financial pressures and the funds that have been allocated to you?

Mrs Hatton: I will kick off, but my colleagues have specific examples. We ensure that the local health plan is affordable in order to link it with the financial strategy. We do not include in the plan aspirations that we do not feel confident about delivering because that would not be fair on our partner agencies or, in particular, on the public. We are not the sole funders of all the developments in health care improvements. We work closely with the three local authorities in a number of areas—through, for example, the social inclusion partnerships, the new opportunities fund and the health improvement fund. We have clear mechanisms to identify priorities together, particularly in tackling the deprived areas. Those external sources of funding do not come into our bank account, so to speak. I invite Dr Green to give two specific examples of highly deprived areas where we have worked with partnerships to tackle that deprivation.

Dr Green: Margaret Jamieson is right to say that there is massive variation in deprivation in Ayrshire. For example, in the middle of Ayr, which is an affluent area, there is one area of marked deprivation that is known as KA7.

We have always worked closely with our local authority colleagues because we have been well aware that one of the problems in Ayrshire, which I am sure is shared by many other areas, is that services are sited where they should not be—they are not in areas of great deprivation.

One of our flagship projects is the Dalmellington project, which was set up with East Ayrshire Council. It includes not only health services, but the police and all the council services, such as libraries—there is even a wedding facility in the building. That project has been a great success that has worked well for the community because the community sees it as its own.

We continue to run such projects in north-west Kilmarnock, for example, where we are again working with East Ayrshire Council to build a facility that is an expansion of an existing facility, including bringing acute services to the people of that area. We are also putting a GP surgery into the facility, which will have primary care services, mental health services and child and adolescent services.

We are trying hard to push into areas of deprivation. Another area in which we have been successful during the past 18 months is a pilot project for emergency hormonal contraception—we have a fairly high teenage pregnancy rate. We issue contraception through chemists throughout Ayrshire so that girls and young women can get emergency hormonal contraception over the counter without paying. That has made a significant difference.

I accept that we have not done enough, but we continue to try to do more.

Mrs Hatton: Mr Lindsay will give the committee two more examples.

Mr Lindsay: About three years ago, we received a stream of funding from the health improvement fund. We worked closely with our local authority colleagues to identify the pilot projects that it would be important to develop. Many of those projects were targeted at deprived areas, such as Cumnock and Kilmarnock, and included breakfast clubs and other initiatives. We are now reaching the end of that three-year funding period.

Throughout Scotland, some £20 million in total was issued to the NHS. However, the budget statement a year ago indicated that £100 million would be fed into health improvement and that the money would come through community planning partnerships in the future. We are therefore working closely with local authority colleagues to establish the use that will be made of that funding, which will be targeted at exercise, school meals and early-years provision, for example. If possible, we will try to roll out and make more widely available some of the projects that were funded on a pilot basis through the health improvement fund.

Mr Glennie: It is right that the public have increasing expectations of the health service, particularly at this time of record investment. I said earlier that we work hard to try to get a shared agreement of priorities in the system. We have also worked hard with the public in a number of ways, talking to them about what they expect of us and what we can reasonably deliver. Much of our thrust is in investment in primary care, chronic care, out-of-hours services and emergency care. We will find it difficult in future to support the number of in-patient beds in the number of locations that we have because of money and staffing. It is likely that staffing resources will be scarce. We must discuss with the public the nature of the service and what redesign will mean in practice. I ask Dr Cameron to respond to the question about deprivation, which has a very different nature in the Borders, as it occurs in small rural communities.

Dr Cameron: In a rural area such as ours, there are pockets of deprivation in the towns. Although they are quite small in number, their problems are just as severe as problems elsewhere. We tackle those problems with health improvement measures that are similar to those that have been

mentioned, such as breakfast clubs and increased input from health visitors in particular.

Rural deprivation is an issue that is sometimes hidden. However, there is a saying that a nice view does not pay the bills. We have a low-wage economy, isolated houses in small hamlets and a relatively limited and expensive transport system, all of which add pressure. The way to deal with that situation is to have well-resourced primary care teams that can get into those communities. We have invested in community hospitals and, in some of the more isolated areas, in small surgeries, such as the one in Newcastleton, which is our most isolated community. By accessing those smaller areas, we expect to help people who face the problems of isolation and deprivation.

George Lyon: I return to the matter of the recurring deficits—£4.5 million for NHS Ayrshire and Arran and £2.5 million for NHS Borders. For how many years have those recurring deficits existed?

Mr Kemp: The audit trail that we put together for NHS Borders goes back about two to three years and covers three separate organisations. That is the period of time over which we have traced the lines on non-recurring funding.

George Lyon: Are you saying that your deficit has existed since 2000?

Mr Kemp: Yes.

Mr Lindsay: In the case of Ayrshire and Arran NHS Board, the figure of £4.5 million emerged only around a year ago. As I said, half of that figure was related to the prescribing increase in 2002-03. Certain emergency acute pressures accounted for the other part of the figure.

The figure is no longer £4.5 million; actions that have been taken this year to address that recurring deficit have reduced it to £1.25 million. We have put in place plans to address the remaining £1.25 million during the forthcoming year.

George Lyon: I want to clarify something that I understood from what the witnesses from NHS Borders said. Is the fundamental cause of the recurring deficit the various national agreements on, for example, out-of-hours services and the European Union working time directive, as well as prescribing costs?

Mr Glennie: The pay modernisation costs are the fundamental reason why our deficit has grown. It is difficult, as Robert Kemp said, to separate out one particular issue, but the deficit has grown significantly during this year and our estimated pay modernisation costs are a major driver of that, alongside what we envisage will be a huge investment in prescribing.

George Lyon: Do you think that the combined costs of those two factors are greater than the uplift that you have received since 2000? I am just trying to understand where the deficit comes from.

Mr Kemp: If we go back to 2000, the main drivers of cost that we have been able to identify from our experience across NHS Borders related to the new deal, the working time directive and drug costs. The cumulative effects of those factors have built up the recurring deficit of £2.5 million.

George Lyon: So the deficit is not about extra service provision; it is purely about those major costs.

Mr Kemp: Yes, in relation to those factors. If we look ahead, there are concerns around the additional costs of pay modernisation that would further increase the deficit.

Mr Lindsay: A year ago, Ayrshire and Arran NHS Board took a conscious decision that our allocation uplift would not be able to cover the deficit that we had identified, so we would have to manage that ourselves. The whole of our allocation uplift went towards pay costs, prescribing costs and other cost pressures that were identified for 2003-04. More than 50 per cent of our allocation uplift goes towards increases in pay costs and another 25 per cent goes towards increases in prescribing costs, so there is a very limited balance available for local decision making or local focus.

George Lyon: Is that the current figure or a historical figure?

Mr Lindsay: It is a consistent figure. During the past three years, more than half of our increased allocation each year has gone towards pay increases and more than a quarter has gone towards prescribing uplifts.

George Lyon: The witnesses from both boards have made great play of the fact that their organisations can deliver efficiency targets. That has certainly not been the case for other health boards. How is that process managed and what are your targets?

Mr Glennie: I ask Robert Kemp to respond first, as he is the chairman of the group that is considering the matter.

Mr Kemp: NHS Borders has a track record of delivering savings, but it is fair to say that during the past two or three years, savings have been increasingly hard to find. As part of the reorganisation, we have set up five groups to target specific areas of savings. In the past, the practice was to set percentage savings targets for different parts of the organisation, but we found that that approach was becoming less productive. Therefore, the board decided to target areas, such as spending on drugs, on out-of-Borders

services—around 15 per cent, which is quite a lot of our allocation, is spent on services that are provided by bodies other than NHS Borders, particularly in Lothian—on bed management throughout NHS Borders and on integrated services to ascertain whether we are making the best of those services. As John Glennie said in his introductory remarks, we are also putting a lot of work into benchmarking value for money, to ensure that our services are benchmarked appropriately against comparable organisations in the Borders.

That is the approach that we are using to underpin our savings plan into the next year. We are targeting recurring savings of around £1 million for next year and we will also look for non-recurring savings to help to support that approach next year. In 2003-04 we secured savings of £800,000, most of which came from management costs savings. That was a deliberate strategy: we wanted to allow time for clinical services to bed down as part of the new clinical executive while we set up the five groups to consider how we might progressively manage savings during the next few years.

10:45

Mrs Hatton: I will make two points in relation to NHS Ayrshire and Arran before I ask my colleagues in finance to give specific examples of the areas that we are targeting. First, we have always ensured that we set a realistic, achievable target, so we have been considering the figures from the healthcare resource groups—HRGs—to ascertain whether there is scope for savings. Secondly, we ensure that we consider the totality of the £400 million budget, rather than just one or two areas in which we might achieve efficiency savings.

Mr Lindsay: Our budget is £400 million, so a target of, for example, £4 million equates to 1 per cent of the budget. That raises an issue about scale and affordability. Obviously, the targets that are set for efficiency savings must be realistic, or there will not be a sense of ownership or realism around them.

George Lyon: Is 1 per cent a realistic target?

Mr Lindsay: It is difficult to achieve in the context of the efficiency that is demonstrated through, for example, HRG analysis, which considers case mix and so on, but we have achieved roughly 1 per cent over recent years, which has been very challenging.

Let me give a specific example of an area in which savings have been made. Spend on agency nursing was increasing, so our directors of nursing worked together to identify and put in place measures such as a local bank for nurses, a west of Scotland agreement to try to minimise the use of the private sector, flexibility around the additional use of part-time nurses, and strict protocols on the use of agency nurses. As a result, significant savings have been achieved in NHS Ayrshire and Arran this year.

Another specific example, which relates to an earlier comment, is the sale of two properties that were the primary care trust's headquarters and the move to a new establishment. That was a spend-to-save scheme, because it involved a capital cost but resulted in revenue savings, which have also contributed to overall savings.

On prescribing, I defer to my colleague Derek Yuille.

Mr Derek Yuille (Ayrshire and Arran Primary Care NHS Trust): A number of points have been raised in relation to prescribing. In NHS Ayrshire and Arran, prescribing costs have increased in five years from £45 million to £72 million, which is an increase of 59 per cent. The number of items prescribed has increased by 18 per cent—or an average increase of 4 per cent a year—over that period. Perhaps that is the bad news, but we forget that there is also good news about prescribing. The rate of prescription of generic drugs in NHS Ayrshire and Arran has increased from 62.5 per cent to 77 per cent; the national rate used to be 67.5 per cent but has increased to 77.5 per cent.

There have also been developments within prescribing. We spend money on statins, which help to reduce cholesterol and therefore can reduce the incidence of, for example, heart disease and strokes. It is not fair to say that there have been no developments in prescribing.

Mr Glennie: I should have made the point that the drive towards improved efficiency and savings has been strongly supported at national level. I draw the committee's attention to two issues. First, the national shared services agenda seeks to make savings in relation to e-procurement in particular. Secondly, Trevor Jones has set up a national benchmarking group—he has asked me to chair the group—which tries to support boards, find efficiencies and benchmark services appropriately. We anticipate help from that area.

George Lyon: What do both boards consider to be a realistic efficiency target? What target is built into your recovery plans?

Mrs Hatton: In Ayrshire and Arran, we have not set a target for 2004-05, because if we consider the HRG figures, we are really one of the lowest in terms of costs, so we do not feel that we can squeeze the system any more. However, we have said, for example, that we will not fund inflation uplift, so the two divisions will have to find ways in which to deal with that. Although the mathematical

figure that is generated might be better balanced, we are now concerned with the whole concept of culture, rather than with saying, "You are not working efficiently".

Alongside the absence of specific efficiency savings targets, we are asking our two divisions to take on service redesign in a way that will enable us to get more out of the same capacity. We are taking a different approach to efficiency savings. In Ayrshire and Arran, we feel that making efficiency savings is no longer the way in which to motivate people to do things. We need to find ways within the available budget of incentivising the system to be more efficient.

Mr Glennie: As Robert Kemp said, we need to differentiate between recurrent and non-recurrent savings. The key to that is our current savings. We are setting ourselves an internal target of 1 to 1.5 per cent; we will probably be near the top end of that target this year.

Susan Deacon: I have a series of points of clarification and follow-up questions on the areas that have been covered—some can be answered relatively briefly.

First, I want to ask a few questions about national funding. I seek clarification on a point that was made in one of the NHS Ayrshire and Arran submissions, which says:

"Budgeting for future years is difficult for the following reasons".

The first reason given is:

"We don't know our income beyond 2005/06. The Department of Health in England knows the funding available for health in 2006/07 and 2007/08, however the Scottish Executive Health Department has not been guaranteed the 'consequentials' of this."

Is that simply a function of the lag factor between the spending review process south of the border and the decision that is then taken north of the border? If not, in respect of your indicative allocations, is there a more fundamental difference in the approaches that have been adopted in Scotland and at the UK level to longer-term financial planning?

Mr Lindsay: We concentrated a lot on the expenditure side—the question that we were asked was how we could ensure that we balance our budgets. We are taking a long-term perspective. In line with the Scottish Executive budget cycle, we were given a three-year indicative budget, which covers 2003-04, 2004-05 and 2005-06.

In England, the Department of Health was given a five-year guarantee of funding, which allowed it to embark on a significant development programme. I understand that there is no guarantee that the consequentials from the health budget in England will be available for health in Scotland. The point that I made is that the Scottish Executive is currently undergoing a spending review that will determine how much is available for health.

Susan Deacon: I appreciate that answer and the points that you made, but I seek further clarification on the issue. Is it your expectation—for that matter, is it the expectation of health boards in general—that, when the current spending review process is complete, you will be able to plan over the same horizon that has been set out south of the border?

Mr Lindsay: Yes—once the spending review is complete, which I understand will take a number of months. Although we are expected to have a five-year financial strategy, the figures that we are to put down for our income in years 3, 4 and 5 are an unknown at this point in time.

Susan Deacon: Thank you; that answers the point.

I do not mean to pick on you, Mr Lindsay, but I want to return to one of the comments that you made earlier. I was interested in what you had to say about the health improvement fund. I guess that I should declare an interest, having established the thing. I recognise the changes that are being made to the funding mechanisms, which you set out clearly in the point that you made about routing resources through community planning partnerships.

What indications have boards been given about the levels of that fund for the future? Notwithstanding how it is to be channelled and who is to make the decisions at the local level, what indications have been given about the continued existence of the fund? I guess that the question does not relate only to NHS boards, as local authorities and others have an interest in the matter.

Mr Lindsay: I mentioned the health funding that came out, which is around £26 million. Locally, we have agreed that it will continue to be spent on similar projects. The figures in the Scottish Executive budget were £23 million, rising to £50 million and £100 million. I understand that the areas to which the funding is to be targeted include early-years provision, activity and sport in primary and secondary schools and school meals.

We have found some difficulty in establishing exactly how the money is to be channelled through the different agencies. Although the money was taken from the health vote, it is to be channelled through various funding mechanisms. We have worked with our local authority colleagues, including our directors of education, for example, to understand the priorities for the money that is earmarked for school meals. We believe that a

significant amount of the money is to go through sportscotland for exercise initiatives.

We have worked with our local authority colleagues around the areas of mental health, well-being and suicide prevention, for which a plan has been prepared jointly with those colleagues. We are trying to work with our colleagues to determine how best to target the money. Obviously, because the money is going to various places, it is hard for us to get our arms round all of it.

Susan Deacon: I appreciate that answer, too.

Finally, I want to look at the big picture. Although I am conscious that the question does not lend itself to brief answers, I want to pick up on a comment that Wai-yin Hatton made a few minutes ago about the need to find ways of incentivising the system. Would you like to elaborate on what those might be? There is now quite a striking divergence between health services north and south of the border, such as the way in which the system—and the more market-driven approach—that has been adopted south of the border has been incentivised. Would either board like to make a comment on those issues, which are more broad and strategic in nature?

Mrs Hatton: I will give three examples. The concept is a new one and we are still trying to find different ways of approaching it. The first is to use incentivising as a replacement for the setting of efficiency targets. We might say to a number of departments in our divisions, "If you are able to release £X, we guarantee that you will keep that money and we will encourage you to apply the money to these specific areas of development that are in line with our strategic direction." If they can generate the money, they can keep it to make those developments. That is a fundamental principle.

I will flag up two further examples in relation to our attempt not to have a finance-driven way of making the system work better in terms of financial balance. We mentioned agency nurses earlier. It is not just a case of saving money in that area; the qualitative components of the agency nurse approach also need to be considered. Our substantive nurses say that if agency nurses come into our wards, that leads to issues of continuity and quality of care. If our own nursing staff know that we are taking deliberate actions in an area, they will be less likely to want to move into an agency nurse arrangement. I hope that we will begin to create much more loyalty in the system.

The third example is sickness absence. We want to let our work force know that we want a healthy work force. Sickness can also cost the system in terms of locum and temporary staff, which means that it is also a qualitative issue that leads to burdens being placed on other staff. If we support the health of our work force, perhaps we will have less sickness. In turn, that will generate the recurring stabilisation of our financial position.

Broadly, those are the areas of incentivising that we are looking at—indeed, we are working on them.

Susan Deacon: I appreciate all the points that have just been made. However, I will make a similar observation to one that I made last week in response to Professor James Barbour of NHS Lothian. Some of the areas that Wai-yin Hatton mentioned have been identified as worthwhile areas for some considerable period of time. NHS Lothian raised the example of the use of agency nursing. That issue brings into even sharper focus the question of how we can create incentives within the system to make things happen. I wonder whether John Glennie might take us on to that stage.

11:00

Mr Glennie: We are taking a similar approach. We have found ownership to be one of the major incentives within the single system. This year we have worked really hard to make people feel that they are a part of the service and the decision-making process and that they have a say in our priorities. As a result, we have been explicit about seeking advice and guidance on priorities and about getting clinical and managerial leaders to sign up to them.

Within that, we are identifying a service strategy for each major service and moving in the direction that the witnesses from NHS Ayrshire and Arran described by asking those services how they will move towards the vision while releasing resources. For us, releasing resources is often about releasing staff into new methods of delivering care, as well as about releasing funds. Perhaps Robert Kemp is better placed to talk about our prescribing incentive scheme, which exemplifies our approach.

Mr Kemp: The example that I will give is a small one, but it might help the committee if I mention something practical that we have done in the Borders. In partnership with all our GPs, we have established a prescribing incentive scheme that has operated successfully over the past two or three years; it has certainly helped us to contain our drugs spending. We have also established with our pharmacists a range of quality markers. As long as practices achieve those standards, they are able to retain on a non-recurring basis a small proportion of any underspend that they might have generated. That has really helped to kick-start management of the prescribing budget.

Dr Cameron: At the GPs' request, we have included technical quality markers such as percentage generic prescribing, antibiotic use and other markers alongside simple financial markers so that we can get away from focusing only on the money. We also reward, based on the quality markers, within the incentive scheme.

Susan Deacon: I want to return to the major national pay awards, but I am aware of the time so, if the convener wishes it, I will keep them for later—if there is a later.

The Convener: This is the most appropriate place to mention the matter, so I am happy to let you do so.

Susan Deacon: I listened with interest to the witnesses' comments about the impact of the three major national pay settlements. I would like to ask one specific question about the general medical services contract, just to get the matter out of the way. Part of the narrative about the new contract, particularly as it has been explained at United Kingdom level, is that it will introduce more of a marketplace and that a range of providers will be involved in out-of-hours service provision. Have you found any evidence of that or have you had to find different ways of contracting and paying the same people who provided the services previously? I suppose that the example of the ADOC service partly answers that question.

Dr Cameron: We have based our planning on the assumption that we will not be able to have contracts with the same people—in other words, with the GPs. I must say that there has never been any access to commercial deputising services in our area because GPs have always carried out the work themselves. However, the clear message from my colleagues over a number of years has been that out-of-hours services have been a major block to recruitment and retention. Indeed, the message from young doctors who have joined the service and enquired about positions has been consistent; the apparent resolution of the out-of-hours issue—at least from the GPs' perspective—is seen as a major gain for recruitment and retention in that they will no longer be responsible for providing a 24-hours service.

We believe that the solution is to develop a fully integrated out-of-hours service that will be run like any other health board service. We plan to unify the accident and emergency department and our present GP out-of-hours centre, which are already geographically side by side in Borders general hospital, and to enhance that approach by developing plans—that have been around for some time—to have an acute receiving unit. The unit will be staffed with primary and secondary care clinicians and will feature enhanced nurse-led roles. We will back that up with several minor-injuries units in our peripheral community hospitals, which will become nurse led. We will then look towards having a visiting service that will be provided by district nurses, a palliative care team or paramedic services. The model will be fully integrated and run as a board service.

Susan Deacon: I will try to summarise in simple terms what you have said. Is it fair to say that we will not see what will happen more in parts of south-east England, where bona fide new providers will come in? You are saying that the GMS contract here is a catalyst for more imaginative use of the range of health professional roles that is available across the service. Is that a reasonable summary?

Dr Cameron: The contract is certainly a catalyst. If we put the financial implications to one side, simple consideration of the number of man-hours that would be required from the existing pool of doctors shows to be untenable the idea that we could allow staffing at anything like the present level. In our area, we have to find alternatives by asking what nurses can do, what the primary and secondary care professionals can deliver together, and by considering paramedics and the minor-injuries unit. New provision will come through integration of systems, rather than through our offering to an outsider a contract to supply a service.

Dr Green: As members know, we have ADOC. However, it is important to understand that emergency unplanned care is not only about medical care; a lot of social care is involved as well. We already have outreach services with our local authority colleagues; those services are accessed directly through ADOC. As I said, we have short to medium-term delivery of services, but we have already set up a group to consider the long-term future of unplanned care. The situation is similar to that which Ross Cameron described: there will be a front door to an accident and emergency service, with primary care people working beside secondary care people. Social care will be attached to that—an important way in which to prevent an admission is immediately to offer a small amount of social care to a person. I have been converted to that idea. As Ms Deacon knows, we set up the integrated care scheme in Darvel. I know that if we give a budget to someone on the ground and get them to use it, we can offer care immediately and keep a person at home.

Susan Deacon: I will ask one last mop-up question. We have spent a considerable time talking about the costs of the various new contracts and pay settlements. Various people have touched on potential benefits, but will you expand on what you hope the benefits to patients will be as a result of these not inconsiderable costs? How can you work locally not only to

minimise costs but to maximise benefits to patients?

Dr Cameron: The GMS contract as a whole certainly offers the chance to refocus on quality clinical outcomes. That chance did not previously exist. The whole quality and outcomes framework part of the new contract will encourage and enable practices to focus on delivering clinical outcomes. That has to be a benefit.

Another major benefit is the removal of concerns about recruitment and retention. Colleagues who operate our vocational training scheme tell me that applications have already improved this year; that is probably related to the good news in respect of people's concerns.

The changes in the out-of-hours system are a considerable upheaval from the patient's point of view; however, once the system is up and running, with trained nurses in place, better access to immediate investigations and links with social care improved to allow home provision, I believe that the quality of care that is delivered in emergencies will improve. What is offered may not be as convenient for patients, but I believe that quality will be better, which is a major plus.

Dr Green: I would not like to isolate any of the three main strands of pay modernisation, which are the GMS contract, the consultant contract and the agenda for change. This is all about service change: how can we deliver high-quality health and social services to patients near their homes? As Ross Cameron said, the GMS contract will enable us to increase chronic disease management, much more of which will be done near patients; they will not have to trek back and forward to hospitals. We will investigate how we can deliver increased services that allow patients to be seen by the acute sector near their homes. That is similar to what we are doing in north-west Kilmarnock and in Largs, where we are bringing the acute sector and primary care together. That is how we will redesign the consultant contract. When I sit down one to one with the consultants, I examine what they do during the week and try to rearrange that so that they will start to deliver the services that I have described.

Agenda for change creates massive opportunities for us to give allied professionals and nurses the extended roles for which they have been screaming for years. Why should a physiotherapist not be able to send someone for an X-ray, or treat people who are on a long orthopaedic waiting list, but be able only to refer patients whom she or he thinks need to be seen by an orthopaedic surgeon, who can then concentrate his efforts on doing what he was trained to do?

There are massive benefits to be had from the pay agenda, although it has cost implications. At the beginning, we feel the costs but do not see the benefits, which will take three or four years to become apparent. However, it is in the interests of the people of Scotland for us all to work to reap those benefits. I am in the business of helping patients to get a better deal and I am sure that we will achieve that.

George Lyon: I want to look forward a bit. Planned expenditure on the NHS in Scotland is expected to increase from £6.7 billion in 2002-03 to £8.5 billion in 2005-06. I want to ask the representatives of both boards three questions that arise from that. First, how much additional funding do you expect to gain between 2002-03 and 2005-06? Secondly, to what extent do you plan to use that additional funding for service development, as opposed to dealing with existing cost pressures, such as staff costs, prescribing costs and other basic issues? How much will be left over for service development? Lastly, how will you ensure that funds that are earmarked for new service developments will be used for that and not switched to another part of the budget later because unplanned costs arise for which you were not prepared?

Mr Glennie: I suspect that Robert Kemp can provide a more detailed answer than I, but I will make a point about the separation of service development and pressures. We have said that drugs budgets are a significant pressure, but they are also a significant investment. From where we are sitting, it is not simply a matter of saying that one thing is a pressure and another is a service development. Dr Cameron will provide an example of our investments in prescribing, which we see as being significant service developments.

Dr Cameron: Two main issues impact on large chunks of the drugs budget. One is the statins question, which relates to chronic heart disease and stroke. Another example that may illustrate the point is anti-TNF—tumour necrosis factor—a unique new drug that is an anti-rheumatoid arthritic agent. The Scottish medicines consortium has identified anti-TNF as a unique drug and we must implement the consortium's recommendations. The drug costs £10,000 to £12,000 a year per patient. We have gone through the clinical process of identifying suitable patients and estimate that it will cost us in the region of £600,000 to supply anti-TNF. That is a very significant investment, but the clinical impact on the 60 or 70 patients concerned will be massive and, hopefully, their lives will be changed. To represent the drugs budget as a cost pressure is to tell only half the story.

To give some specific figures, our allocation will grow by £9.3 million next year and we anticipate a

similar growth in 2005-06. Subject to the caveats that were mentioned in the discussion with Derek Lindsay about the spending review for 2006-07, we plan on growth of just under £8 million. Borders NHS Board gains under the Arbuthnott formula, so our growth will be ahead of the national average.

11:15

George Lyon: How much did you gain from Arbuthnott? That information is not given in your submission.

Mr Kemp: We are £2.6 million below our Arbuthnott parity target.

George Lyon: Do you expect to gain that sum?

Mr Kemp: Yes.

George Lyon: Is that reflected in the figures?

Mr Kemp: It is indeed. Arbuthnott works about three years in arrears. On the main pressures and use of allocations during the three years, we estimate that we will need to put aside about £2 million per year for general pay uplift—that sum is not for pay modernisation, but for a 3.25 per cent pay uplift each year. Expenditure on drugs will account for about £2.5 million per year, based on a 10 per cent increase per annum, and we have built in extra funding for some consequentials from the GMS contract quality markers and the Scottish medicines consortium guidance. Non-pay inflation accounts for about £1 million per year and, as we discussed, we are putting aside £1 million per year for out-of-hours services. For pay modernisation, we have put aside £3 million this year and £1.6 million next year—that is the impact of the agenda for change.

On top of that, there are a range of investments because, as always, we have to strike a balance and make sure that services can move forward. We have identified investments of about £1.4 million next year. Cost pressures of about £1 million have arisen this year, and we will need to address those on a recurring basis. To be prudent in our financial planning, we have set aside £1 million per year for in-year cost pressures. If the actual figure is less than that in any one year, the plan will benefit, but if the figure is more than that, we will have to make adjustments to take that into account. That is a new feature that we introduced to ensure that our planning is on as firm a basis as possible.

On ensuring that investment is targeted at the areas that we set it for, the best answer is that all our financial information is open to scrutiny through the clinical executive. The priorities for targeting of investments are agreed at clinical executive level, before a recommendation goes to the board, which is the main scrutiny body in that it includes the four clinical chairs. That is how we ensure that money is targeted at and delivered to the intended areas.

George Lyon: I would like clarification. I added the moneys quickly; the £9.3 million that you mentioned appears to cover just contractual issues, pay and prescribing. Is it correct to say that there is nothing left over?

Mr Kemp: There are quite a few other costs for smaller items; for example, we will have to pay more next year for some out-of-Borders services because the consultant contract is impacting on Lothians and we will pick up a share of that additional cost. We estimate that the cost increases for next year will exceed the increase in the allocation that we have been given, so our deficit will increase.

George Lyon: So apart from the gains that you will get from the new contracts, no other service development money is available.

Mr Kemp: That is correct.

Mr Glennie: Within that list, there are some service development—

Mr Kemp: Some £1.4 million of service development is included in that list.

Mr Lindsay: You mentioned the additional resources that will come out during a five-year period—

George Lyon: No, the period is from 2002-03 to 2005-06.

Mr Lindsay: Okay. The increase for NHS Ayrshire and Arran has been about £30 million per year; in 2002-03, the increase was £25 million, in the current year it is £30 million, and we expect that to increase to £32 million next year. The pattern of where the money has gone is fairly consistent. Roughly £15 million to £16 million has gone on pay and that is also our assumption for the forthcoming year. However, capital charges are variables in those figures; last year, there was an increase of about 6 per cent, but this year we are budgeting on an increase of about 14 per cent. That is based on indices that have been produced nationally. The increase will be a one-off hit as a result of the revaluation. The sum that is spent on prescribing is fairly consistent; it is about £7 million to £8 million of the £30 million increase.

Broadly, therefore, for 2004-05, we are looking at £16 million being required for pay and roughly £8 million for prescribing costs out of a £30 million increase. There will be investment to address waiting times, which I would class as development in that it relates to new resources for orthopaedics and other areas. We are looking at a cost of around £2 million for that.

We are also committed to funding a number of national and regional commitments. For example,

we must contribute to the development of new linear accelerators in Glasgow, and part of our development money must go towards our share of funding the development of national services in paediatric intensive care and neonatal care. We are in a similar position to NHS Borders in that, when all the sums of cost pressures are added up, they exceed the additional allocation for 2004-05. That is why we are having to go through a detailed scrutiny of all those areas to try to narrow things down and say what the risks are of not funding certain things. Some health and safety requirements, for example, are very strict and there may be orders in place that require us to take actions. Other investments would be desirable and we need to make judgments on the risks of not funding certain things so that we can inform our budget setting.

You asked how much money may be identified for service developments for future years. In respect of identifying cost pressures, we are going into 2004-05 having to make best estimates in a number of areas, such as on capital charges as a result of revaluation; we do not know what the outcome of that revaluation will be. We are working on the consultant contract, but the final outcome is not available to us. Out-of-hours services are still being negotiated. We will make a best guess about prescribing costs, based on history and increases that we have seen in past years, but that cost can swing. The figure will be around 10 per cent, but it could be 8 per cent or 12 per cent. We must have in-year flexibility to be able to manage such fluctuations.

George Lyon: I appreciate that and ask the convener whether we could formally ask each board to provide a note with the answers to those questions for each year, which would be useful.

The Convener: I see the representatives of the boards agreeing to that, so that information will be forthcoming.

George Lyon: I have a final question. At our meeting two weeks ago, Professor Barbour told us that he believed that there was local and national evidence that activity has dropped off in the health service despite a substantive uplift in financial investment in it. Have you done any work in respect of monitoring and evaluating activity? Will you deal with the issue of demand? I notice that you are making good progress with waiting lists and waiting times. Will you say a little about those, because they are two important factors that we and the general public are interested in.

Mr Glennie: We have done work on activity, demand and productivity. In the Borders, activity as we currently measure it is roughly static, although it varies between headings. Our day-case activity appears to have gone down, but that is because we have followed the reclassification that has been led by the information and statistics division nationally, which has reclassified cases that were previously day cases as outpatient cases. Broadly, our activity is static, although medical emergencies activity is increasing.

Of course, there are changes in clinical practice behind the figures. We are trying to see more people on a day-case basis and to treat more people in the community, and we are trying to prevent—through, the admissions unit, for example—people getting into overnight beds. It is true that productivity as measured per head of staff has gone down in the acute sector because we are employing more staff for that level of activity as a result of junior doctors' hours and the working time directive. Therefore, I cannot give a simple message—the issue is quite complex.

Mrs Hatton: On activities, we have tight monitoring and management reporting in Ayrshire and Arran. Our elective figures have come down, but there has been a corresponding increase in emergencies, day cases and out-patients. We would encourage further work to be done on that nationally. It is necessary to establish a way of reflecting the changes in practice, which are not compatible with the current way of recording the information centrally—especially as significant developments are taking place in respect of the shift from secondary care to primary care in a community setting. Those changes are not currently captured, so we get a skewed picture by comparing data on a purely historical basis.

Although the elective figures in NHS Ayrshire and Arran have gone down, the number of emergencies has gone up. That reflects much more complex cases plus an aging population. As Dr Green highlighted, a number of initiatives are being taken in the community in an attempt to reduce and prevent inappropriate admissions to hospital. Ideally, we want fewer and fewer people to go to hospital. Work is being done on day cases and out-patients to address waiting lists, but because of the way in which the definition operates, the complexities of activities are not captured. We urge a review of that matter, especially in relation to the community.

I will flag up two points about how we tackle capacity in parallel with the financial challenges. We currently have a capacity project that spans primary and secondary care. That project is examining where the hot spots and bottlenecks are and it is investigating what solutions there might be. The findings from the project will feed into the current services review, which spans the whole patient journey, so that we can establish what we can do to tackle the issues. Although there might on the surface appear to be a decrease in the elective figures, we need to

consider what is happening in parallel areas of increase.

George Lyon: You said earlier that you believed that the new ways of working and the new contracts should deliver better services. Therefore, one would imagine that it should also deliver better productivity and better quality outcomes. How will you capture whether that is happening and establish that we are getting something back for the substantial investment that has been made in changing the different contracts?

Mrs Hatton: I will give a significant example, which has already happened, and I will ask Dr Green to give the committee some other examples.

George Lyon: My question is on how you will measure the outcomes; I am not asking you to give us examples.

Mrs Hatton: The first example that I was going to give you is in plastic surgery. As a result of the new way of working between the GP and secondary care in plastic surgery, we have significantly reduced the waiting time for the current backlog, so patients are being treated much more quickly. The statistics and waiting times in that particular area of the exercise have given us clear evidence that partnership works.

Dr Green: I will refer to several other areas. It is necessary to consider how we are coping with delayed discharges and how we are dealing with our local authority colleagues. We have significantly reduced delayed discharges.

Another initiative that we are keen on pushing forward is the Runcorn initiative, which took place in Cheshire. It was certainly well funded and a lot of support was put into one practice. The initiative showed that admissions could be reduced by anything up to 33 per cent. We have piloted the initiative in Ayrshire and to date we have found that we already have the resources; we are dealing with people over the age of 65 and are trying to put in place simple measures that prevent them from becoming revolving-door patients or patients who get admitted. We have found that we already have the measures in place. We can now measure the number of people who are at home and are being kept at home.

We must also consider other client groups—this is not all about emergency care. We have a massive programme for our people with learning disabilities; we now have a package of care with our local authorities to ensure that people who are discharged from institutions have appropriate social and medical care at home. We are building up our medical teams to deal with that very vulnerable group of people, who have the right to live at home just as everybody else has.

We can give the committee measures of the number of people whom we discharge from long-term care; the number of elderly people with complex care packages who are at home; the number of children who are discharged from Yorkhill hospital, who are on ventilators but who can be kept at home because of a combination of social and medical care; and the reduced number of delayed discharges. We can show that high-quality care is being offered.

11:30

Mrs Hatton: We can look at outputs, which are the tangible figures, but we also have to look at outcomes and the performance assessment framework that we all have to keep within and report against. There is a significant range of health outcomes and we have to consider them. We have to consider both the qualitative and the quantitative.

Mr Glennie: A lot of investment goes into the quality issue. Wai-yin Hatton and I have talked about the ways in which we measure health care; perhaps we need to move on. In addition to those mentioned by NHS Ayrshire and Arran, there is a range of other markers that we can measure against. We have quality standards from NHS Quality Improvement Scotland; we have compliance with health and safety requirements; and we have compliance with the new deal for junior doctors and the working time directive. Those are all ways in which we can show that there has been movement on the quality agenda. As a service, we probably need to improve the ways in which we are accountable to the public for our quality improvements. We also have to demonstrate those improvements.

Dr Cameron: Another area that has yet to be established is that of the data that will arise from the quality and outcomes framework in general practice. The payment system is geared towards outcomes, so the electronic data gathering that will back that up should provide detailed evidence on improvements in outcomes for diabetics, hypertensives, asthmatics and so on. We have not had such evidence before and we have yet to see what it will generate but, in theory, it should give us a good database on where clinical improvement is occurring.

Mr Glennie: Another measure that we are currently putting in place with our local authority partners is a series of satisfaction surveys. The first satisfaction survey, which we carried out recently, has given the health service in the Borders an extremely high satisfaction rating as a service provider. We intend to carry on with such surveys so that we can measure change over the years.

Margaret Jamieson: I want to pick up on the issue of patient satisfaction. I feel that patients are seldom asked their views on the journey from the first knock on the GP's door. Were they able to access the GP? How many buses did they have to take to get there? What was the follow-up if they were required to have an episode in secondary care, whether as an out-patient or an in-patient?

It is great for you to tell us how all the statistics are gathered and what they mean to your finances; but how do they relate to the health plan and to the objective that you as accountable officers have of ensuring that the population that you serve is getting a good service so that their health and well-being improve?

As of Thursday this week, every person in Scotland who knocks on a GP's door should be able to see a health professional within 48 hours. If you were to issue patient-satisfaction forms on Thursday, it would be interesting to see whether that target was achieved. Are you on course to meet the national target? What measures have you put in place to ensure that the service is delivering in communities?

Mr Glennie: I would ask Dr Cameron to pick up on the 48-hours question first.

Dr Cameron: We have asked the LHCCs to monitor the situation and provide evidence. The information so far indicates that the target is being achieved already. The target is complex and is not as simple as obtaining an appointment within 48 hours—various qualifications relate to members of staff and the type of consultation. The ultimate measurement would come from widespread and repeated public consultation. The local health council has fed in views. The local health council's chairman is a member of the Borders LHCC's board, so the LHC and the LHCC have a direct link. The LHCC has regular updates from the LHC.

Dr Green: The quality practice award and practice accreditation are the quality measures that are in place for general practices and on which most areas have been fairly successful. Ayrshire has been extremely successful.

Last year, the Executive started the primary care collaboratives initiative. Five practices—including one from each local authority area in our health board area—are participating in that. A main strand that primary care collaboratives are examining is advanced access, which is a mechanism for shifting appointments to allow access when it is needed.

We have surveyed our practices, which will conform with 48-hour access or better. There is no doubt that all general practice in Scotland offers an appointment on the same day when somebody has the clinical need for it, but we are talking about regular access for routine appointments. In the past three years, primary care collaboratives in England have shown that 48-hour access will deliver such regular access. The Scottish initiative has put measures in place to provide that. The first wave will be completed by June this year, after which the second wave will start. That will involve the remainder of practices.

We have an electronic tool to measure the number of appointments with 48-hour access or better. On a Monday morning, the practice in which I work can provide much better than 48-hour access and prove that electronically.

The Convener: I have a final question on financial and service planning. As you have explained, many of the pressures that your organisations face arise from salary agreements, which can be national agreements that do not necessarily take account of different work practices between boards or between Scotland and England. When the uplift is received and consultant contracts, for instance, have to be dealt with, the pressure that you face may be different from pressures south of the border. If that happens, do you have to make different efforts to find the resources to fund the agreements, or do you seek to change work practices so that pressures are similar to those south of the border?

Mr Glennie: I will give an example of that situation, to which I have referred. In the Borders, we have small working rotas. We have a small district general hospital and small services compared with those south of the border, where services tend to congregate in larger areas.

In addition, we have traditionally had seven clinical sessions from our consultants, as opposed to the six or even fewer that are provided in many other parts of the UK. We start from a point at which we obtain a large amount of clinical care from our consultant staff. That is a different starting point, so we have a different funding point. The answer is to sit down and work through job plans for the medium term, to redesign the way in which we provide services, as Dr Cameron said. The ways in which the systems work have clear differences that relate to private practice or a lack of it and other such issues, which we must work through one by one.

Dr Cameron: Private practice is not a big issue for us, but numerically small rotas are an issue. Our week has the same number of hours as the week in the Edinburgh royal infirmary does, and the new contract is based on hours, rather than work load, so we are under pressure on that. In addition, peripheral units tend to have a smaller number of more experienced junior staff than teaching units do. The relative impact on the out-of-hours period can mean that the consultants are more involved, and are involved more often, on site, because, proportionally, they do not have the

same large number of experienced junior staff. That is a further complicating issue for us.

Mrs Hatton: I agree with what my colleagues from the Borders have already highlighted. I would reinforce what Dr Green said: in Ayrshire and Arran, we want to examine all three streams in the pay modernisation agenda together, rather than looking at the three of them in silos. All three will present opportunities for and provide flexibility on how we can shape services in the future, so we should be getting the maximum possible mileage out of them. My colleague Mr Lindsay would like to add a comment about the funding differences between north and south of the border.

Mr Lindsay: England has received additional resources for health compared with Scotland, as there has recently been a commitment to move to the European average over five years. The fact that England has received significant resources perhaps gives it extra flexibility to implement the national pay modernisation agenda and to make a little extra available for other things, too. Scotland has to make its own decisions as to how much to invest in health compared with other areas. Because the agreements are national agreements, there might be some extra flexibility in England.

The Convener: I propose that we suspend the meeting for five to 10 minutes, so that we can all have a comfort break—you have now been giving evidence for more than an hour and a half. We have some further questions on trust integration and performance management to ask you, but we will take a break first. I ask everyone to be back and ready to start again at 10 to 12.

11:42

Meeting suspended.

11:52

On resuming—

The Convener: We will now ask about the benefits of trust integration and the lessons that can be learned.

Mr Kenny MacAskill (Lothians) (SNP): Mr Glennie, to what extent has NHS Borders identified economy and efficiency savings as a result of the integration, to what extent has it identified where other gains might arise, and what more needs to be done to fully integrate the NHS in the Borders?

Mr Glennie: We have secured just over £0.5 million of recurrent savings from the management side of the organisation. We are pressing on and looking at further reorganisation to see where further savings can be made, but that money is in the bank, so to speak, and it has come entirely from the integration process.

On the benefits of reorganisation, ours feels like quite a different organisation at the moment. Through the clinical executive we have managed to get one clinical voice, which Dr Cameron could expand on. We are seeing a much more joined-up approach to finding solutions to issues and redesigning care. We are seeing a much quicker decision-making process.

As I said earlier, NHS Borders is a small system that is coterminous with one local authority, but it is on the edge of a big system, so the external relationships are vital, particularly in the area of service redesign. By having one executive team, we can better relate to our partners in Lothian and in Scottish Borders Council. Indeed, only three months ago, we set up a joint management team with Scottish Borders Council. Both teams now meet on a shared agenda on a monthly basis. It would have been much more difficult to achieve that when we were sitting with three management teams. The clinicians and clinical leaders feel that they are much closer to the decision-making process, that their views are working through the system more clearly and more easily, and that they have ownership of the agenda and the issues that face us.

Perhaps Dr Cameron could pick up on the clinical executive issues.

Dr Cameron: The four main clinical boards—the two LHCCs, the BGH and mental health and learning disability services—are represented. We have a clinical lead from all four through two GPs and two consultants. We have the system managers and representatives from other senior clinical groups such as pharmacists and allied health professionals.

We meet weekly and some of the meetings are operational. We also have a formal meeting monthly in which we consider financial data and performance review matters. The senior social worker from Scottish Borders Council is present at the formal meetings and we have a permanent partnership forum representative. Additionally, we have support services such as estates, planning and human resources, all of which can help us.

The main message from clinicians that came out of the consultation that took place before integration was that the board should have a strong clinical voice at the centre of the main strategic planning process. As medical director, I chair the group. The nursing director is the vice-chair, and the senior operational manager of the system is the director of integrated care. We are all on the clinical executive and the board management team, and the nursing director and I are on the health board. There is therefore a very

short chain between the operational management of the services and the board, which is very useful.

Mr MacAskill: What effect have the bureaucratic changes had on management staff numbers? Have the staff been reallocated or has there been a reduction?

Mr Glennie: There has been a reduction in the number of staff. I do not have the exact numbers in front of me, but I can get them. The £511,000 saving comes from a reduction in the number of management staff.

Earlier, I talked about some of the problems of a small system, but one big advantage is that we have been able to have a single operating division—the clinical executive—which means that all the key leaders can get round one relatively small table in one board, and the clinical leaders attend that board. There is a real sense of ownership and of people signing up to issues.

George Lyon: What percentage of your total costs do management and administration costs represent and what percentage do the costs of front-line staff represent? What were those percentages in your previous budget? It would be interesting to do a comparison.

The Convener: If you do not have those figures to hand, you may write to us.

Mr Glennie: We will submit them to the committee. We know that we have made a significant reduction in management costs and we want to continue in that way, but we do not have the figures with us today. Can we send the figures to you?

George Lyon: Yes, and I ask Ayrshire and Arran to let us know what it expects when it makes those changes.

Susan Deacon: I will pursue a similar line of questioning with Ayrshire and Arran, although obviously Ayrshire and Arran is at a different stage of development. What benefits do you think will arise when the board moves to single-system working and the trusts are integrated within the board?

Mrs Hatton: I will speak to the general strategic policy and invite Dr Green to talk about clinical services and integration of primary and secondary care. In terms of economies, we do not foresee the same result as in the Borders because our two trusts already have one of the lowest management costs. The HRG in the acute trust was recently ranked in the top five for costs. There is little scope to make further economies from the change.

We have concentrated on cultural rather than structural changes. Because of the various pressures that we were discussing before the break, we had to keep our eyes on the ball rather than on the significant changes. That cultural change has enabled us to ensure that across the system we have a shared understanding of the issues, so we have moved away from the days when one trust might accuse the other of shroud waving, because we have a shared understanding of solutions.

We have achieved that by setting up—18 months ago—the corporate team, the members of which are drawn from the chief executives and directors across the three parts of the system. They have already begun working together—even though no structural changes have been made—to make collective decisions and recommendations on policies and strategic and financial directions.

Through that way of working, we have been able to facilitate the taking-on of corporate leadership responsibilities across the patient's journey by the three chief executives in the three legal bodies. For example, I have taken on responsibility for learning disabilities and the primary care trust's chief executive has taken on responsibility for coronary heart disease and stroke. We are already able to begin to adopt the culture of thinking about the patient's journey at individual level. I will let Dr Green explain how that culture or overarching way of working has translated into support for the front line in the further integration of primary and secondary care, without the need for any structural changes.

12:00

Dr Green: The first thing that we did was to examine the medical and nursing representation on the unified NHS board. I sit on the board as a medical director, but the nursing director of the acute trust sits on the board as well so that there is equal representation. We have agreed that that will be the case for a period of four years and that the position will then reverse—the medical director of the acute trust will sit on the board, along with the nursing director of the primary care trust. In that sense, we are starting to work closely together.

There has also been a sub-committee of the board, which we call our clinical executive. It is made up of the two medical directors, two nursing directors and a director of public health. We meet every six weeks to discuss the pressures that are facing each of the systems and how we can work together to resolve some of those issues collectively. As Wai-yin Hatton said, we also have the corporate team, on which the clinicians and the managers come together to consider the system's problems and to try to solve any system-wide problems.

We are embarking on our services review, which will cause major changes throughout the system. As part of the process, the public will be heavily involved. We want to know what they think we should be considering, what services they want us to change and how they want those services to be changed for their benefit. That is about to take off; this month, we have had several public meetings on the services review throughout Ayrshire and the review will probably begin in April or May.

There is also the joint future agenda, with which we have had some problems, because we cover three local authority areas. It is right that our LHCCs are now coterminous with those areas. The three local authorities have different priorities, but we must provide an NHS Ayrshire health service. We have had to accommodate our local authority colleagues by considering their priorities and to retain an overall strategic view of how health can deliver services in an integrated way with local authorities.

Finally, I will deal with the development of the LHCCs. Initially, we had eight LHCCs. That was because LHCCs were voluntary organisations and we had no say over what they should do. I was always of the view that we should have had three LHCCs and we have now developed three LHCCs that are coterminous with the local authority areas. Those LHCCs will develop into community health partnerships. There is a great desire to move that agenda forward, in secondary care as well as in primary care.

We have migrated all our services to LHCCs. All our mental health services, all our allied professionals, all our nursing services and our major in-patient facilities are at LHCC level. All our community hospitals are managed by LHCCs and, from 1 April, Ailsa hospital, which is our largest in-patient facility, will be managed by the south Ayrshire LHCC. We feel that we have started a full integration and that there are noticeable bridges not only between secondary and primary care, but—just as important—between primary care and local authorities. That is the way in which we think that we are moving forward.

Susan Deacon: I want to follow up on that answer, for which I am grateful. What steps have you taken to ensure that the structural changes that you have described remain focused on the delivery of service improvements? Also, what steps are you taking to ensure that staff—who might be considerably removed from some of the structures and processes that you have described—are kept informed of the developments and how they will be affected? Similarly, how are you ensuring that the public, who will be much less concerned with the details of the decision-making processes—important though those are—are kept informed about what the developments will mean for them? I put those questions to both boards, although they are at different stages of development in relation to integration.

Mrs Hatton: We have taken particular care for some time to ensure that there is an ethos in which staff are empowered and involved. That is a challenge; we have 10,000 staff in NHS Ayrshire and Arran and it is difficult to engage them all at the same time. We rely heavily on the area clinical forum and the area professional committees, as well as on the area partnership forum and the three local partnership fora, as the vehicles for ensuring that staff are involved and given equal opportunities from the outset in relation to the planning and design of services. We ensure that people on the front line are involved, so that we can take on board what they believe to be the service needs.

The services review, which Dr Green highlighted, represents a classic example of that approach. He referred to the significant number of workshops that take place, both with staff and with the public, in which the participants are told, "We are not determining the priority areas of review for the health service, but we want to learn from your perspective, as patients and staff, and hear about what you regard as priorities. We will base our action plan on what these workshops feed into us." We make that very clear.

We also involve staff in the development of the local health plan and in project developments. We ensure that the area clinical forum and professional committees and the partnership fora are represented on the service planning groups and are involved in the local health plan process. In terms of the budget allocation, which ultimately affects staff and the way in which they deliver services, the chair of the area clinical forum is part of the corporate team, so the forum will have a part in the collective recommendation to the NHS board.

Mr Glennie: Our starting point was the recognition of how fundamental public and staff involvement would be. There is a director on the board management team whose designated role is to lead on those areas and who attends all board meetings. We have put a significant amount of time and resources into that.

It is important to recognise how our reorganisation started. It started with a staff and public consultation, during which people said to us, "We believe what you say about integrated care being the future, but we think that the management structures are getting in the way of that." A lot of the structural change started from that point, rather than as a result of a management reorganisation.

We ought to pay tribute to our partnership forum and our employee director, who have been fundamental in relation to staff involvement. Without their proactive role, the reorganisation would have been much more difficult for staff. We recognise that to opt for a fundamental reorganisation, as we did, raises staff anxieties—the Auditor General referred to that in his report—but we have worked hard to ensure that staff feel that they have a real voice. For example, the employee director sits on our board management team. He attends all meetings so, when issues arise, he is present from the outset. Each clinical board has a staff representative, who attends all meetings. Staff representatives are therefore involved in all management discussions, planning and proposals. Through our employee director we have made a major effort to liaise with staff and to attend staff meetings and functional meetings.

Similarly, we have made a huge effort to engage with the public. For example, we have established a health panel as part of the process, which feeds back to us the reactions of the public.

Susan Deacon asked how we ensure that we focus on improving services. The best answer that I can give is that, by putting our clinicians and the clinical executive at the centre of our services, we have the best guardianship of services that it is possible to have. Our clinicians and clinical executive are the people who are there to deliver services. I agree that they have signed up to the management agenda, but that was done against a background of people saying, "We are here to improve services for our clients and patients."

Dr Cameron: The discussions at the clinical executive's operational meetings are clinically driven. Most of the agenda items are clinical matters such as clinical improvements, changes in technological development, and new drugs. The agendas for the operational meetings are very clinically focused.

Robin Harper: John Glennie mentioned community health partnerships in his introduction. When the Audit Committee last met, Professor Barbour of NHS Lothian told us that he felt that the management structure of NHS Lothian might change as the community health partnerships develop. How does the panel see the board structures of NHS Ayrshire and Arran and NHS Borders developing in future? Do you have plans to review their structure? How does that fit with the work that you are undertaking to continue to improve on the management savings that you have made to date?

Mrs Hatton: It is a bit premature for me to say whether the management structure will change. There are two points, the first of which is how the community health division will operate from 1 April. The chairs and leaders of the three current LHCCs will be heavily involved; they will not be excluded from participation. We need to gauge the way in which the CHPs want to go. We will need to find out whether they want to become committees or to continue to act as sub-committees of NHS Ayrshire and Arran. That is why I said that it was premature for me to comment.

The second point is the other side of that. We have ensured that we are going for cultural and not structural change. We will not make major changes to the management structures of the trusts when they become the two new divisions. Rather than have structural change for the sake of change, we are saying that we need to wait for the outcome of the CHP guidance and for progress on the joint future agenda on various fronts—particularly the service review. That will ensure that the basis for any structural change is service led and is not part of a management agenda per se.

There may well be tweaking in the future, but it is too early to say that that will be the case. We need to wait until we have engaged with the new CHPs to say how and at what pace they will want to move in the future.

Mr Glennie: When we set up the structure, in effect the Scottish Executive allowed us to design it ourselves. We believe that what we have at the moment is appropriate and that the clinical executive achieves many of the objectives of the community health partnership. If we were to consider the underlying objectives and principles, we would see that the clinical executive achieves many of them.

We have an agreed direction of travel with our LHCC partners. There is one local authority and one large and one smaller LHCC. In future, there will be one community health partnership for the Borders, which we see as sitting naturally within the clinical executive.

There will have to be some of what Wai-yin Hatton called "tweaking" done at the edges. We need to understand better how the CHP will relate to our local authority colleagues. Having set up the joint management team, to which I alluded earlier, we have a good vehicle for that to happen. We do not feel that we need to do nothing, but we feel that the community health partnership will be a natural extension of where we are at the moment.

George Lyon: I have a quick question for NHS Ayrshire and Arran. Under your new set-up, when the trusts become divisions of the board, will they have completely devolved financial control over budgets? If auditors or, indeed, the Audit Committee looked in from the outside, would it be possible to see where cost pressures were arising between the divisions? One of the great concerns about the abolition of the trusts relates to

transparency about where cost pressures arise and how gaps are filled.

12:15

Mrs Hatton: Balancing devolution and accountability is a challenge. In NHS Ayrshire and Arran we have agreed to move towards a devolved approach with clear schemes of delegation and accountability that have all been agreed and will have to be ratified by the new board at its first meeting in April, when it will be legally operational. My colleague Derek Yuille will be the divisional director of finance and will be looking after the conglomeration of financial functions and workings. There will be a clear line of professional accountability from him to the corporate director of finance, so the transparency and openness will be there to allow scrutiny. In parallel to that will be a single-system audit committee.

For the non-financial devolved agenda, we will have a health governance committee that encompasses clinical health, health care and local health plan development. The implementation of policies and staff governance standards will be devolved to the two divisions, which will continue to be accountable to the staff governance committee. That comes under the umbrella of the two divisions being accountable in the first place to their respective divisional management committees and ultimately to me. A strong performance management system is being set up to cope in the new era.

George Lyon: Will you elaborate on that? Will each division be allocated a set budget and will they have to report monthly?

Mrs Hatton: Yes. They will operate with clear set budgets within the scheme of delegation. My colleagues are desperate to share their enthusiasm.

Mr Yuille: The budgeting will remain the same as it was at the start. The two divisions will have to produce monthly financial reports right down to budget holder level. The intention is that we will continue to break down the figures at NHS Ayrshire and Arran level so that the board can see the monthly position in each of the divisions.

George Lyon: How will that be visible to outside bodies, such as auditors? Will the figures be reported in a unified board manner or will the reports say, "The divisions did X against budget," which we would be able to see? That is the point that I am trying to get at.

Mr Yuille: Each division will report monthly against their budget lines and the NHS board will see each line for the divisions broken down.

George Lyon: How does that get reported to the outside world? If I looked at your accounts, how would I be able to tell in which division the cost pressures were arising and where the overspend or underspend was? You are not being clear on that.

Mr Lindsay: Currently, the reports that come to the board have three annexes. One is an overview, the second is for the acute hospitals trust and the third is for the primary care trust. In future there will continue to be three annexes, which will show line by line the income and expenditure position for each operating division. We will continue to report in the public session of the board meeting the same level of detail that we report currently. Auditors have access to all records, so they can examine reports in more detail if they wish.

Mrs Hatton: The point to emphasise is that we have been anticipating the establishment of a single system for the past two years. The three components have already been producing joint financial reports monthly and then six-monthly to coincide with the NHS board meeting cycle. The existing arrangement of reporting that level of detail for the three components in the public domain will continue in April, although thereafter we will report as one legal body.

The Convener: I presume that Mr Glennie has already gone down that road to some extent. Will he give us the perspective of NHS Borders?

Mr Glennie: I will ask Robert Kemp to explain the process that we have used.

Mr Kemp: Retaining financial transparency is important to us. Pre-integration, we put a lot of effort into bringing together our financial planning and operating as one corporate body, as in NHS Ayrshire and Arran. In setting up the new structure, we have redesigned our financial reporting. The individual department will report all the detailed budget performance. Individual department performance is summarised at clinical board level. That is then rolled up to clinical executive level and is considered at the public session of the board. There is transparency about the performance of each clinical board area in the Borders. Each of the clinical chairs attends the public board session and is invited to comment on any issue that has arisen in their area. That is completely open to scrutiny at the public board session.

In addition, we have set up the board's policy and planning committee. The chairman was keen that we should consider the detailed financial plan once a quarter and go through all the assumptions and issues that have arisen. The clinical chairs are in attendance at those meetings. That is an important scrutiny committee for NHS Borders. It

examines the pressures that have arisen and considers any savings. It examines the assumptions that the plan contains on prescribing, consultant contracts and so on, which are open to challenge. Like NHS Ayrshire and Arran, NHS Borders has established a single audit committee, which operates across the system. We have been mindful to retain as much transparency as possible.

Mr Glennie: We were aware of the danger of centralisation in moving to one system. We have been clear in keeping decision making and budgetary control delegated; indeed, we are trying to extend that as far down to the front line as we can. With the public sessions, there is complete transparency about reporting, targets and achievement throughout all divisions.

The Convener: That is all for the questions on trust integration, so we will move on to performance management.

Susan Deacon: I want to ask about the performance assessment framework. I would be grateful if the witnesses would share with the committee their views and experiences now that the system has bedded in. I am deliberately giving you a broad brush to comment and feed back to us, but I will also give some prompts for areas that it would be particularly useful to have covered.

To what extent does the PAF aid performance management processes and give effective performance information at local level? To what extent is that information available to the public? How effective is the PAF in presenting a national picture that gives a real sense of relative performance in different board areas? Is the PAF acting as an aid in delivering marked improvements in quality? Are there concerns about it becoming a tick-box exercise? Are there too many boxes? In a number of places, concern has been expressed that lots of things are being added to the process and that it is growing a little bit out of control. Is that a fair suggestion?

Mrs Hatton: In Ayrshire and Arran, we have found the PAF to be a useful tool and not a tick-box exercise. That is probably because, when the Health Department first designed it, the ultimate users, on the front line, were significantly involved in the process. It was not designed from a one-sided point of view; both sides of the coin were involved.

We have found the PAF to be particularly useful because it covers the complexity of health and health care components, which was not the case before. We have been able to focus on areas that might otherwise have been missed. An example of that is breast-feeding, which I think Dr Green alluded to earlier. Because it was not such a hot topic, we might have been missing our performance in that area. However, when we considered our performance about 18 months ago, we realised, "Oh dear, this is an area that needs serious attention." Then we focused a lot more energy on addressing what was at the time an area of weakness.

We have also found the PAF useful because it has provided us with a genuine, constructive basis for dialogue with the Health Department's performance management team. It has been used not as a knuckle-rapping tool, but to say, "If this is what the indicators show, what might you need to do, and will you have done it by this time next year?" For us, it has been useful. Our local front-line people who use the PAF a lot and fill in all the forms find the number of boxes about right, but we do not want any more or substitution without continued dialogue, which I am sure the Health Department will have with us.

Mr Glennie: Perhaps this is the first area of difference between us today. I have campaigned to have more boxes, because I have campaigned for environmental and property issues to be more easily recognisable within the PAF, so it would be hypocritical for me to say that there ought to be fewer boxes. It would be lovely to have a performance assessment framework with 10 areas, but that would not reflect what we have to deliver, as Wai-yin Hatton said. We find the process useful.

I said earlier that we are keen to have a delegated system. Therefore, alongside the PAF we have put in place a board-wide performance management system. On a quarterly basis, we bring performance management information to the public session of the board on a traffic-light basis. That is substantially informed by the PAF—not just by it, but the PAF is one of the building blocks. We report on a quarterly basis against the achievements. That focuses our minds in those areas. It allows us to have a comprehensive system that runs through the clinical executive and the clinical board, so that there is a clear performance framework. We all know what we are trying to do and what we have to deliver, and we know where we are against that, which allows us to operate in a hands-off way. We think that the PAF is a useful tool.

The Convener: Are there any final questions?

Margaret Jamieson: I would like information on the cross-funding of projects. The witnesses talked about how they are working more closely with CHPs—or LHCCs as they are just now—and local authorities. There will be projects for which the health service puts in so much capital, the local authority puts in some and, on a good day, the Scottish Executive puts in some. What impact is that having on capital being transferred to revenue? Are there barriers? Are there issues that

we should be raising with the Health Department or other departments that would bring some of those projects back on-stream or make your life a wee bit easier?

Mr Glennie: As I said earlier, we set up a joint management team with the local authority, which is starting to deal with a number of the funding issues. We are keen on co-location. We have a joint property group and we are trying to agree property strategies. We are just coming to the point of trying to tackle the logistical and statutory issues around sharing property—we are perhaps behind NHS Ayrshire and Arran, which has a good example of such working.

Robert Kemp chairs a funding group that sits between the two authorities. We now have detailed plans for a shared learning disability service and we are working through the issues around different pay and reward systems, particularly for occupational therapists.

The joint management team is bringing many such issues sharply to the fore, but we will be better placed to answer questions in six months' time. Clearly, there are statutory issues that we must deal with, and one way in which we have got round that is by setting up a Scottish Borders well-being board, which consists of board members from NHS Borders and the leader, chief executive and some elected members from the council. We try to take such issues there. A governance framework sits between both authorities, and governance issues can be dealt with in the partnership board.

12:30

Mr Kemp: One issue that you mentioned, regarding capital to revenue transfers, could create difficulties in the future, as many of our properties are small and one legitimate use of money that is transferred from capital to revenue is for the refurbishment of some of those buildings. The forthcoming change in Treasury rules could constrain some of our joint working in that respect. That concern is on the horizon.

Mr Yuille: Similarly, although we have in place a property strategy and a group to take forward that strategy, we also have legal commitments with one of our local authorities to provide a project whereby there is a transfer of funding to us in capital and we have to transfer that funding into revenue in order to meet the payments to the council. Those commitments total about £2.5 million over the next two years. If, as Robert Kemp says, the Treasury scheme disallowing such capital to revenue transfers is introduced, that would cause us some difficulties.

Margaret Jamieson: What would the impact be on the community in which you want to improve health?

Mr Yuille: It would have an enormous impact on the community. We should not allow accountancy rules to drive change and partnership working between local authorities and the health sector. We need to find out how we can get round the accountancy rules.

Mrs Hatton: I support what my colleagues have said. We do not want to use capital to revenue transfer as a recurring financial solution, but there needs to be crystal clarity to distinguish capital to revenue transfers that are genuinely used for capital projects. As the regulatory regime for the health service differs from that for local authorities, the definition needs to be reviewed to avoid restrictions. Otherwise, the joint projects might well drop out of the priority list, as they would be competing for NHS resources for developments. That is a real danger. We do not want to move into that arena.

Margaret Jamieson: I certainly do not want you to do that, because I think that it is my area that you are talking about.

Is there a way in which the process can be managed? Treasury rules are Treasury rules, but the health service in Scotland is operated differently and is encouraged to collaborate with local authorities. For example, as CHPs are coterminous with the local authorities, are they a vehicle through which money can be drawn down from the board? There may be more than one way to skin the cat.

Mr Lindsay: You are right in saying that there may be options that we could look at in terms of vote head transfer to try to achieve some of those things. However, we must be mindful of the distinction between revenue and capital because, with the introduction of private finance initiative projects, capital demands have been less but the revenue demands have increased. If we are not allowed to make transfers from capital to revenue, our revenue may be out of balance but there may be surplus capital. That issue must be considered nationally. A permanent transfer from capital to revenue might be appropriate, but the issue needs to be examined.

George Lyon: I have a general question. It is clear from the presentations that both NHS boards have given that there is a strong emphasis on meeting financial targets, on financial planning and on the need to have a robust budgeting process. Can you comment on the fact that, over the past two to three years, the Executive has tended to use end-year flexibility to help boards that are in financial difficulties? Does that aid or detract from the robust financial planning process that you

have conducted, as boards that have done your best to stick to your budgets? Is such use of the funds helpful or unhelpful? Does it lead boards that have overspent to build that source of funding into their expectations at the beginning of the financial year?

Mr Glennie: We have strong support from the Scottish Executive as we try to balance our financial targets with service continuity. It is important to see health care in the medium to long term. In-year flexibility is vital. If we do not have that flexibility, trying to meet financial targets in one year could put the continuity of clinical services at a significant disadvantage. Provided that it is within the current framework of understanding and that we get the current position right, the use of in-year flexibility is helpful. We have had in-year flexibility this year in capital and revenue, which has meant that we have been able to protect clinical services while we put our savings plans in place.

Mr Kemp: At NHS Borders, we put strong emphasis on focusing on the recurring position rather than on any non-recurring issues that arise in a year. In that way, we keep people fixed on the long-term outlook.

Mrs Hatton: NHS Ayrshire and Arran takes a similar view. Although any help is useful and we have balanced our books so far, we face similar challenges, as the committee will appreciate. The Auditor General's report recognises that we will face serious pressures in the coming years, so any help is useful.

I agree absolutely with my colleagues from NHS Borders that we need to be funded adequately on a recurring basis as part of our base budget so that, for example, when we are trying to meet nationally agreed pay rises, we have enough scope to fund the developments that we want to make to benefit our local population. One-off payments allow for flexibility, particularly on a non-recurring basis for specific use, but the recurring baseline is fundamental to allowing us to sustain and develop continued high-quality services in our local areas.

The Convener: Very good. You have exhausted the committee's questions in what has been a marathon session. We look forward to receiving those answers that you have said you will provide in writing. I thank you for your time and perseverance in giving us evidence today.

Under agenda item 6, the committee will consider the evidence taken today and at the meeting on 16 March on the Auditor General's report "Overview of the National Health Service in Scotland 2002/03". I invite comments from members on the evidence that we have taken, after which we will ask the Auditor General for his comments.

Margaret Jamieson: The Auditor General indicated that he was happy to look at the issues identified in the *Official Report* before making his comments. I am happy to wait until he has seen the *Official Report* from today's meeting so that we can make progress.

The Convener: Is there nothing that you want to say about the Auditor General's report?

Margaret Jamieson: The new Treasury rules were mentioned today and are quite worrying. Perhaps the Auditor General will reflect on those and their impact on future developments.

George Lyon: I agree with Margaret Jamieson. I read the *Official Report* of the evidence session with NHS Lothian. More questions than answers arose from that meeting and we could do with further clarification, if the Auditor General will look through the *Official Report*. From the evidence session a couple of weeks ago, it seemed that there had been a complete loss of financial control during the transfer from one system to another, as demonstrated by the predicted losses. However, the two boards that gave evidence this morning seem to have had greater control of the system in the past few years. The stark message that came out of this morning's meeting was that the national agreements did not appear to be fully funded. We will need to go through all the evidence that we have heard, pull it together and have a meeting to discuss where we go from there.

Susan Deacon: The Auditor General and his colleagues will probably know that my primary concern is that we should not simply continue to reinvent the wheel in terms of the analysis of the problem; we should consider how we can put greater momentum behind the delivery of the solutions.

We heard some interesting and informative evidence today and were given some tangible examples of service improvement that are germane to the "Overview of the National Health Service in Scotland 2002/03" report and other areas that we have considered. As we discussed in relation to the "Supporting prescribing in general practice" report, there is an issue about the pilot project and the isolated example of best practice. For how long can there continue to be a commonality of agreement about how people want health care to be developed before we move to the next stage of ensuring that such practices are the norm across the service? That is an over-arching preoccupation of mine.

In relation to one or two specific areas that were mentioned, problems have been identified previously and I am perplexed as to why there has not been more progress towards resolving them.

The question is not simply of service improvements, but of measurement systems. The issue of waiting times, for example, is interesting. I think that the representatives of Ayrshire and Arran NHS Board spoke about that. The fact is that much of the information that is collected and reported on with regard to NHS performance belongs to a bygone era, as it does not measure modern clinical practice. For example, it does not pick up on nurse-led clinics or reflect the shift towards the delivery of many health care elements in primary care.

That observation is not new. I can testify that, more than three years ago, a tangible commitment was given to revise the measurement systems. I would genuinely like to know how far that work has got. For how long will we continue to measure the system in the wrong way? That is quite worrying, given the impact that it could have on the skewing of resources and effort.

The Convener: That sounds like a question for Trevor Jones. I invite you to put that to him when he comes before us.

Susan Deacon: I will happily do that.

Robin Harper: I support everything that Susan Deacon has said. Having a further report from the Auditor General on the basis of what we have heard today would help to give a focus.

George Lyon: Further to what Susan Deacon said, another point that I took from the evidence that we heard this week and last week is that, although there are claims that the new contracts and arrangements will deliver better care, better outputs and more flexible services, it is clear that there is nothing in place to capture whether that is being delivered.

If we are investing such large amounts of money in the hope of creating more flexibility and different ways of delivering services as a result of greater integration between the disciplines, it is fundamentally important that we can capture that and tell the general public what is happening. However, when we asked our witnesses the hard question today, they had no idea of what would actually happen. They hope that the system will deliver, but there is no method by which we can capture the information that would demonstrate that it is delivering.

Professor Barbour's view was that activity was decreasing at a time when investment in the health service was at an all-time high. The two things just do not square up. There are issues about quality and junior doctors' hours, but we still have to ask whether we are getting something back for our investment. The role of the Audit Committee should be to ask that hard question. That is an area that we need to explore in the report.

12:45

The Convener: The points that George Lyon, Susan Deacon and Robin Harper have made will prove useful in formulating questions for Trevor Jones from what we have learned from this meeting and our previous meeting. They can also form part of the basis of the paper that will be produced by the Auditor General, whom I now invite to make his observations.

Mr Black: We will produce a paper for the committee, which I hope that members will find helpful. On that last point, which raises one of the most significant issues, I absolutely agree. It came over very clearly from the witnesses that the pay modernisation costs were the biggest source of financial pressure, together with movements in the cost of drugs, and so on.

I found, in listening to the evidence, that it was interesting to put the pay modernisation costs in the context of the developing strategies of the new, unified health boards. We heard from both health boards—perhaps it came across more strongly in the evidence from Borders NHS Board than it did in the evidence from Ayrshire and Arran NHS Board, as Borders NHS Board is already operating as a unified board—that pay modernisation, as well as being a significant source of cost, offers the prospect of reconfiguring the way in which services are delivered. However, that is a matter for the future rather than the present.

We heard some interesting issues around, for example, the emerging effectiveness of a core clinical executive, which will drive the strategy from a clinical point of view, and we heard some interesting thinking around how the costs of out-of-hours services can be contained through the board taking a centralised approach. Clearly, a lot of thinking is going on in both health boards, although we must recognise that it is early days to see the results. The consequence of that for our work is that the whole agenda of pay modernisation costs will feature as a serious option for a medium-term programme of studies on which we will consult the Parliament and our key stakeholders in the future.

Related to that is the fact that the management of both bodies are clearly enthusiastic about the potential of the unified board set-up, not least because of the opportunities that are opening up to overcome some of the old organisational and institutional barriers in planning care packages. It came over clearly in Wai-yin Hatton's evidence that measuring things in the old way is no longer helpful, as health boards are moving towards different packages of care and systems in which primary, acute and community care workers are working more closely together. The challenge for us, in our work for the Audit Committee over the

next few years, is to redesign the way in which we report in order to reflect what is really happening, supported by good, strong evidence.

We will try to capture those and other issues in the note that we give to you. I agree fundamentally with the point that the whole pay modernisation agenda is important in relation to both cost and the provision of independent evidence over the next few years on whether the NHS is delivering a better quality of care, which is what this is really all about.

The Convener: Thank you very much. We look forward to receiving that note. Am I right in thinking that we will consider it before the meeting on 27 April?

Shelagh McKinlay (Clerk): We will not have an opportunity to do that formally.

The Convener: However, it may form part of the discussion on lines of questioning to provide some background at that meeting.

That is the end of agenda item 6. We are still quorate—just. We have one final agenda item, on medical equipment, which we will take in private.

12:50

Meeting continued in private until 12:56.

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Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178