AUDIT COMMITTEE

Tuesday 27 April 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
† 9th 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)
Barbara Hurst (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

Dr Peter Collings (Scottish Executive Health Department)
Caroline Gardner (Audit Scotland)
Mr Trevor Jones (Scottish Executive Health Department and NHS Scotland)
Mr Alastair MacNish (Accounts Commission)
Bill Magee (Audit Scotland)
Mrs Sarah Melling (Scottish Executive Health Department)
Mr Mike Palmer (Scottish Executive Health Department)
David Pia (Audit Scotland)
Mr Gordon Smail (Audit Scotland)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Christine Lambourne

LOCATION

Committee Room 2

† 7th and 8th Meetings 2004, Session 2—held in private.

Scottish Parliament

Audit Committee

Tuesday 27 April 2004

(*Morning*)

[THE DEPUTY CONVENER *opened the meeting in private at 09:11*]

09:26

Meeting suspended until 09:32 and continued in public thereafter.

Items in Private

The Deputy Convener (Mr Kenny MacAskill): Good morning. I welcome everybody to the public part of this meeting of the Audit Committee. I do not know whether all members of the public and press have entered, but I make the usual announcement about ensuring that mobile phones and pagers are switched off. We have apologies from George Lyon, who has a constituency meeting in Argyll, and from the convener, who is in transit. Because of the vagaries of the rail network, which also caused difficulties for another member, the convener is currently somewhere just across the border, but he is en route. I will convene the meeting until his arrival.

Agenda item 2 is to consider whether to take items 7 and 8 in private. Item 7 is consideration of the second draft of the committee's report on the Auditor General's report on the Scottish Enterprise network. Item 8 is consideration of the second draft of the committee's annual report. Do members agree to take items 7 and 8 in private?

Members *indicated agreement*.

"Supporting prescribing in general practice"

09:33

The Deputy Convener: The next item is on the response to our report on the Audit Scotland report "Supporting prescribing in general practice—a progress report". I invite members' comments.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): I read several times with interest the Health Department's response to our report on the Auditor General's report. The response contains much interesting information, but I have two primary concerns about it. First, I find it somewhat impenetrable, despite being familiar with much of the jargon and with the acronyms. I cannot work out whether it was by accident or by design that the response was blinding us with the science of the various activities, strategies, steering groups and the like that are in place. I do not believe that any of us question that an awful lot of activity and processes are going on around prescribing practice. Such work might well be bearing fruit, but I find it impossible to establish from the response whether that is the case. That remains the committee's key question on the issue.

I also cannot work out from the Executive's response how many patients in Scotland—the response uses the word patient sparingly—get access to repeat prescriptions through means other than the traditional visit to a general practitioner, and how many patients have systematic medicine reviews; nor can I work out what proportion of hospitals now have good linkages with primary care in terms of admission, discharge and exchange of information about medicines and so on. I cannot find such information in the response. I want to know much more about the impact that all the current activity—laudable though it may be—and planned activity is having and will have on the five million Scots who use the health service.

Secondly, I found it difficult to find anywhere in the response what the Executive's investment strategy is to ensure that its pilot initiatives will be rolled out. Paragraph 24 of the response states that systems would be developed nationally,

"taking account of affordability and relative priority for the use of resources."

That is not an unreasonable statement, but it is a pretty big one to make.

I could say more, because my highlighter pen went through much of the response. However, my

two essential questions are: what impact is all the pilot activity having on patients and what is the investment strategy to support national implementation?

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Annex A to the Health Department's e-pharmacy update letter gives the impression that the electronic transmission of prescriptions is being rolled out across Ayrshire and Arran, but that is certainly not the case. I was in a pharmacy yesterday that was using the original script. The ETP initiative has not been rolled out across the Ayrshire and Arran NHS Board area; if it is anywhere, it is still only in the pilot sites. I get the feeling that the Executive's response is just a lot of words without substance and I am unhappy about that. Susan Deacon is right to say that the response uses acronyms and all the rest of it but does not tell us what the patient gain is.

Rhona Brankin (Midlothian) (Lab): I looked in particular at complementary therapies and alternative approaches and their effectiveness and value for money. However, I am extremely disappointed by the Executive's response to those areas. There seems to be no thinking around comparing the different approaches.

Robin Harper (Lothians) (Green): I echo Rhona Brankin's concern about that. Much work has been done in complementary therapies and we should be pursuing that. It is clear from the experience of parts of the health service that such therapies have much to offer.

The Deputy Convener: Does the Auditor General have any comments?

Mr Robert Black (Auditor General for Scotland): We do not have much to say at this point. Perhaps Barbara Hurst can offer a thought or two about what the Executive's response says about the significant issue of risk strategy.

Barbara Hurst (Audit Scotland): In the detailed Health Department response—which contains, as Susan Deacon said, much information—the key issue for us was the risk assessment for the general medical services contract in the quality framework. We assure the committee that we regard the GMS contract as a risk and that we will deal with it as such in our audit process. We will bring back information on that. We want to ensure that the committee feels that we are addressing that key concern.

The Deputy Convener: I presume that we should seek clarification from the Executive. There are four points. The first two, on input into practice and the investment strategy to support that, were made by Susan Deacon. The third point is where the roll-out has reached and what the time scales are. The fourth point, which was raised by Rhona Brankin and Robin Harper, was where we stand with complementary medicines and how they are factored in.

Rhona Brankin: It would be useful to get specific information. The Executive's response states that

"Homeopathy is available on the NHS",

but I am not aware of it being available on the NHS throughout Scotland. It would be useful to get clarification on that point.

The Deputy Convener: That is a valid suggestion. The clerks are fine with those actions.

Susan Deacon: I have a similar footnote. Can we ask the Executive to double check some of the statements that it has made and the assurances that it has given in the response? I know that this is not about prescribing per se—I have just spotted the caveat—but page 1 of the response states:

"All computerised GP practices have … access to laboratory results electronically."

The e-health strategy that has just been published states specifically that computerisation coverage currently is only 50 per cent. I am not saying that that statement is designed to mislead, but I found it slightly misleading and contradictory. It goes back to the question, "Can you just tell us in simple terms what the degree of coverage is now, and what you expect it to be next year and five years from now?" It would be useful to get clarification on that statement.

Similarly, statements have been made south of the border about specific targets and the progress that has been made on, for example, repeat dispensing schemes—which it is said will be nationwide by the end of this year—the coverage of medicines management schemes and pharmacist prescribing. I would be interested to know in simple terms what progress has been made on those tangible and important areas.

The Deputy Convener: We will write to the Executive, thanking it for its response and asking it in a short but pointed letter to address the points that have been made, including the final matter raised by Susan Deacon about greater clarification.

Accounts Commission

09:42

The Deputy Convener: That takes us to item 4. We are slightly ahead of schedule. I welcome Alastair MacNish, the chairman of the Accounts Commission; Caroline Gardner, the deputy auditor general; David Pia, the director of performance audit at Audit Scotland; and Gordon Smail, senior manager at Audit Scotland. I should explain to the witnesses that I am standing in for the convener, who is in transit, having been delayed by the vagaries of the railway network.

I advise members that the Accounts Commission witnesses are likely to refer to their recent report "Overview of the 2002/03 local authority audits". It is important that we bear in mind the fact that that report is not laid by the Auditor General for Scotland and that therefore it is not within our remit to report on it. Accordingly, questions should be general, rather than specific.

I ask the witnesses to introduce themselves, outline their areas of responsibility and make any introductory statements that they wish to make.

09:45

Mr Alastair MacNish (Accounts Commission): I am the chairman of the Accounts Commission and Audit Scotland. As the chairman of the Accounts Commission, I am responsible for taking an overview of the performance of local government in Scotland. I will say more about that in a minute or two.

Caroline Gardner (Audit Scotland): I am the deputy auditor general. I am responsible for all our stakeholder reporting on behalf of both the Accounts Commission and the Auditor General.

Mr Gordon Smail (Audit Scotland): I am a senior manager in Audit Scotland. I am responsible for local government audit and put together the report that we are going to talk about.

David Pia (Audit Scotland): I am director of performance audit. I am responsible for leading the work on the local government sector in Audit Scotland.

Bill Magee (Audit Scotland): I am the secretary to the Accounts Commission.

Mr MacNish: I thank the committee for giving us the opportunity to share some of the issues arising from the local government overview report for the year ending 31 March 2003. I will briefly outline the role of the Accounts Commission and its responsibilities.

There are 12 commissioners appointed for a three-year period by ministers on a rolling programme. We are responsible for holding councils to account for financial and service performance. The Accounts Commission secures the audit of the 32 councils in Scotland and the 34 joint boards by appointing external auditors from both Audit Scotland and the private sector. In addition, performance studies of specific services are undertaken, some of which are commissioned jointly by the Accounts Commission and the Auditor General—for example, the recent youth justice report. A new responsibility for us this year—we discussed this last week—is the examination of best value in each council over a three-year cycle. That work will become increasingly important over the coming year. Currently, some 76 statutory performance indicators of council services are published each year. An example of such an indicator is the council tax collection level.

All that work culminates in an annual overview report by the controller of audit. The annual overview report for the year to 31 March, which was published earlier this year, included some of these main messages. First, on the positive side, councils' financial controls are improving year on year and, for the first time since reorganisation in 1996, there are no audit qualifications on any of the accounts. Secondly, council tax collection rates are at their highest level, in real terms, since 1997. Thirdly, home care of the elderly in the evening, at weekends and overnight has increased significantly over the past two years. Fourthly, the proportion of waste that is recycled rose to 9.6 per cent in the year to March 2003, although that is still considerably short of the Scottish Executive's target of 25 per cent by 2006.

On the flipside, first, the proportion of people who are borrowing from libraries fell for the fifth year running. Only 24 per cent of the adult population borrow from libraries now. Secondly, the Accounts Commission is concerned that corporate governance—particularly audit and scrutiny—is far from independent in many councils. Thirdly, as the committee knows, financial monitoring by elected members requires timely and relevant service information to inform sound judgment; however, that still requires attention in several councils. Fourthly, there has been a reduction in the value of assets in the local authority pension scheme. Although that is consistent with all other pension schemes, it is nonetheless worrying. The overview report states the reduction in the value of assets in the year to March 2003. Lastly, reference has been made in the press recently to the levels of reserves that are being retained by councils. The Accounts Commission is quite clear that it is the responsibility of each council to be prudent in

deciding those levels. However, we urge councils to take such decisions with appropriate openness and transparency, so that the reasons for such balances are understood widely within their areas.

My colleagues and I will be happy to take any questions that committee members wish to ask.

The Deputy Convener: You mentioned that there has been a reduction in the number of adults using libraries to 24 per cent. Has that been offset by the extension of library provision from books alone to computers and the internet? Is there any perception that the statistical decline is being addressed by libraries' attempts to broaden service provision?

Mr MacNish: There has most certainly been a reduction. Even taking into account the change in usage, there has been a clear downward trend over a period. The level of funding that the councils give to the library service is important in terms of maintaining a balance. However, there will be a transfer across. I ask David Pia whether we have any information on that.

David Pia: The figures quoted refer only to the borrowing of books. The performance indicator covers that aspect of library services; it does not cover the other aspects that Mr MacAskill mentioned.

The Deputy Convener: Are there performance indicators that cover those aspects? Given the direction in which libraries are going, we should perhaps change the indicators.

David Pia: The performance indicators that we use are kept under constant review. We discuss with the relevant stakeholders which are the most appropriate indicators to measure the various services that councils are providing. The issue that you mention is being discussed with them at the moment. You will appreciate that there are obvious difficulties in finding a good, simple, numerical measure for the services that you mentioned.

Rhona Brankin: I declare an interest, in that I am the chair of the Scottish Library and Information Council.

I was particularly interested in Kenny MacAskill's question. I have seen figures that suggest that new people are starting to use libraries as a result of the national grid for learning. Given the Executive's policies on lifelong learning and the important role that libraries have to play in that, I would be interested to see some performance indicators in that regard.

Mr MacNish: As you know, that has been a trend for the past five years. In the past two years, we have highlighted that trend in the overview report. The Accounts Commission and Audit Scotland will examine that aspect closely, as it is important. If the balance has changed for good reason, that is fine, but it would be worrying if use of one service increased while the use of another—the borrowing of library books—dropped dramatically. That will be part of our examination in the coming year.

Rhona Brankin: Is there overall information about spending on new books? Do we have a Scotland-wide picture of that?

David Pia: We do not collect data on spending on new books. We are trying to develop indicators that tell us something about performance—what one gets for the money that one spends, rather than how much money is spent.

Every year, when we get to the stage of proposing the indicators that will be used in the next year, we go through a stage of public consultation. Of course, councils and other interest groups are consulted on the indicators. That provides an opportunity for people, including MSPs and councillors, to come back to us with comments on changes to the indicators that they think would be worth making.

Rhona Brankin: With regard to making an evaluation of value for money, would you take into consideration factors such as the quality of the library stock?

Mr MacNish: Such factors will play a significant role in the best-value audit. When we examine individual councils, we will be able to compare the levels of spending and whether there has been reinvestment in the library service. That will be much easier under the best-value regime. In future, we will be in a far better position to give you definitive answers on each council area.

Margaret Jamieson: It is on the best-value aspect that the interesting work will take place in the next three years. We accept that the number of books lent by libraries has decreased over the years but we have never examined the ways in which the service has developed to ensure that it is as up to date as possible. I am well aware that a significant number of young people get compact discs, tapes and DVDs from libraries, and those items are significant investments for young people. They are not all about leisure, as a number of them aid young people's education. We must consider the matter in the round. It would be crazy for libraries to stock up with every single brand new book if no one went to libraries to borrow them. On the other hand, it appears from some of the data that there is a growth industry that has not been captured. How will that be reported in the best-value audit, given that each council will do the work differently?

Caroline Gardner: In the best-value audit, we are looking for evidence that a council has decided for itself what it wants its library service, or any

other service, to achieve. It would be quite reasonable for a council to say that it wants to hold spending on books steady but to invest in access to information technology or different formats of information, as long as such investment is based on discussion with local people about what they want from their library service and the council is clear about how it will measure that it is delivering what people want in practice. The Accounts Commission can also use the evidence that comes from the best-value audits of individual councils to say that there appears to be a common problem with library services, refuse collection or any other service and ask Audit Scotland to do a study on that service throughout all 32 councils. The two bits of work feed off each other, and that will happen increasingly.

Margaret Jamieson: So there will be a link to the best-value audits, and we have your assurance that further work will be undertaken in an area if there is a pattern throughout Scotland.

Mr MacNish: That is the great advantage of the overview report—it is not about specific councils but is a general report on trends in Scotland. That is why it is possible to pick out key messages each year, which is a huge advantage to any group that is examining specific areas. The best-value audit will strengthen the overview report.

Susan Deacon: I will pick up on something that Caroline Gardner said. A common and important theme both to Audit Scotland and to the committee is that you are looking to see that the authority is acting appropriately—I am paraphrasing badly—and operating within its policy. I will tease out a little further the distinction between policy and the audit process and, by way of illustration, I will take a different area: education.

There has been, and no doubt there will continue to be, debates throughout the country on schools provision, the number of schools, patterns of provision, class sizes and so on. Will you talk a little about what the Accounts Commission is looking for from education authorities in that area? In particular, something that is often cited is the Accounts Commission guidance on occupancy rates and the ways in which local authorities can meet your organisation's requirements while having flexibility to develop education policy that meets the needs of the local area.

10:00

Mr MacNish: The single most important issue is the need for councils to have a clear policy. That sounds simple, but it is important for a council's education policy to be clear and transparent. At council level, audit and scrutiny play an important and invaluable role in relation to occupancy levels and so on; unless audit and scrutiny are robust, we fall between two stools. It is very important that that audit and scrutiny take place and the overview report expresses concern about the levels of audit and scrutiny in some council areas and the information that is available to council audit committees.

It will be for councils to decide occupancy levels and we will continue to highlight where they are dropping. It is important to understand that best value does not always come from the cheapest option; it is about getting the best value for the community that one serves from the service that one provides. Policy should tie into that, but the Accounts Commission, through Audit Scotland, has a duty to identify trends and to ask local authorities why they have taken specific routes and what their views are of prudence and the future. As long as policy is clear, local authorities, as democratically elected bodies, can justify it to their electorates.

The Deputy Convener: Considering local authorities in Scotland from a national perspective, there are areas of conflict between them and there are also areas in which they try to co-operate by sharing services. Conflict could come from transport and planning matters, for example. Is there a need for any legislative or structural change to allow local authorities to co-operate more when it would be in their shared interests to make savings in common services, or should there be a change that would allow a brokering of agreements when actions that clearly impinge on a neighbouring authority are taken without overall arbitration, such as in transport and planning matters?

Mr MacNish: We do not need to change the legislation. Community planning is vital for the future in terms of overlap and working at council or agency level. That work will continue.

We are developing indicators for community planning to make sure that, as stated in the Local Government in Scotland Act 2003, local authorities play a major role in community planning with their colleague councils and with the other agencies that they serve. I do not suggest that we have to have major change at the moment, but we should never say never to anything. Time moves on and things change.

At the moment, councils are working a lot closer together than they were in the past. For them to function and make the best use of scarce resources, they have to do so, particularly in smaller areas of service provision. Unless councils maximise that closer working across boundaries, they will not get the best out of it.

That is part of what the Accounts Commission will consider when it examines local authorities' community planning responsibilities. The Auditor

General will pick up on health and all the other agencies that lie outwith the Accounts Commission's remit.

Rhona Brankin: How is the public consulted on best value in local authority services?

Caroline Gardner: The Accounts Commission spent a lot of time considering that issue as the new responsibilities were coming in. On the one hand, community engagement is central to best value. We have to ask what local people want from services, how services can best be delivered and whether best value is working in practice. On the other hand, councils have to do that work and the Accounts Commission was wary of stepping on the legitimate responsibilities of councils.

In relation to the new audit process, the Accounts Commission has decided to focus on looking for evidence that a council is engaging properly by talking to a range of local people, and that it can demonstrate the way in which those views are being translated into service provision and development. If there is no evidence on which we can rely of that happening in practice, the Accounts Commission reserves the right to go in and do some of that work directly. However, that is a last resort; the main focus will be on how well a council engages with local people and turns that engagement into developing and delivering services.

Mr MacNish: The main reason for that is because resources are scarce and we have to be careful. Going into a council would be a last resort, so we hope that councils will be able to show clearly that they have carried out those consultations.

Susan Deacon: I will ask about contracts under the public finance initiative and public-private partnerships, which are of growing significance to many local authorities. The overview report says that the current value of such contracts in school projects is £2.5 billion. Given the growing amount of activity in that area, will you give us an indication of the role that the Accounts Commission is taking in, for example, monitoring how practice is developing, learning lessons when they need to be learned and sharing such experiences?

Mr MacNish: As you know, we carried out a fairly full review of the first 12 PFI/PPP projects in the education service in Scotland, which was highly publicised at the time. I think that that was about 18 months ago.

Caroline Gardner: It was two years ago.

Mr MacNish: We are now following that with a further study, which will examine how our recommendations have been implemented; it will also examine the additional PPP contracts that have now been signed. We cannot go any further than we have gone today, but PFI/PPP contracts are a major issue for the Accounts Commission, and we will report back, in public, as soon as we have carried out the review.

Rhona Brankin: On education issues, how does the Accounts Commission have regard to Executive policies when developing its performance indicators? For example, does it take into account the Executive policy on sustainable rural development when developing its PIs for local authorities?

Mr MacNish: As Caroline Gardner said earlier, the statutory PIs are developed in consultation with local authorities and other inspectorates, so any indicators or policy on sustainable development from the Scottish Executive or the Parliament would be considered in that context. If we felt that we were able to produce a PI that was robust, we would discuss it with local authorities. Our discussions with them to try to agree PIs tend to go on at length. There is a danger that we might suddenly have 250 PIs, so if we add a new PI, we try to remove one. Otherwise, the administrative base becomes claustrophobic and a blockage is created.

Caroline Gardner: We have a range of criteria for our PIs, such as that a PI should be clear whether a change in performance is good or bad and that PIs should be based directly on information that councils need to manage their services and on national standards rather than local standards so that comparisons can be made between different council areas. I do not think that we have a PI on sustainable rural development at the moment, but if we did, we would tap into the national standards. David Pia might want to add something to that broad description.

David Pia: I will add only the general point about PIs that they are indicators, not measures, of something. They must be seen in context and, often, understood in relation to other indicators. I know of Rhona Brankin's interest in sustainability and rural schools. The statutory PIs produce data on school occupancy levels and we draw attention to drops in occupancy levels, but we do not suggest that that means that such schools are inefficient or should not be retained. There is no such implication, and we recognise that councils may have to take into account wider considerations when they make decisions.

Rhona Brankin: Sustainability is obviously important to Executive policies, so how is the broader concept of sustainability woven into the PIs?

Mr MacNish: I believe that councils take the issue very seriously. It is one that they consider and on which they try to come up with a clear

policy. However, there will always be grey areas in the middle, for which we need to develop indicators—as far as we can—to help to judge how a council is achieving. That is not easy to do. We need to work at it, which we will continue to do. There is no yes or no answer to the question.

I make no apology for returning to the subject of best value. As we continue to go down the best-value audit route, which is an unbelievably significant change to the role that Audit Scotland and the Accounts Commission play, we will be able to give out far more information and best practice across Scotland. That will be of benefit to the whole of the Scottish community.

Robin Harper: If I may, I will comment on that point before I ask my question. There are plenty of examples of good practice on sustainability and even more examples of good theory on the subject. It is a matter of urgency for councils to get involved in the issue to an even greater extent that they are at the moment.

My question arises from the figure that you gave on recycling. If councils are to meet the Government target, they will have to achieve somewhere between double and treble their recycling rate within two years. Clearly, that is not going to be possible, although I would love to think that it would be. Councils will have to work very hard at it. The Executive has made at least £50 million available, but I do not know at what rate it is being taken up and spent. Is the commission tracking best value on the money? Is it tracking how the money is being spent and what the results are from the tranche of money that is available to councils?

Mr MacNish: First and foremost, councils have a considerable way to go to get anywhere near the target of 25 per cent by 2006. I believe, as does the Accounts Commission, that a significant additional injection of capital funding is needed if councils are to get close to the figure. Considerable money has been allocated and councils are now progressing with their usage of the allocation. We are currently in discussions about a study of that area, for which we will come up with the parameters shortly.

The commission does not believe that the 25 per cent can be achieved without significant extra generation of expenditure. That is a statement of fact. The evidence shows that councils are treating the issue very seriously. They are trying very hard to improve their recycling levels, but sometimes they do not get the credit for doing so.

Robin Harper: I did not mean to suggest for a minute that £50 million is a lot of money. It is less that £2 million per council and yet they have to achieve a huge target. You are quite right in the observations that you have just made.

Margaret Jamieson: I want to pick up on the fact that the money that was allocated was ring fenced. A significant amount of money is ring fenced year on year for specific projects. How will you ensure that you can track the money from the Scottish Executive through the council to service delivery? How will you measure the best value of the spend for communities in each council area and for the Scottish Executive?

Mr MacNish: Ring fencing is a big question. Different views on the benefits and disadvantages of ring fencing would be expressed across the Scottish local authority community. Tracking the spend from the Executive to council level is something that we can do with reasonable confidence. Our external auditors are well aware of the issue and are conscious of the amount of money involved. Over the past five to 10 years, significantly more money has been ring fenced, particularly in education and the like. The external auditors track it down and report back on it in their report on the accounts of the council. I am confident that we do that. I hope that some of the best-value techniques will bring out the smaller levels of spend, but some of it will not be apparent. We are talking about a 20-week best-value audit, so there will be areas on which we have to make a risk management judgment.

Sometimes issues about which one feels strongly will not be part of the audit in that year. We will revisit each council every three years. At the end of that period, any improvement plans or issues on which action was required will be checked. The best-value audit process is some comfort, but ring fencing is still a big issue.

10:15

Rhona Brankin: I am interested to hear what the Accounts Commission does. That fact that it publishes information is interesting in itself. However, I would like to know what happens when councils spend above their allocation in a particular year. I am thinking of grant-aided expenditure for social work. The Education Committee has considered child protection issues and has become aware that councils often spend above GAE in a policy area.

Mr MacNish: For 10 seconds, I will wear a different hat. In my previous life in local government, I found that different departments fought religiously for their GAE if they were spending under it and did not say a word if they were spending over it. Putting my Accounts Commission hat on, I reiterate that this is a policy matter for councils. The important point for audit and scrutiny is that spending is identified and transparent and can be challenged. We are pleading with all local authorities to ensure that corporate governance is robust, clear and useful

for determining future service provision in each council area.

The Deputy Convener: I thank Mr MacNish and his colleagues for their attendance, evidence and fortitude in answering our questions.

We are slightly ahead of schedule and the next set of witnesses has just arrived in the building. I suggest that we suspend the meeting for 10 minutes to allow witnesses to come and go.

Susan Deacon: We have been constrained in raising issues with the Accounts Commission, on the assumption that the agenda was tight and we needed to move on. If we have 10 minutes in hand, there are issues that we could usefully pursue with the witnesses who are here.

The Deputy Convener: Having discharged the witnesses, I am reluctant to recall them.

Mr MacNish: That is very good of you.

Susan Deacon: We have been very gentle.

The Deputy Convener: We are in some difficulty because we are awaiting our convener, who is in transit. A suspension might have provided the convener and deputy convener with an opportunity to change places. However, if members still have questions to put to Mr MacNish and his colleagues, they should do so. We are not constrained by time. My suggestion was simply a courtesy to the next set of witnesses and might have allowed for some clerking musical chairs. Members should indicate as soon as possible whether they have questions. If not, I will let Mr MacNish go.

Rhona Brankin: I would like to ask about the way in which the Accounts Commission works with other bodies such as Her Majesty's Inspectorate of Education and the care commission that deal with quality assurance issues in local government. That is an increasingly important issue.

Mr MacNish: To date, one of the major successes of the Accounts Commission and Audit Scotland has been the way in which they have worked together with other agencies such as HMIE. We are now working more closely with Communities Scotland and work closely with the Auditor General on health and so on. We are also now working more closely with social care agencies. The relationship has worked well to date. Under best value, it is important that we do not duplicate effort and that we use the best practice and information that we get from other agencies. To date, there has been no conflict about our role. Conflict may come—that is one advantage of the commission's being totally independent. If we were not happy with the level of co-operation between agencies and the commission or if an agency such as HMIE were in conflict with us, as an independent body we would have the right to make our reports. Co-operation makes our lives an awful lot easier, because it allows us to produce succinct reports on time.

Caroline Gardner: We think that we have a good understanding with all the inspectorate and scrutiny bodies about how our roles fit together: they are complementary, but they are not the same. For example, HMIE examines the quality of teaching in ways that we could not—and should not—duplicate, because we do not have the skills to do so. The inspectorate might inspect professional development aspects of education authorities while we might examine elements such as financial management to ensure that there is a single, joined-up approach to the inspection.

All those different professional scrutiny streams are pulled together in the best-value audit in which the council can be examined as a corporate organisation to find out whether its education department is doing more than simply providing schools. For example, how is it approaching issues such as the well-being of young people or how community schools link to community planning and social inclusion? The ways in which we and the inspectorate work depend on our very specific sets of skills and experience and form a powerful means of considering the council's overall organisation.

Mr MacNish: Joint working is also useful in planning the best-value audit for each council area. For example, if HMIE had produced a report on a council three years ago, it would not make much sense for us to carry out the best-value audit now. We try to marry the two aspects, because such joint working eases the flow of information.

Rhona Brankin: I presume that you regard it as important that councils do not feel that a massive number of people are descending on it to examine its approaches to best value, quality assurance and so on; that they see that the process very much goes two ways; and that they feel engaged and do not find the audit to be too much of a burden.

Mr MacNish: It might seem strange, but we broke new ground last summer by meeting all the council leaders and chief executives at four venues to explain how we would carry out best-value audits for each council area. It was important that the audit did not become another paper mountain and that the councils were able to give us succinct evidence of what they were doing in their council area without creating any further bureaucracy. The commission is aware of the danger of duplication. Indeed, one can reach a point at which officers cannot deliver services because they are constantly filling in forms. We are trying hard to avoid such a situation in every area. All the same, we require certain information to carry out external audit work.

We keep talking about best-value audits, but the overview report does not make it particularly clear that the statutory audit is paramount to the well-being of a council area. We must never forget that.

Susan Deacon: I am reassured by the fact that some of your comments have pre-empted my next question and, in particular, that you understand the importance of not creating another paper mountain. Scottish local government and the public sector in general are enormously concerned about the sheer volume of audit, inspection, regulation and so on that is taking place. I am pleased that, without being provoked, you made it clear that local authority officials should not be diverted from providing services in order to carry out audit work.

Given your many assurances that the Accounts Commission and Audit Scotland are mindful of the need to avoid such a situation, do you wish to stray into the terrain of suggesting what the Parliament might do to ensure that the monitoring and inspection process is as efficient as possible and adds value to delivering and improving public services in Scotland? In particular, I wonder whether you would like to add anything to your previous comments about the range of bodies that exists. Although I am pleased that you and those bodies have a good relationship, managing it must take a lot of time. Can that approach be simplified?

Mr MacNish: I do not think that it would be of any great advantage to the committee if I were to stray into an area that is not our responsibility. We work very well with those agencies with which we work. It would be folly for me to say that I would like many more agencies to be created, as we can cope with only a certain number. However, speaking from practice, what I have experienced in my two and a half years as chairman of the Accounts Commission is a good and fruitful relationship with the agencies, which has been constructive at all times. I promise you that, if it was not constructive, we would be the first to cry foul. We are not here to pay lip service to what I and the commission passionately believe is the quality of service that local government delivers to communities across Scotland.

We will not demur from that, whether that makes us popular or unpopular with any agency or group, whether the Parliament or the local authorities. If we do not stick to that moral high ground, we are not doing the job that we have been set to do. As long as we are here, we will continue to do it. That sounds pious, but I genuinely mean it.

Susan Deacon: On the theme of managing relationships and boundaries, an increasingly important relationship for local government is its relationship with the health service. We are all aware that many issues arise both nationally and locally from the lack of coterminosity between the two. I do not think that any of us would want to wade into suggestions of redrawing the map or undertaking big structural reforms for the sake of it, but do you have any comments on how that relationship can grow and develop with the maximum amount of time spent in delivering effective joint working and joint services and the minimum amount of time spent in managing all the different relationships with different authorities—which, in some cases, can involve as many as five or six local authorities within one health board area?

Mr MacNish: The community planning legislation will help in a statutory sense, as health boards and local authorities now have a statutory duty to work together. The Accounts Commission's joint working with the Auditor General is vital in that context and has been especially useful in relation to youth justice, special educational needs children and so on. As time moves on, because we are measuring the best value per council, more and more of our performance-specific work will be done jointly with the Auditor General. It is already clear from our forward work programme for next year that joined-up working will be of most benefit to our reporting.

On the relationship between health boards and the local authorities, the community planning agenda has to move forward. It is moving forward a lot quicker in some areas than it is in other areas. The local authorities need to push to make it move more quickly and effectively, and the Auditor General has exactly the same role and the same principle to follow.

The Deputy Convener: As there are no more questions, I thank Mr MacNish and his colleagues not only for giving evidence twice, but for entertaining us last week. I suspend the meeting for five minutes to allow our witnesses to come and go and to allow members to take a comfort break or replenish their coffee.

10:28

Meeting suspended.

10:37

On resuming—

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

The Deputy Convener: The next item on the agenda is the third evidence session in our examination of the Auditor General's report, "Overview of the National Health Service in Scotland 2002/03". In previous weeks, we have taken evidence from representatives of NHS Lothian, NHS Ayrshire and Arran and NHS Borders on the financial and other pressures that are facing the NHS throughout Scotland. Today it is the turn of representatives of the Scottish Executive Health Department to give their perspective. We shall ask questions on three main areas: financial and service planning; the benefits of trust integration; and performance management and accountability in the new NHS organisational structure. I welcome the witnesses to the Audit Committee and ask them to introduce themselves and outline their areas of responsibility.

Mr Trevor Jones (Scottish Executive Health Department and NHS Scotland): I am head of the Health Department and the chief executive of NHS Scotland.

Mr Mike Palmer (Scottish Executive Health Department): I am head of the work force and policy division in the human resources directorate of the SEHD.

Dr Peter Collings (Scottish Executive Health Department): I am the director of performance management and finance in the Health Department.

Mrs Sarah Melling (Scottish Executive Health Department): I am head of the financial performance and accounting division within the finance directorate.

The Deputy Convener: Mr Jones, do you have an opening statement?

Mr Jones: Yes—a brief one.

I am pleased that the Auditor General has again recognised that, overall, financial management in the NHS continues to be of a good standard and that there were no qualifications to the true and fair opinions that were provided by auditors in any of the 54 NHS organisations in 2002-03. The auditors found that the key financial systems are of a good standard and that most organisations' budgeting and planning operated satisfactorily and soundly.

Good progress is being made in developing corporate governance. As part of that, most boards found that the performance assessment framework provides a useful tool to develop performance. That was positive from our perspective.

I was pleased to note that 12 of the 15 NHS boards were in surplus at the end of 2002-03, and that NHS organisations overall had a net surplus of £14 million. However, we are not complacent about the NHS's financial position. We recognise the pressures that the NHS faces from a number of factors. Changing demography means that there will be more older people in the community, which increases pressure on the NHS. New treatments continue to be available to the NHS, which increases pressure on the finances. We are driving up the standards of care that are provided nationally, which adds to the service delivery agenda. At the same time, the labour market in Scotland is shrinking, so we need to ensure that NHS Scotland is able to recruit the best staff to deliver care, which adds cost pressures.

From that, it is clear that the status quo is not an option when it comes to health care delivery. We need to see fundamental change in how health services are delivered, which will put pressure on health budgets. It is our task in the Health Department, and my task as chief executive of the NHS in Scotland, to work with the service to ensure that we manage those pressures co-operatively across the whole system.

The Deputy Convener: Thank you. As a matter of courtesy, perhaps I should have explained why I, rather than my colleague Brian Monteith, am convening the meeting. We are awaiting his arrival because his train is late. My colleagues and I are making our best endeavours to keep matters going while the convener is still in transit.

We have heard about the financial difficulties that some boards face. What assistance do you provide to boards that are managing financial challenges? Under what circumstances do you request boards to prepare financial recovery plans? How do you monitor the boards that have the greatest financial difficulties?

Mr Jones: I will begin the answer, but it might be useful if Sarah Melling, who manages the performance of NHS organisations, takes us through the process that we call escalating intervention. That will provide detail on how the monitoring process works.

The planning system starts with the allocations that the department makes to NHS boards. We give boards an indication of their likely income over the spending review period, so they have an indication of future resources. The boards get firm allocations for the year into which they are going, which are based on an assessment of health care need. We do not fund specific issues; we give a

general allocation, which takes into account the age and sex make-up of the population, rurality and deprivation.

The allocations that are going to health boards—I speak as a former chief executive in the service—are probably much higher than any of us would have expected five or six years ago. Significant investment is going into the NHS based on the health needs formula. It is for NHS boards to assess the likely financial pressures that they will face locally, and to use their general allocation to best effect. They need to use that allocation first to meet financial pressures, such as inflationary pressures and the cost of pay awards, and then to think about how to develop services. We do not expect the boards, in doing that, to concentrate simply on the increasing resources that they get every year. We expect them to examine their total budget and think about how they can improve services, and to make non-clinical services more efficient to release cash for reinvestment in clinical services. Financial planning should be about the whole budget, not simply the marginal increase that a board receives every year.

The Health Department has a detailed performance management function, which examines everything that an NHS board does, not just its financial targets. In the days of the internal market, performance management tended to focus on financial performance. We now examine the whole performance of a health board. If there are financial issues—which is what you want us to concentrate on—and if we have concerns about financial management, we have a process of escalating intervention, which means that the more significant the potential financial problem, the more intervention there will be from the centre. Sarah Melling will take us through the steps of the escalating intervention process.

10:45

Mrs Melling: As Trevor Jones has said, all boards produce a financial plan at the beginning of the financial year, usually covering a five-year period. We monitor on a monthly basis all boards and their performance against the plan. However, there is a process of interventions if boards start to deviate from their plan or show significant financial difficulties.

We meet boards on a regular basis, but if a board starts to show variance from its target of greater than 10 per cent and no meeting has been arranged, we will initiate a meeting to discuss with the board the reasons for the problem and how the board intends to address it. We will then await the next month's monitoring to see whether the situation has improved. If it has not, the next meeting may involve not just me, but Dr Peter Collings. Again, the board will be asked how it is addressing the problem and how its plans have been adjusted to do that. We will also involve performance management colleagues. Although the pressure is manifesting itself as a financial issue, there may also be operational issues that need to be addressed.

If, after a period of three to four months, the problem has not been solved, we will ask the board to produce a financial recovery plan and give it time to do that. We will then assess the recovery plan. If we do not believe that it is appropriate, we will send in an independent team to help the board to address its problems. The board will then be given an opportunity to show that the recovery plan is working. We will monitor that and meet the board regularly.

The Deputy Convener: We have taken evidence and both general and specific matters have been raised. What do you assess the total cost to be of the new consultant contract, the new GMS contract, agenda for change and the new deal for junior doctors, and how do you propose to fund it? Borders NHS Board indicated that it was having particular difficulty in providing out-of-hours GP services. How will you address that problem? How will you address and factor in the difficulties that Borders NHS Board and, presumably, other boards are facing because of the late agreement of various national deals?

Mr Jones: I reiterate what I said—we do not fund specific issues. We do not retain all the development funds for the NHS at the centre and issue them as pay agreements are settled nationally or as inflationary pressures hit the service. I have had discussions with all the boards about how we should manage finances in the NHS. There is a strong view across the NHS that it is better for cash to be allocated to the system earlier and for boards to be allowed to manage pressures locally than for the Health Department to retain large central reserves and to dish out money as bids are received at the centre. That would be a very bureaucratic process that would not allow creativity locally and would not encourage boards to manage problems at local level.

We will not issue cash specifically to cover the total cost of the consultant contract, the GMS contract and so on. My colleagues will be able to give members figures for the cost of those contracts.

Dr Collings: The main concern about the consultant contract has been about its impact on budgets for 2003-04. That is not yet firm, because the cost depends on the outcome of discussions between individual consultants and their line managers and job plans for each of the consultants in NHS Scotland. At present, we

estimate that it will amount to 21 per cent of the pay bill for consultants—£55 million.

The GMS contract was part of an overall three-year package that is not funded out of the general allocation to boards but is subject to ring-fenced funding. At present, it appears that the whole cost can be met from within the moneys that are allocated to primary care. With one exception—the out-of-hours service—there will not be pressure on general allocations. When GPs opt out of providing an out-of-hours service, an alternative service must be provided, which looks as if it will be a significant cost pressure on boards. However, that will hit mainly in the next financial year, rather than this one, as the new service will start towards the end of 2004, at different dates for different boards. It will have an effect for only part of this year but will be a significant factor next year.

Mike Palmer is the expert on progress with agenda for change. Pilots are being conducted and much work is still being undertaken on what the deal will be.

Mr Palmer: Under agenda for change, we are evaluating pilot sites. Four pilot sites in Scotland are dry running elements of agenda for change. In England, several early implementation sites are piloting comprehensively the whole agenda for change package. We are beginning to receive feedback through management data from the early implementation and pilot sites, which will be fed into a review that we will have with the trade unions. That is kicking off and will continue into the summer. It is a bit early to say what the package will look like, because it will be subject to that review. After that, Unison and Amicus will hold further ballots of their members. The deal is still a little way down the track.

The Deputy Convener: How do you expect late deals to be factored in? Such things happen. In the course of events, matters arise late. When boards are cheek by jowl with preparing their finances, what action will they be expected to take if they are suddenly faced with significant changes? Should such matters be factored in? If so, on what basis should boards do that?

Mr Jones: Boards should be aware of the major financial pressures. We work with boards and share intelligence about financial pressures that might be in the system. We expect boards to put all those pressures in their financial plans. As with any plan, all that can be guaranteed is that a financial plan will be wrong. The outcome of any negotiation or the inflation rate over the coming year cannot be forecast precisely, so variations will always occur. We expect boards to make provision.

A problem arose with the consultant contract, which involves a UK-wide pay deal. Early in the negotiation, a UK-wide survey was conducted of what the impact of the contract might be. The survey suggested that, after account had been taken of changing working practices and service changes, the result of the consultant contract would be that the average consultant would receive one additional sessional payment—a session is equivalent to half a day. It was expected that consultants would work five and a half days a week; the old contract was based on a fixed amount for five days a week.

While the detailed work on implementing the contract is being done—as Peter Collings said, that work continues, because it involves a discussion between every consultant and their clinical manager to agree the consultant's work plan—the additional figure is turning out to be about 1.4 sessions. The average addition to a consultant's working week that is being built into the contract is higher than the figure from the survey and that extra sessional payment is producing most of the additional cost.

As I said, the survey was based on assumptions about how working practices might change. At present, implementation of the consultant contract is being based on existing working patterns. An extra cost is involved. Early in the negotiation, the additional cost was estimated at 8 per cent and that was the information that boards had when they thought about their financial planning and the contract's cost in their areas. The additional cost has increased to about 20 per cent, as Peter Collings said, which has created an additional pressure that boards could not reasonably have forecast 12 months ago.

The Deputy Convener: We have heard evidence that GP out-of-hours contracts, which are being dealt with locally, will be a problem in some areas. How are you factoring that in? Are you leaving that to boards?

Mr Jones: The cost of the GP out-of-hours service is for the local boards to meet from their allocations. We are aware of the costs of that service throughout Scotland and we are having discussions with the boards. There is a national reference group for Scotland and the lead for the GMS contract in each board comes together with our pay modernisation director. They are considering the implementation of the out-of-hours contract to ensure that there is national consistency in the way in which it is implemented. At the moment, there is quite a variation in the costs that are being forecast by different boards.

Susan Deacon: I am keen to pursue the wider contractual issues that have been mentioned. There are three major pillars under pay modernisation—GMS contracts, consultant contracts and the agenda for change—all of which are being implemented on a UK basis.

I would like to pursue the Scottish dimensions of pay modernisation, if they exist. First, how effectively were the distinctive needs and conditions of the NHS in Scotland addressed during the negotiation process and in the final outcome? Secondly, what differential impact might the various changes have in different parts of the UK? For example, there is generally a higher number of staff in the NHS in Scotland, so how might the NHS in Scotland be differentially affected by the pay awards and other changes that are coming through? Thirdly, given the degree of rurality in the NHS in Scotland, what differential impact, if any, do you consider that the changes in the GMS contract might have, particularly in relation to out-of-hours services?

Finally, in relation to the consultant contract, will you comment on the relationship with the private sector, given that traditionally there has been a considerably lower level of private sector involvement in health care and provision in Scotland? How satisfied are you with the outcome of the contract negotiations, given that, as I understand it, a considerable element of the contract is about retaining the commitment of consultants to the NHS in Scotland, but that that might not be the issue in Scotland that it has been in other parts of the UK?

Mr Jones: It might be useful if Mike Palmer talks about the Scottish elements of the contracts, but I will talk generally about the negotiation process. All four health departments were actively involved in that process, as were the different branches of the British Medical Association, so there was a Scottish dimension to the negotiations. However, realistically, because we are a 10th of the size of England, which is the key driver, our influence over the outcome will not be as great as that of the English.

At the start of the negotiations, there was a clear view that one of the key drivers for the consultant contract was the relationship with the private sector. I used to work in north-east London, where consultant work in the private sector was a significant issue. All the consultants in the hospital for which I had responsibility had significant private sector commitments and that needed to be clarified. At the start of the consultant contract negotiation process, the intention was to reduce the commitment to the private sector and increase the commitment to the NHS. At the end of the negotiation process, the emphasis on that element of the contract had been significantly reduced. Again, Mike Palmer was actively involved in those negotiations, so he can describe that.

11:00

The issue of the differential impacts of the contracts on Scotland is interesting. You are quite right: we have more doctors and nurses in Scotland per head of population, so the pay award is significant to us. If we think of the English-Scottish dimension, rather than of Wales and Northern Ireland, one of the key differentials results from the impact of the Barnett formula. For a number of years, the level of growth that has come into the NHS in Scotland has been less than the level of growth that has gone into the NHS in England. The Westminster Government made a clear commitment to bring up the funding of the English NHS to the European average. Scotland is there already.

More growth funds are going into England in relative terms than is the case in Scotland. Obviously, that makes it easier for the NHS in England to bear the cost of any of the pay awards or of other cost pressures. That is one of the things that feels very real in Scotland. We are playing with a smaller development fund when we handle UK-wide pressures, and we have to be acutely aware of that in terms of the management of the Scottish health budget. Mike Palmer might want to say something about the Scottish element.

Mr Palmer: I will pick up on the point about higher staffing levels. To a certain extent, the question is one of timing. It is clear that England is on a significant growth track in terms of raising the number of staff. In a way, we are a bit ahead of the game in that we have a higher staff baseline. Although extra financial pressures will be felt in Scotland because England will be catching up proportionately, so to speak, for a time, in a way we are in the position that England is aiming to reach.

Susan Deacon mentioned the private practice element of the consultant contract in the context of the differentials between the different deals. As Trevor Jones said, for a long time the emphasis in the negotiations was on retaining consultants for the first seven years of their contractual term in the NHS and not allowing them to do any private practice during that time. As Susan Deacon rightly said, that was the result of a clear steer from England, which was motivated by concerns about the encroachment of private practice. The emphasis on retaining consultants for the first seven years of their contractual term in the NHS fell away towards the end. In return, we managed to gain an extra half session for direct clinical care from all consultants. That is of clear benefit in terms of the pressures that we face and our objectives in Scotland.

The issues around rurality and the extent to which the different deals are sensitive to remote and rural problems were raised. It is absolutely right to flag up some of the difficulties that exist in rural and remote areas around out-of-hours services. I think, however, that those challenges

can have a silver lining in so far as they offer enormous opportunities for boards in rural areas to take a much more co-ordinated, holistic and coherent approach to out-of-hours services. The issue is neither as doctor-centric nor such a burden on individual GPs as has been the case in the past. Some innovative ideas are being introduced by boards such as NHS Highland.

One of the big messages that came through consistently from the profession was the difficulty with recruitment and retention of GPs in rural and remote areas. That was simply because the GPs could no longer stomach the out-of-hours responsibilities and the way in which they were being asked to sustain the service. In quite a significant way, the new contract is a direct response to the plea that the profession made for the removal of that responsibility.

Susan Deacon: I am grateful for all that information. I want to return to the comparison between Scotland and other parts of the UK. Trevor Jones made the point, which is important for the committee, that the impact of Barnett has meant that the lines for levels of growth north and south of the border look very different. Mike Palmer made a point about the differential impact and increased costs of the pay modernisation changes. He said that the issue was one of timing—which I understand—and that Scotland's higher staff levels are making a disproportionate impact in the short term. He also said that England is working quickly to catch up with our level of staff capacity.

You might like to quantify what you mean by the short term—are we talking about one, two, three, four or five years? What will the impact of all that be? What will be the impact of having, in your words, a smaller development fund in Scotland? What has to give?

Mr Jones: That is a critical point. The NHS in Scotland spends significantly more per head than the NHS in England. In terms of spend per head of population, a levelling-up process is going on—that is the starting point. The reality is that the extra cash in Scotland is being spent on services; we have more doctors and nurses. A simple example is beds for older people. In the NHS in England, it is hard to find traditional beds for care of the elderly because beds in the old geriatric wards no longer exist and functions have transferred to local authorities. However, in Scotland we still provide those services.

The matter is not just about pay; I described in my introduction the overall pressures that face the NHS. The status quo cannot continue, and we have to reform the way in which we provide NHS services. We have to think about providing a different model of care, and that requires fundamental reform and change, the key foundation for which is pay modernisation. We need a work force that can work more flexibly and it needs to move out of the silos in which the NHS has tended to work. We need to reward staff for the skills that they bring, and we need to develop staff to do jobs differently. We need pay systems that support that, and those systems need to recognise changing working practices and the importance of work-life balance. To take GPs as an example, we cannot expect people to be on call 24 hours per day, seven days per week, 365 days per year—that is no longer acceptable and people will not apply for such jobs. We have to reform the pay system and use it and the new contracts to drive the reform agenda. In time, that will lead to a different NHS in Scotland.

We need to think about why there are differences in service provision between England and Scotland and decide what is right for the Scottish population. We do not necessarily want to mirror the service in England. We have to think carefully about the differences and about the direction in which we want to take the NHS in Scotland, taking into account the differences in the Scottish demography.

Susan Deacon: If smaller levels of growth money are available in Scotland, which I do not dispute, and if smaller development funds are available in Scotland in the short term, which I understand to mean at least several years, what developments are not taking place in Scotland that are taking place elsewhere? I would be grateful if you could return to that point. Much of what you said, the philosophy of which I would not disagree with, applies equally to other parts of the UK. That includes your remarks on using the contracts as levers for reform, so those remarks do not in themselves answer my question. What developments and modernisation processes are not moving forward in Scotland, or not having the same investment put in as elsewhere, because of the differential that you identified?

Mr Jones: A major modernisation process is taking place both north and south of the border. One of the things that England has been trying to do is to increase the number of acute beds. We have more acute beds than England, and some of the extra development funds in England are being used to enable it to mirror the service provision that we have in Scotland. We are not doing that work because we are already there; England is trying to move towards the number of acute beds that we have in Scotland. The extra development funds in England are being used partly to move its output level to that of Scotland.

Another good example is waiting times; in England there is huge investment of additional funds to reduce waiting times. Traditionally, Scotland has had better waiting times than

England, so England is trying to catch up. We are concerned that in some areas England has overtaken us—for example, England has exceeded us on out-patient waiting times because of the huge investment that it has put in.

We identify the key priorities for the NHS in Scotland and we use the funds that are available—that is, the £7 billion, not just the development funds—to improve the service. It is fair to say that it is easier to drive change with new money from development funds than it is to drive change from within the system. The Scottish agenda is about driving change within the system, using the £7 billion, which is a higher level of funding than in England. The challenge is bigger for us.

Rhona Brankin: I have a question about best value. How will you ensure that the changes to GPs' contracts will not negatively affect services to patients?

Mr Jones: Mike Palmer will take you through the improvements for patients under the GMS contract, after which I will mention some general best-value issues.

Mr Palmer: The GMS contract is underpinned by the patient services guarantee, which is written into the legislation and which guarantees that the range of services that patients have enjoyed until now will at least be maintained. The focus on quality services for patients runs right through the contract. Perhaps the most revolutionary and significant element of the contract is the quality and outcomes framework. This is the first time that a country the size of Britain has developed and delivered a framework that is based on quality outcomes, and which links reward to clinicians and their teams to those outcomes. That pioneering work is focused absolutely on how improvements can be made for patients.

Under the quality and outcomes framework, there are three domains: various clinical indicators, to which all practices are asked to aspire; organisational indictors; and the theme of improving the experience of patients in general medical services. The quality and outcomes framework will be fully audited. We will assess GP practices' aspirations to provide the various improvements in services for patients that are flagged up in the indicators, and the degree to which the aspirations have been achieved. Visits will be paid to every GP practice to assess and manage performance in that aspect of the contract.

The audit is a major step forward in giving the contractual arrangements for GP practices a quality outcomes focus. Checks will be made within the assessment of the framework. For example, if it is found that a GP practice has an unreasonable degree of referral to secondary care in a way that unfairly ratchets up its quality outcomes points, that will be picked up in the audit and will not be sustainable. We must think about an integrated approach across primary and secondary care to ensure that we do not simply create knock-on problems for secondary care. Those are the key aspects through which improvements to patient services will be monitored.

I should mention out-of-hours provision, about which there has been much concern. Under the new contract, out-of-hours services will have to meet independent standards for the first time. NHS Quality Improvement Scotland recently issued a consultation document on the standards. The contract will ensure that every out-of-hours service provider meets the standards, which should bring greater benefits for patients. The consultation on the standards will last until the end of May. The process is inclusive—we have ensured that patient groups have input.

Mr Jones: I will pick up on best value in the NHS in Scotland. We discussed earlier with Susan Deacon the need to use existing funding better. Best value is a key tool in that.

11:15

A range of initiatives are under way, which I think will produce significant savings and release cash to invest in the service or to address some of the pressures that we have been describing and which I will run through quickly. The policy of the NHS in Scotland is to develop the concept of the national service. The entity is NHS Scotland and 15 boards will work together nationally and regionally to deliver a national service to common standards. We are first working to ensure that we provide non-clinical services in the most cost-effective way so that we get best value for money.

An initiative on improved procurement systems is under way, which we think will by 2006 release about £50 million through the whole service using its purchasing power and the latest technology to get better deals from suppliers; the same goods will be coming in, but they will be significantly cheaper. We are considering whether we could improve nationally, rather than at board level, the non-clinical transactional services—such as paying invoices—and parts of the human resources function, such as paying staff. We are working with the staff organisations in NHS Scotland on a project that could release about £17 million by improving those processes using the latest technology. A business case is being presented for a new logistics process in Scotland, which addresses whether we can manage better than we do now the process by which goods are delivered from suppliers to ward. The first draft of

the business case shows that that could release about £11 million. About £70 million to £80 million could be released from our improving back-office functions, which is important.

In addition, we are about to commission a major benchmarking exercise on the NHS in Scotland, which will examine the relative cost of provision of the service throughout Scotland. We will benchmark the service from an efficiency perspective. Why should the same service cost more in Lothian than it does in Fife? Why should the same event cost more in one part of Scotland than it does in another? We will also consider access. Why should more service be provided in one board area than is provided in another?

We will benchmark the service in terms of the quantity of service that is being provided and the cost of the individual service that is being provided. The exercise will allow us to identify areas where we can do better, which could release resources to address some of the financial pressures that we face. It will also provide us with international comparisons. We do not want to look just at Scotland; we want to compare ourselves to the rest of the world in terms of how we deliver health care, and to see what we can learn from that. That is a much bigger exercise, in which there is probably 12 months' work before we start to see results. We can do a lot of work around best value, which will allow us to use differently the cash that we have.

Rhona Brankin: Will you be benchmarking against what is happening in England?

Mr Jones: We will benchmark against the four United Kingdom countries, against Europe and against the rest of the world, if we can get comparators. We do not want to focus only on England; we need to look at health care systems generally. We can probably learn a lot from some European systems of service delivery.

Margaret Jamieson: Planned expenditure in the NHS is expected to increase from £6.7 billion in 2002-03 to £8.5 billion in 2005-06. In our evidence-taking sessions we have heard about increases in individual boards. Ayrshire and Arran NHS Board indicated that its uplift was £30 million, but that only 10 per cent of it would be available for service developments. Given that service developments are linked to health gains, do you expect that the additional funding will improve the health of the people of Scotland? How can that be measured in relation to the constituency profiles that were published recently, which are a poor starting point? How will you ensure that NHS boards use funds that are earmarked for new service developments for that?

Mr Jones: I will pick up the inequalities issue first. The formula that allocates the percentage increase to boards takes into account deprivation, so the more deprived a community is, the greater will be the increase it will receive. There is a step in the formula that addresses the inequalities agenda.

I understand what Ayrshire and Arran NHS Board said and I have read the *Official Report* of that meeting, but the matter can be oversimplified. It would be wrong to assume—we would be missing a trick if we were to do so—that investment in the new pay modernisation system does not provide an opportunity to improve services. If the new contracts are simply pay awards for staff, we are making huge investments for very little return. They are not about that: the pay modernisation agenda is about changing services.

Part of the problem with the consultants' contract is in the working group's assessment of how much it might cost. The group made assumptions about improvements in service provision, and we need to encourage all boards to use discussions with individual consultants on their work programmes to improve the service for patients. The boards are all aware of that. As Mike Palmer said, part of the agreement is an assumption that the amount of time with patients will increase in the consultants' work plans. Part of the agreement was to increase that clinical interface, which is good. It is therefore wrong to say that the £20 million that you quoted for inflation and pay awards does not produce patient benefit. It does—Mike Palmer has described some of that benefit.

Margaret Jamieson: I am not the one who said that; it was your officials at board level.

Mr Jones: I understand that. I am saying that investment in staff should not be regarded simply as an increase in pay for which the service gets no benefit. The service must get a benefit; we are investing huge amounts in the new contracts, and we must see an improvement in services to patients from that. If we do not, we will have lost a huge amount. That is the distinction that I draw.

I understand that board officials were saying, "If you take the costs of pay modernisation away, this is the amount we're left with." That is right, but they do not only have the increase in their allocation; they need to consider their whole allocation and think about how they can do things differently. I have just said that, through back-office functions, £80 million can be released for Scotland to develop patient services if boards work together to improve how they do things.

Margaret Jamieson: Your answer is fine, but there have obviously been discussions with health boards, and if you are saying that the explanation that you have provided us with—that the amount

of money that they will allocate for pay modernisation will provide service benefits—has also been given to boards, why did that not come through when we took evidence? We are still in a silo culture, and, to a certain extent, you have demonstrated that you are in that mould. Best value is not always about saving money; it is about how a service is provided and how the public are consulted and involved in shaping that service. Some boards are good at doing that—others are poor.

At the end of the day, the figures that we go on are the amount of money that comes through to the NHS in Scotland and which, through the Arbuthnott formula, arrives eventually at local NHS boards. In spite of those figures, we get profiles that are absolutely shameful. When will we see tangible improvements in health?

Mr Jones: You can see the health of Scots improving now; health is improving throughout the world. There is an issue about the rate of that improvement; I do not think that any of us believe that it is fast enough in Scotland. That is because of our starting point, and that is why we are putting significant emphasis on the health improvement strategy and why we are allocating additional funding not only to the NHS, but to the public sector in Scotland, to improve the health of the people of Scotland.

Significant investment is being made on the health improvement agenda and we are starting to see signs of improvement but—as you know well—we do not get a quick return from investment in health improvement. It is a long-term investment, but it is the right thing to do. Probably the most important thing that we are trying to do is to address the wider health improvement agenda. We must drive that forward.

There was one question that I did not approach, which was about how we manage the funding through boards and ensure that we get outcomes from it. Perhaps Peter Collings would like to talk about performance management.

Dr Collings: I will make two points. Most of our funding to boards is a general allocation. Within that general allocation, it is for boards to decide how they will use the money in a way that reflects local priorities. That said, we get boards' plans for how they will use the money and we use the performance assessment framework and other tools to assess their performance. We have a system for ensuring that money is spent well. In addition, for some sorts of expenditure—for example, that which relates to coronary heart disease, stroke and cancer—there is ring-fenced money that boards can use only for particular development purposes.

Susan Deacon: I appreciate the substance of Trevor Jones's answer to Margaret Jamieson's question about what is happening with regard to health improvement and the timescale that is involved, and I acknowledge that what will deliver results is action across Government and not just within the Health Department. However, previous witnesses have commented on the national health improvement fund, which is one of the mechanisms that the Health Department is using to bring about change. One witness said:

"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 boards, it is to be channelled through various funding mechanisms … Obviously, because the money is going to various places, it is hard for us to get our arms round all of it."—[*Official Report*, *Audit Committee*, 30 March 2004; c 454-55.]

In the first few years of the fund, Scotland's share of the tobacco tax was ring fenced. It was earmarked for health improvement and allocated to health boards to be put into local projects in conjunction with partner agencies. However, as I understand what that witness told us, the channel for the resources is to change. Can you clarify what is happening in relation to channelling those funds? Also, is the fund to be retained? To what extent is the practice of ring fencing that share of the tobacco tax to be continued? If the funds are to be channelled through various agencies, how will the level and impact of the investment be monitored? The evidence that we heard suggested that at least one board was struggling to understand how that could be done with the clarity of previous years.

Mr Jones: Dr Collings can talk about the detail of the funding streams; I will talk about the principle of the fund. The health improvement fund was a useful tool for raising the profile of the health improvement agenda and the need to refocus on health improvement. In practice, that cash was used right across Scotland for relatively small projects, as you said. That was fine, but I believe strongly that we cannot make a fundamental shift in the health of the people of Scotland simply by having a lot of small projects. We have to make health improvement a part of the core business of every public sector body, although the private sector is important as well. It is not about using a small fund; it is about using the existing spend. How can we change fundamentally the approach to health improvement? That is what we are moving towards.

Through last year's spending review process, significant additional funds were allocated for health improvement, but they were allocated for major issues relating to a range of Scottish Executive departments. The money was not

coming through the Health Department. Cash was going through the Education Department to local authorities for schemes in schools that were designed to improve the health of children in Scotland. In that way, we would fund initiatives that would improve health through the normal funding streams of various bodies.

It is interesting if people in the national health service are concerned that they cannot trace the cash and see what is being done with it.

11:30

A key driver for health improvement is the community planning process. It is not the responsibility of NHS boards to control that; we would expect NHS boards to be the drivers and facilitators for health improvement, but we would expect the local authorities to be driving that as well—and they are. The Convention of Scottish Local Authorities is extremely interested in the health improvement agenda. In fact, in the past 12 months, we have set up a joint ministerial group involving the local government ministers, health ministers, COSLA and the NHS to drive the health improvement agenda across the wider public sector.

The fund was very useful at the start of that, as it put the issue on the agenda. We have now moved it up four or five gears, and we are seeing a significant investment in the core budgets of the public sector bodies that are responsible for making changes. We need the change to happen, and we expect the community planning process to be the vehicle through which all the public sector bodies feel that they have ownership of the funding and can see change happen. We are trying to step the process up and drive it much harder. The projects were useful in their time, but we need to move away from that. The matter has to be about using core funding to make fundamental change. That is the only way we will catch up with the rest of the world.

Susan Deacon: To avoid doubt, is there to be no such fund in the future?

Mr Jones: Peter Collings will talk about the funding streams.

Dr Collings: As Trevor Jones said, there is not a single fund: money goes out through the health and education budgets. What will happen in the future is all part of this year's spending review process. There will in the autumn be announcements of ministers' decisions in the spending review, which will cover all our expenditure including, I expect, health improvement.

Rhona Brankin: I am interested to hear that. I accept that there have to be partners in improving public health across government areas. How is investment in improvement tracked across those different government areas? We have just had a session with the Accounts Commission. How are you working with other bodies to ensure that that investment is making a difference?

Mr Jones: Looking backwards at previous decisions on spending, we have a range of funding initiatives through last year's spending review process. We will have to see that the outcomes that were promised as part of those spending decisions were delivered. They will be monitored by the appropriate Executive spending departments—the Executive Education Department will monitor local authorities on its health improvement areas and we will monitor the NHS on its health improvement areas. That monitoring will take place as part of the existing performance management systems for the different parts of the public sector.

We are engaged in an interesting discussion with NHS boards and local authorities about whether we should bring together the performance management systems. It has been suggested that the NHS accountability review process should have the local authorities round the table. At the moment, they attend as NHS board members, but the question is whether local authorities and NHS boards should work with us through that process. That is something that we want to discuss with COSLA.

The Deputy Convener: We have had a great deal of comment on benchmarking. If Robin Harper does not want to ask anything specific on finance, trusts and planning, I propose that we move on to trust integration.

Robin Harper: I have one question.

Have you identified any further efficiency savings that could still be achieved in the NHS under benchmarking?

Mr Jones: No. The back office functions are described and are well advanced. We are having detailed discussions with the service and the trade unions about how we might take those forward. The benchmarking initiative is very new and we are still putting together a team to manage that project. I suspect that it will take six months for us to see some early results and it will probably be 12 months before we get into the meat of what might come out of the initiative.

Robin Harper: I have two other questions on issues that have been covered, but I will defer them until the end of the session, if there is time.

The Convener: Okay. We will move on to the benefits of trust integration.

Rhona Brankin: The trusts have been wound up and integrated with NHS boards. I have a

series of questions. First, what does the department see as being the key benefits that will arise from integration? Has the department set economy and efficiency targets for trust integration? From the lessons that were learned by the first NHS boards to undergo trust integration, to what extent has the department provided guidance or disseminated good practice to other NHS boards? Finally, how is the department monitoring NHS boards' progress in establishing the integrated structures?

Mr Jones: On the question of benefits from integration, we must take a step back and think about the philosophy behind the creation of trusts, which was about creating relatively small organisations that would compete with each other to drive up standards in the service. It was about bringing in the internal market, which had benefits in its early days. There were significant improvements in UK-wide service delivery.

In Scotland, however, we quickly recognised that it was difficult to create an internal market. For example, there is little competition between a hospital in Inverness and one in Aberdeen, so it was difficult to get a market concept working in such an environment. Furthermore, we quickly questioned the divide between acute care and primary care. The organisations that were set up through the internal market process were based on the institutions that provided care; they were not based on the experience of the individual patient.

Since 2000, we have had a clear policy direction. We surveyed the public in 2000 and the clear message that came back was that they wanted a national health service. They were not impressed with the idea of 54 organisations—with different letterheads that no one understood—working against each other. The public wanted a national service with national standards.

In 2000, we created the unified boards by bringing together around a single board table typically three independent organisations: the acute trust, the primary care trust and the old NHS board. The unified boards were created in September 2001, but in the parts of Scotland in which the system was felt to be working best it quickly became obvious that the separate statutory organisations had no added value. They were operating as single bodies and the fact that there were three chairmen, three finance directors and three human resource directors was getting in the way. We wanted a single organisation that focused on the patient experience. That was not about focusing on institutional care and care in the community, but on the experience of the individual cancer patient or the individual patient with mental health problems.

We have taken away independent status, so that a single system operates throughout Scotland in which NHS boards can organise themselves to suit local problems. We have not prescribed an organisational model. Each NHS board has stood back, considered the issues that it faces and devised a management structure to address local health issues.

Since 1 April, some boards have stuck in the first instance with the acute and primary care divide, some have gone for having a single operational unit and one board has organised itself geographically. It is still early days, but all the feedback that we have had is extremely positive. I met the NHS board chairs with the Minister for Health and Community Care and the Deputy Minister for Health and Community Care yesterday, and we had a good discussion about how we will assess the effectiveness of the new organisations. We agreed that we will stand back in September to evaluate how the transition has worked and how effectively the new organisations have improved services.

To dissolve trusts requires public consultation, but there was no lobby in NHS boards throughout Scotland to retain the trusts. It was probably the quietest and easiest consultation that I have ever seen in the NHS. We have had one or two difficult ones recently.

Rhona Brankin: That must have been a blessing.

Mr Jones: The important message is that the people of Scotland did not believe that the old model was the right one.

We issued detailed guidance to the boards on how they should approach trust integration. The thrust of the guidance was simple: we needed the least change possible and evolution, not revolution. A lesson that we learned from taking a big-bang approach to reducing the number of trusts in 1997-98 was that everyone got focused on organisational change and we lost control of the finances and waiting lists and times. People's concentration was too focused on applying for jobs for them to do the day job. As a result, the guidance told boards to stick to the knitting, to concentrate on clinical services, to bring the change in as quickly and quietly as possible and to get on with the real business. I want to congratulate everyone in the NHS on making the whole thing work remarkably well. It is good that patients have not noticed the change, which has just happened quietly.

We have set no efficiency targets for the change, as it was not about saving money; it was about getting the right organisational model. If, as the experience of NHS Dumfries and Galloway and NHS Borders suggests, boards can reduce

their costs and save money through the change, it is up to boards to decide to use that money for local issues. Dumfries and Galloway and Borders have suggested that they saved about £500,000 in the senior structure of the organisation. As I said, we are not setting any financial targets; boards need to find the right structure and to drive the change forward.

The Deputy Convener: We move on to questions about performance management accountability and the new NHS organisational structure.

Margaret Jamieson: I want to return to my hobby-horse of the performance assessment framework. Obviously, as the framework has been in place for some time, there is some scope to refine it. Do you have any plans to review the scope of health activities within the performance assessment framework? Given our earlier discussions about best value in local government and how that approach might extend into other areas such as the health service, how do you think the accountability review process will develop? Will you consider giving the public a role in reviewing the current PAF?

Mr Jones: Where does one start with the performance assessment framework? I suppose that the first thing to say is that it is simply a tool that helps us with the performance management process. It is not the performance management process itself. The PAF allows us to work up jointly with an NHS board a helicopter view of the board's performance. We examine the seven fields of activity for which the board is responsible, which means that we are not concentrating only on money—indicators for each of those fields give us a feel for whether certain aspects are improving or getting worse.

We provide that PAF information to the NHS boards and ask them to prepare a self-assessment and give us a view on their own performance. Although we use the data and the self-assessment to construct the agenda of the accountability review meeting, we also have detailed discussions with clinical staff and staff members more generally in the area partnership forums to allow them to express their views about how an organisation is working. We then meet representatives of the NHS board, which would usually include a local authority representative. In fact, I think that last year every meeting was attended by such a representative.

That approach has dramatically changed NHS Scotland's accountability review process. The process used to be hated and feared by the service, because it was more a discussion about negatives than a general assessment of how things are working. Instead of having a debate about the system's operation and thinking about how to share good practice and improve poor practice, boards and staff simply received instructions. We now have an open dialogue with boards.

You asked what we are thinking of doing with the PAF. In that respect, we commissioned the University of Aberdeen health economics research unit to review the framework. The unit's draft document, which we will publish in June, is called "Experiences and perception of the NHS"—we are happy to share it with the committee.

The view that is coming back from those who took part in the survey—I do not know who they are—by the health economics research unit is positive. The service is saying that the PAF is useful and that we should not change it; the message is that we should stick with what we have. The people who took part in the survey are saying that, although we should let the system evolve a wee bit, we should not change it every year, because we need to identify trends. Those people speak positively about the accountability review process. One of the key messages concerns the fact that the review process takes place in the board area. People from the department go to the board area to see and discuss the service; staff are not summoned to Edinburgh. There is a clear message in the report that that simple point is seen as positive.

11:45

We need to keep on evolving. When we designed the PAF, we assumed that we would work in seven fields of activity. Currently, only five of those fields are operating effectively. There is still work to do on staff governance, which we have not quite got right, and public involvement, on which we do not have indicators that will allow us to test how a board is performing. The work is evolving—it is new, but a good start has been made.

On performance management in the NHS in general, we are starting a review of the health statistics. We believe that the categories of statistics that we collect are a result of history and we will undertake a fundamental review to see whether they give us useful information that allows us to manage the performance of the new agenda. That review is under way and it will help.

We are also undertaking a best-value review of the performance management function in the Health Department to see how we can improve performance management in its widest sense. In addition to being subject to that process, health boards have performance management functions hitting them from other bits of the department. We want the best-value review to ensure that we are aware of everything that is going on in

performance management—we want to streamline that work and make it more helpful.

A good start has been made. We recognise that there is more to be done, but in general the reaction from the service has been positive. Every year, after the accountability review, we survey the boards to seek their views on how the accountability review process works and how we might improve it. I am happy to share the results of the previous survey with the committee, if members would like to see them. From my perspective, the results are positive, but I guess that I always see the glass as half full.

Margaret Jamieson: I would expect that to be the case, given that the boards would not want to upset the individual who is responsible for their budgets for the following year.

You talk about best value, but your concept of best value appears to be totally different from the concept that is emerging from the Accounts Commission, from which we heard this morning. That body, together with the Auditor General for Scotland, considers best value in terms of taking the concept into other areas. You are inventing your own wheel; you want to put things in place and roll them out for the health service so that you are ahead of the game, so to speak.

Mr Jones: I do not think that I would ever want to wait for another organisation to come in before I improved anything in the Health Department. If we see scope to improve, we will do that.

Margaret Jamieson: I am not saying that.

Mr Jones: I thought that you were saying that we should wait for the Auditor General—

Margaret Jamieson: The Auditor General's concept of best value is totally different from the concept that you outlined this morning.

Mr Jones: I do not think that it is. We contributed significantly to the guidance on best value that has been issued by the Scottish Executive. The Health Department has been a major player in that. The best-value review of performance management is absolutely around those definitions. Earlier, when we had a discussion about how to use the NHS resource differently, the committee might have heard me emphasise the fact that best value in the back-office functions is about making the service as effective and efficient as possible, to release cash for clinical services. Our approach to best value is exactly the same as the approach of the rest of the public sector.

Margaret Jamieson: Do you accept that best value is not always a cost-saving exercise?

Mr Jones: Absolutely. It is about making the service as good as possible within the resource that we have.

Margaret Jamieson: Yet your previous emphasis was always on saving.

Mr Jones: It was. I was trying to demonstrate a point.

Margaret Jamieson: That clarification is fine.

Robin Harper: Some people think that, under the new single-tier NHS system, there is a risk that financial performance and the reasons for underlying deficits in particular services or directorates will become less transparent. What guidance or instruction has the Health Department given to NHS boards to ensure that the accountability for the financial performance of operating divisions will be maintained and the results reported? Do you expect the financial performance and activities of operating divisions to remain visible outside NHS boards?

Dr Collings: The key point about deficits is that the overall finances of the NHS organisation in an area are managed properly so that the organisation balances its books. One feature of having several organisations in an area is that numbers get bandied about—one bit of a service can be in deficit, while another is in surplus. To an extent, that does not matter; what matters is that the board in an area manages funds properly and that, overall, it is coping. In some instances, a deficit existed simply because a board had not yet released extra funds to a trust, although it intended to do so. The money existed, but there were headlines about the trust being in deficit, even though that was not the real situation. To that extent, the new organisation will better illustrate the real situation.

I have two points about transparency. One is that NHS board papers are in general made public—that situation will continue. Boards produce detailed reports on their finances and the finances of their individual components. In future, that will vary, because boards will have differing divisional structures, as Trevor Jones said. However, the information will still be in the public domain. Secondly, at national level, we produce the costs book on the "Scotland's health on the web" website, which sets out in exhausting detail what it has cost to provide services. Much of that information is provided not on an organisational basis, but by hospital. That information will continue to be provided.

The new management structure is more robust and will prevent some of the game playing that has taken place—sometimes in the media, unfortunately—between NHS organisations. The public will continue to be able to find out about the finances of organisations.

Robin Harper: Are you saying that people will be able to distinguish between the operating divisions in boards' published accounts?

Dr Collings: Depending on the structure that boards adopt, their published accounts will give varying breakdowns. However, at the national level, we will continue to publish financial information that is broken down into more detail than that, which is the sort of information that you are after.

Robin Harper: One way or another, the breakdown will be available. Why are you not issuing direct guidance to the boards to print the information in that more detailed form?

Dr Collings: We issue guidance to the boards on the format of their accounts, but the format will inevitably follow the structure, which means that, if a board has stuck to an acute/primary care structure, the accounts will be split in that way. If a board has gone for a geographical structure, it may use that to monitor finances and some of the information in the accounts is more likely to be structured in that way. We will continue nationally to collect and publish detailed cost information.

Mr Jones: I question the value of making divisional information available, because it is not comparable across NHS boards. What purpose would it serve? How would it help the people of Scotland to understand the quality of the NHS system? Performance management information is much more valuable and the performance assessment framework is on the web. It is much more important to look at health outcomes and inputs in a way that enables us to compare performance across Scotland. If we simply say that the division that manages hospitals and community services in the Borders has one cost and the division that manages part of the acute service in Lothian has another cost, the response might well be, “So what?” We cannot compare the two.

Susan Deacon: I want to continue the theme of performance monitoring and review. An enormous amount of development and change has taken place in this area, most of which is generally acknowledged to have been for the better. I return to something that Trevor Jones said in an earlier answer to Margaret Jamieson. The comment was made several times that the reaction from the service has been positive. One of the key reasons for the improvements, however—indeed, I do not even need to say this—was the need to ensure that the public had a better insight into and appreciation of the way in which their money is being used in the health service. I am concerned to know where in the myriad bits of information the public can get an accessible, almost light-touch, indication of how their board is performing relative to other health boards.

Indeed, I raised the issue when Lothian NHS Board gave evidence to the committee. I confess that it had been a wee while since I had looked at accountability review letters. On looking at the last letter that was sent to Lothian NHS Board, I was quite struck by the fact that it erred terribly on the side of the positive; it made no reference to some of the hard-edged difficulties that exist in Lothian.

I want to be crystal clear on the issue. I for one do not want to advocate pointing the finger, laying the blame or concentrating on shortcomings. Far from it; I think that it is good, helpful and healthy that achievements in the service are highlighted wherever possible. Equally, however, on looking at the letter, I felt that its contents were not balanced. I raised the matter with James Barbour at the time. I said that particular, profound problems, including those of long waiting times relative to other parts of the country in key specialties, were not referred to. I also raised the fact that there was no reference to the extent of delayed discharge in the Lothians; the only reference was to the input and effort that were being made to address the problem.

Ultimately, I cannot help but feel that all that energy and effort will be effective only if the public can achieve a good sense of how the health service in its area is performing. At the moment, it seems that people have to spend two or three hours on the internet if they want to gain access to such information.

Mr Jones: I agree. At the moment, we are looking forward: we are developing a report on performance for the NHS, although members will appreciate that the matter is still subject to ministerial approval. We intend to issue the report probably in the late autumn—possibly around October or November—if ministers think that that is the right thing to do.

The report would try to give a national overview of the performance of the NHS, and the performance assessment framework data are part of the background to the report. Current thinking is for those data to be issued as an annex to the report, which would mean that we would have a short, sharp report on the performance of the NHS that was accompanied by a technical appendix within which the hard evidence to support the report’s findings could be found. In my view, we should probably do that annually. The report would allow the people of Scotland to form a view about how the NHS is performing.

If Susan Deacon were to read 15 of the accountability review letters, she would get a different view of how each health board feels. If we are reviewing a board that is performing well—and Lothian is one such board—one would expect it to receive a very positive letter. Health systems are huge and the letter cannot be expected to cover everything. Before the review begins, we agree jointly what the key issues are. I guess that the letter records my view of how the board is performing.

Even in a case of a board that is having problems, when I write expressing a view about its performance it is important for me to strike a balance between the things that are going badly and the 95 per cent of the organisation's work that is going well. The board with the biggest problem in the year before last was probably Argyll and Clyde NHS Board, and the accountability review letter for that year included some very hard messages. In that letter, members would see not only those hard messages about the performance of the board, but an absolute recognition of the contribution of the people who provide the services in Argyll and Clyde. The accountability review has to strike a balance. At the end of the review meeting, I do not think that anybody is under any misapprehension about what we are concerned about and what we are not concerned about.

12:00

Rhona Brankin: I want to clarify a point in layperson's terms. Are you considering producing information that would allow a cancer patient who was considering moving house to make an assessment about what the quality of their care would be in one area of Scotland compared to that in another?

Mr Jones: No. We could not go into that level of detail in the document that I am describing. We are talking about a high-level overview of the performance of the NHS. If we had to go into that level of detail for every procedure or every clinical service the document would be pretty thick. I was talking about the performance of the service. You would have to dig down to test the data that you are talking about.

Rhona Brankin: How do people find that information at the moment?

Mr Jones: They get it from a range of services. There is a waiting times database—the waiting time of every clinical department in Scotland is on the web. When general practitioners decide whether a patient needs a referral for surgery, they and the patient could consider not only their local hospital, which tends to be everybody's first choice, but, if they wanted earlier treatment, they could find the next available slot to see a consultant anywhere in Scotland. A lot of information is available around clinical reports on quality of service, but someone would have to dig for those, because there is not a single directory of them.

Rhona Brankin: So currently it is not easy to get information for outcomes for cancer treatment and care.

Mr Jones: We would have to assess the practicality of what you are suggesting. I can see the value of it, but my knee-jerk reaction is that it sounds like a huge exercise; it would be complex to put together a document containing information that would enable someone to decide which cancer surgeon they wanted to see. The suggestion seems difficult, but we could think about it.

Rhona Brankin: It just struck me that patients with major illnesses such as cancer, which cause a significant number of deaths, would find such information helpful. If someone is moving house, they need to be able to access information about the quality of care that they can expect in an area to which they might move.

Mr Jones: That is right. The other side of that coin is that that patient's family could need a range of NHS services and, in practice, there would be a range of performance in those services in any given area.

Rhona Brankin: There could well be.

Mr Jones: If someone was basing a decision on where to move simply on health considerations, they would have to be able to forecast what conditions they might face in the next five or six years and decide which is most important. People face a multiplicity of conditions.

Rhona Brankin: But you would accept that, in an ideal world, patients should have access to as much information as possible to allow them to make informed decisions.

Mr Jones: Yes, absolutely.

Robin Harper: I want to return to the issue of health promotion. I have heard ideas about doctors being able to prescribe home insulation on the basis that it would save the health service a considerable amount of money, given the number of repeat illnesses that older people get as a result of living in damp houses. I have also heard about doctors being able to prescribe health clubs and homeopathy—that already happens in some cases. How much are GPs involved in health promotion? Might we get to the stage at which GP practices' performance in health promotion is monitored and audited?

Mr Jones: Health promotion tends to be a rather narrow term in the NHS. The wider health improvement agenda encompasses everything that we have to do to improve Scots' health. We see the new community health partnerships, which are being created now, as a key plank in the development and implementation of the health improvement strategy and GPs are obviously among the major clinical players in those partnerships. It is critical that we drive the agenda at community level. Indeed, we have to drive health improvement at a range of levels—for example, at a local community level in Craigmillar,

then across Edinburgh and then nationally. There must be different approaches at different levels of society.

Margaret Jamieson: My final question concerns the issue of capital-to-revenue transfers, which has been raised. Given that last year £50 million was transferred from capital to revenue, can you give us an indication of the point that we have reached in discussions with the Treasury regarding its quest to tighten up the rules on capital-to-revenue transfers?

Dr Collings: It is important first to provide some background. Capital-to-revenue transfers are an issue because at the UK level the golden rule states that we should borrow only to fund capital expenditure. At both the UK and the Scottish levels, there is a concern that sufficient capital expenditure should go into public services and that we should enhance capital assets in the public services, rather than let them degrade. If money is moved across simply to prop up the short-term financial position of a public body, we will not get reinvestment.

However, capital-to-revenue transfers will still be possible for NHS Scotland. We will manage how we do that within the Scottish Executive budget. In the next few days, I will write to NHS boards to ask them to submit proposals. I will accept some and reject others, depending on their merits and, in particular, on whether they seem to be related to other sorts of investment, as opposed to simply propping up revenue positions.

Margaret Jamieson: I am interested in some of the innovative ways in which boards are working with local authority partners, the police service and so on that involve transfers of capital to another organisation. It would be of great concern if under your new guidance that were not allowed.

Dr Collings: The projects to which Margaret Jamieson refers account for a small proportion of total transfers, but they are one of the issues in which we will be interested. Some projects are genuinely capital investments but are classified as current expenditure because the NHS will not end up owning the asset. We will deal with those as a particular category.

Margaret Jamieson: Perhaps NHS Ayrshire and Arran has jumped the gun a bit.

The Deputy Convener: I thank Trevor Jones and his colleagues for their forbearance and for their attendance.

We move to item 6 on the agenda. I am aware that we were running ahead of schedule but are now somewhat behind. I suggest that we crack on and deal with item 6 before I demit the chair and hand it back to the convener, who has arrived after an epic journey. We are still in public session, and I will give Trevor Jones and his colleagues time to depart.

Our discussion relates to the evidence that we took from NHS Lothian on 16 March and from NHS Borders and NHS Ayrshire and Arran on 30 March, as well as the evidence that we have just taken. I seek comments from members.

Mr Brian Monteith (Mid Scotland and Fife) (Con): I apologise for my late arrival. Fortunately, I will have nothing to do with the award of railway franchises.

I will take the unusual opportunity to comment at the outset. Members will be aware that, in the papers that we have received today, we also have a briefing on evidence that we have taken. It is not a complete summary of what we have heard, but it points out some of the relevant areas. If we were to compile a report, I would like it to be based on that paper; however, it would require the addition of some of the details that we have received from NHS Lothian and from some of the other health boards about the difficulties that health boards are facing because the uplift in funding is essentially being used for changes in contracts and increases in salaries and the cost of drugs. The difference between the perception of what might be available to improve health service delivery or introduce new systems of delivery and the reality is something that the committee has brought to light and which should be included in our report.

The paper mentions the agenda for change, which was an issue of concern because it looks as if that, too, will have a significant impact on spending patterns in the NHS. A question was asked seeking further evidence on the new Treasury rules. That is an issue that we have stirred up and we must see what we can say about it in our report. I have not had the benefit of hearing all the evidence this morning, but the evidence that we heard from NHS Lothian, NHS Borders and NHS Ayrshire and Arran is sufficient for us to put into the public domain the concerns that I expect the committee to have about how tough it is for the boards to deliver improved services when so many different new contractual arrangements are coming together at the same time. That is something that the public has to be aware of.

The Deputy Convener: Do any other members have comments?

Susan Deacon: Is the aim at this stage just to get an indication of key themes that we might want to develop further?

The Deputy Convener: Yes.

Susan Deacon: That was just my insurance policy. Often, after we have had these sessions, we need time to reflect. I sense that, from what we

have heard, we clearly need to reflect on what we are going to say about the pay modernisation issues.

Although I would not want to push the committee down the road of the questions that I pursued with the minister, I think that a big question remains about what the cost of pay modernisation will be—that is a simple question that has been made explicit—and what its impact will be. I raised the issue of comparisons with other parts of the UK. I would not always go down the road of making comparisons with the situation elsewhere, but this is an area in which such comparisons are germane, given the fact that the contracts are UK-wide. There are issues not only of direct costs but of opportunity costs, and some of the specifically Scottish dimensions to the changes need to be considered. I am not sure that I would want to go further than that at this stage. I just note that.

The only other point that I would make is that, in line with what we have explored not only in relation to the overview report, but in relation to a number of service-specific or area-specific Audit Scotland reports on health service issues, there are still profound questions about the scale and pace of change and development in Scotland, some of which are linked to the question of what investment is available to catalyse and support the change and some of which are about how to incentivise change within the system in Scotland. There are a range of different reasons as to how and why that might happen, and there are issues that need to be explored.

12:15

Although I said that that was the last thing that I was going to say, I would like to add a third point. On the issue of making the process more transparent and accessible to the public, we should not simply be putting more and more information in the public domain—often, that can have an adverse impact—but should be making information available in a language and form that the public can genuinely understand and access. Although a lot of the material and mechanisms that have been discussed today in relation to performance monitoring and accountability are terribly laudable and give us more of an evidence base for performance in the health service, it is difficult enough for us to get a handle on them, so heaven help Joe Public. I would like us to think not only about what the performance-monitoring process is but about how it can be improved.

Mr Monteith: Might it be possible for the clerk to give us an indication of how long it will take her to prepare a draft report for us? That would allow us to consider how we might reflect on the evidence that we have heard today. Once the *Official Report* of this meeting is published, it would be useful if we were able to compare the evidence that was gathered at previous meetings with what was said today. To some extent, that will slow down the production of the draft and the process of producing a report. I am conscious that we have four committee meetings left before the summer recess. Given the other work that the clerks have, what progress will have been made on the report at various stages before the recess?

Shelagh McKinlay (Clerk): To a certain extent, that depends on the progress that the committee makes on reaching decisions about what to put in the report. Had I been sent off today to write a report, I would have hoped to have been able to bring a first draft to the meeting on 25 May. Clearly, the committee has decided that it does not want me to do that. Realistically, the first time that the committee will see a comprehensive draft report will be the first meeting in June, which I think is on 8 June. It might be possible for us to produce some kind of key issues paper in time for the next meeting or the meeting after that. That would help us with our further discussions about the key messages.

Mr Monteith: I suggest that we ask the clerk to produce a key issues paper. It could highlight the issues that we have taken evidence on and give us a chance to focus on those. Would that be a way forward?

The Deputy Convener: That would seem to be helpful.

I ask the Auditor General to give us his views on what we heard in today's evidence-taking session and before the session.

Mr Black: My first thought is a statement of the obvious. I do not think that any of us can be in any doubt about the significance of the change that is taking place in the health service at the moment. We will have to maintain a continuing interest in the health service in order that we can demonstrate to the satisfaction of the committee and the Scottish Parliament whether the benefits that are being promised are delivered.

A lot of evidence has been given regarding the costs of the various contracts and pay uplifts. The general response from the NHS witnesses is that they are optimistic that the changes will produce different and much more effective models of care. That must be encouraging. Again, we will have to monitor that. I expect that, for example, in relation to something as significant as the GMS contract, I will want to ask Audit Scotland to consider seriously undertaking an examination of whether the benefits are being delivered. However, that will be some way down the road. Clearly, we will also have to work closely with other agencies, not least bodies such as NHS Quality Improvement Scotland.

It might be worth offering a thought or two on the best-value agenda. Most of Trevor Jones's answers on best value related to the economy reviews of support services, in relation to which a great deal of activity is undoubtedly going on. In due course, we will report on whether the anticipated benefits have been delivered, but that will be some time. There are differences in the best-value regime for performance and quality between the NHS and local government, which reflect the different accountability regimes that operate. Ultimately, the chief executives of health boards are accountable principally to the chief executive of the NHS in Scotland and onward from that to ministers, whereas local authorities are independent democratic institutions. Therefore, it is inevitable that the best-value regimes will be different.

However, many of the underlying principles are similar. Public bodies—whether they are local authorities acting on behalf of their community or NHS boards—should be clear about their priorities and where they wish to put resources; they should be rigorous in evaluating performance; and they should report the results of performance reviews in public, clearly and unambiguously. Trevor Jones, with whom I have regular conversations, is equally committed to that model. That is a parallel between local government and the NHS. Another parallel is that there is a role for audit in providing independent assurance on whether the performance that is being reported is appropriate and fit for purpose and whether the right issues are being highlighted.

One issue that is related to best value is the transparency of reporting. NHS managers are clearly positive about the new single-system regime, under which individual health boards will co-ordinate the delivery of services in acute and primary care. We will have to monitor carefully how performance is reported. It is important that reports consider how the whole system operates. Increasingly, the work of Audit Scotland will be driven by a need to consider whole systems; indeed, earlier this morning, in conversation with the Accounts Commission, the committee heard how we work jointly on issues such as community planning, community indicators, joint future and so on. That will be a growing part of our work.

My personal view is that, in addition to considering whole systems, we must be able to see transparent information about how parts of systems operate. If we lose that variety and detail, we will find it difficult to explain differences in performance and cost at board level. Therefore, while I accept entirely the value of operating the NHS in whole-system terms, I remain of the view—which I expressed in the overview report—that it is vital that we consider the big cost drivers such as hospitals, drugs budgets and community and residential care. We need to analyse those drivers because it is only at that level and below that we really get explanations for variations in performance. I encourage the committee to think seriously about supporting the view that we need performance and financial information about parts of systems as well as about whole systems.

On the issue of public reporting on the NHS as a whole that is understandable to and informative for the public, I am sure that the committee was encouraged that Trevor Jones mentioned that ministers are thinking seriously about publishing a performance report on the health service in the autumn. I confirm, however, that before the summer, I will lay before the Parliament an NHS overview that considers performance. In that study, we have taken all the available sources of information and attempted to draw them together to present some kind of overview of what the people of Scotland get for the £7 billion plus that is spent on the service. I would like to think that that report will be taken in the manner in which it is given. It is not the last word on NHS performance but an attempt to encourage a debate and to indicate how we can take complex NHS information and present it at a high level in a way that is helpful and can be readily understood by people who are not NHS managers.

The Deputy Convener: We will commission an issues paper that will be considered either at the next meeting or the one after that, which will give members the opportunity to consider the *Official Report* of this meeting and the Auditor General's points.

12:26

Meeting continued in private until 12:40.

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Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178