AUDIT COMMITTEE

Tuesday 19 April 2005

Session 2

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AUDIT COMMITTEE
† 8th Meeting 2005, Session 2

CONVENER

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

DEPUTY CONVENER

*Mr Andrew Welsh (Angus) (SNP)

COMMITTEE MEMBERS

*Susan Deacon (Edinburgh East and Musselburgh) (Lab)
Robin Harper (Lothians) (Green)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*George Lyon (Argyll and Bute) (LD)
*Mrs Mary Mulligan (Linlithgow) (Lab)

COMMITTEE SUBSTITUTES

Chris Ballance (South of Scotland) (Green)
Mr Ted Brocklebank (Mid Scotland and Fife) (Con)
Marlyn Glen (North East Scotland) (Lab)
Mr John Swinney (North Tayside) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Barbara Hurst (Audit Scotland)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

David McLaren

ASSISTANT CLERK

Clare O'Neill

LOCATION

Committee Room 5

† 6th and 7th Meetings 2005, Session 2—held in private.

Scottish Parliament

Audit Committee

Tuesday 19 April 2005

[THE CONVENER *opened the meeting at 10:02*]

Items in Private

The Convener (Mr Brian Monteith): Good morning, everyone. Welcome to the eighth meeting in 2005 of the Scottish Parliament Audit Committee. I welcome the Auditor General and his team from Audit Scotland, as well as members of the committee. We have received apologies from Robin Harper, who cannot be with us this morning. No other apologies have been received. As usual, we have some important items on our agenda. I remind members to switch off mobile phones and pagers.

Item 1 on the agenda is to seek the committee's agreement to take agenda items 4, 5 and 6 in private. Item 4 is to enable the committee to consider its approach to the report by the Auditor General for Scotland entitled "A review of bowel cancer services: An early diagnosis". Item 5 is to enable the committee to consider a draft report on our inquiry into the section 22 report by the Auditor General entitled "The 2003/04 Audit of the National Galleries of Scotland". Item 6 is to enable the committee to consider a draft report on our inquiry into the report by the Auditor General entitled "Overview of the financial performance of the NHS in Scotland 2003/04". It is our standard practice to take draft reports in private. It is also suggested that we discuss in private concerns arising from the briefing that we receive on bowel cancer services. Do we agree to take agenda items 4, 5 and 6 in private?

Members *indicated agreement*.

Visits

10:04

The Convener: Item 2 on our agenda is a discussion of committee visits. Members have received a paper that explains the history of visits by the Audit Committee to other audit bodies or audit-type committees in different Assemblies and Parliaments. The deputy convener, Andrew Welsh, who is a former convener of the committee, had experience in the previous session of visiting such bodies.

The purpose of the paper is to allow us to consider the possibility of a visit to another organisation—either a parliamentary committee or an audit institution—so that we may improve our working practice and learn lessons from others, not just specifically about financial audit but about the overall structures of audit. In the past, we have visited the National Assembly for Wales, the Westminster Parliament and institutions in Europe. Members will see from the paper that there is the possibility of further visits to those bodies. There is also the possibility of visits to Ireland or Denmark.

The purpose of visits is for us to examine institutions that work differently from us, so that we can see whether there are advantages to the way in which they work. It is fair to say that members found the only visit that the committee has made in this session to Westminster quite useful, as it enabled us to observe practice there. Consideration has been given at least to attempting to use some of the approaches that are taken at Westminster in our future work.

Originally, it was intended that the paper should be discussed at an away day, but the demands on our time are such that we do not have an opportunity to have an away day before the end of the parliamentary year. It will be possible for the committee to consider at its next away day a paper on further visits next year. However, I believed that it was important for me to bring this paper before the committee, so that if we wish to make a visit before the summer recess we can set that in train.

I invite comments from members and the Auditor General, so that I may gauge views before we reach any conclusion.

Mr Andrew Welsh (Angus) (SNP): I would like the committee to be in the mainstream of developments, both national and international. The purpose of the visits that we made was to share ideas and methods and to seek out best practice, to see how that could benefit Scotland. We wanted to maintain lines of contact and communication with equivalent bodies elsewhere.

The earlier visits were the groundwork. We can now be more targeted. I look forward to the further paper that will be issued, but I am happy with the suggestion that we visit Denmark, for the reasons that are given in the paper. We have already made contact with our colleagues in Denmark. I hope that we will continue to be in communication with Westminster, the National Assembly for Wales and the European Parliament, so that we can have an exchange of ideas. I would like the committee to be at the cutting edge of the very latest developments in audit practice.

George Lyon (Argyll and Bute) (LD): My only experience was of our visit to the Committee of Public Accounts at Westminster. I found it informative to hear about how the committee goes about its work. Given that the Copenhagen model is totally different from the model here, I question the value of a visit to Denmark. At this stage, it is unlikely that we will consider a major reform of how our committee works. I am inclined to take the view that a visit to the Dáil would give us an opportunity to re-examine the way in which we go about our work, because the Dáil operates the same basic set-up. That approach might enable us to improve what we do and how we do it under the model that we currently operate in the Scottish Parliament.

We should concentrate on learning lessons from other institutions that operate largely the same model that operates here and at Westminster. For that reason, on balance I come down in favour of our visiting the Dáil and seeing how it approaches its work. One slight criticism that could be made of Westminster is that the approach that is taken there involves grandstanding and running the rapier through the poor old accountable officer. I would be interested in seeing how the Irish system operates.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I fully accept where George Lyon is coming from. However, we can learn lessons from considering different models. The issue is not whether we should adopt those models. We should look at them to see whether they might assist us in the work we do. It is perhaps appropriate to consider Ireland, but I think that looking at models that are different would be of more use.

The Convener: Do other members wish to comment?

Susan Deacon (Edinburgh East and Musselburgh) (Lab): Although I do not want to make myself unpopular with colleagues, I do not hanker after a look at yet more legislatures or equivalent committees in other legislatures. Rather, I would like the committee to have more time. We intended to spend time on this subject at our away day and, although I understand why that did not take place, I think that we need more time to reflect on where we are going within the Scottish context, given that Scottish devolution is still embryonic and has continued to evolve and develop, and that we have all learned along the way. It seems to put the cart before the horse to cast around, picking up ideas from elsewhere when we have had insufficient time to take stock of our experience. I accept that it is not necessarily an either/or question, but I would like to factor that point into the discussion.

The Convener: It is an important thought. Would Mary Mulligan like to speak?

Mrs Mary Mulligan (Linlithgow) (Lab): I suppose that I will have to now. I have some sympathy with what Susan Deacon has just said, but I think that we should never shy away from learning from others and looking at other ways of doing things. My preferred framework for achieving that should involve asking what we can learn, rather than just looking at those who are doing similar things and finding how we can improve on them. However, although that is my inclination at the moment, in many ways Susan has said what I was feeling in that I think that we need more time to develop what we are doing before we can learn new lessons. We need to find a balance.

Mr Robert Black (Auditor General for Scotland): One or two comments might be helpful. I am sure the committee is absolutely right to be sensitive to the fact that different systems of government can create quite a different context within which a committee like this or other bodies operate. For example, Denmark is similar to Scotland in that it has a population of 5 million people and is almost an island off the north coast of Europe, and there is a lot of similarity in what one might call the underpinnings of how audit is carried out. For that reason, we find that speaking with the Danes at official level works very well and we have had some useful exchanges.

However, the public accounts committee of the Folketing is a different animal from the Audit Committee of this Parliament. As the clerk's note says, it is made up of appointed, paid members, a number of whom are not politicians but private citizens. I think that I am right in saying that that committee does not take evidence. It is much more of an oversight board that works with the Danish auditor general and can advise and instruct on the work that is undertaken. There may be an advantage to learning more about that process but, in many ways, the public accounts committee of the Folketing might have at least as much in common with the Scottish Commission for Public Audit, which Margaret Jamieson chairs, as it does with the Audit Committee.

If the committee was minded to take this further, it would not be difficult for us to produce a fuller note because we have contacts with other audit agencies. That might help the committee to decide whether it wants to take these matters further. The Dáil is also a different case because, self-evidently, it is the Parliament of a Republic where things are done rather differently from here. The judgment for the committee is whether the context is so different in the Dáil that there is little to be learned or whether, before the committee takes a final decision, a better understanding of the constitutional and government context might help. We can certainly provide the committee with short briefing notes on one or two of the other arrangements.

The Convener: Thank you. After hearing what the Auditor General and members of the committee have said, I am happy to give my reaction. Although the Audit Committee looks into the efficient value-for-money behaviour of public bodies, that does not mean that we should shy away from going beyond our boundaries to find out what good practice is and what different practices exist.

Susan Deacon is right that devolution is at an embryonic stage. For me, that means that it is important for us to have sufficient time to consider the workings of the committee. However, we also need to draw on the experience of those who are in some respects ahead of the game to see whether there are areas—with regard to the scrutiny not just of financial audit but of government in the broadest sense—where we might, as parliamentarians, improve the development of the Parliament in its embryonic stage. Therefore, I make no apologies for putting this item on the agenda. It is important that we consider other audit models in other countries.

I am attracted more to looking at the Copenhagen model because it is so different from ours and I am curious to see to how much it differs, how it works and whether we can learn from its experience. However, I would be happy to take a further paper from Audit Scotland on that model and the model that operates in the Dáil, for members to consider further before we make any final decision. We can consider that paper at a later date. Meanwhile, we can also consider the suggestion that we draw up a paper for discussion during a future away day, when we can take the sufficient time that Susan Deacon says that we require to look not just at other aspects of our procedure but at other areas where we might learn more. Does that meet with the committee's agreement?

Members *indicated agreement.*

The Convener: That is fine.

"A review of bowel cancer services"

10:16

The Convener: Item 3 is a briefing from the Auditor General on his report "A review of bowel cancer services: An early diagnosis".

Mr Black: As committee members are aware, tackling cancer in Scotland is one of the top priorities of the national health service. Colorectal cancer, which is sometimes called large bowel cancer, is the third most common cancer in Scotland and the second most common cause of cancer deaths. In this report, Audit Scotland has looked at the performance of the Scottish Executive Health Department, the regional cancer advisory groups, the managed clinical networks and the specialist hospital-based bowel cancer services in Scotland, and how they are planning and delivering bowel cancer care. The team visited 26 hospitals, including hospitals from each of the mainland health boards, collected management information and clinical performance data, and conducted interviews with staff to identify good practice and review performance against clinical standards and national waiting times targets.

For this study, we also commissioned independent research on the experience of bowel cancer patients. The sample was not large, but it allowed us to form general conclusions about patients' perceptions of the service that they were receiving. We would like to do more of such research as part of our performance audit work in future, so that we are able to report on the impact and quality of services as they appear to the people who are using them.

There are encouraging conclusions to be drawn from our findings. Most patients suffering from bowel cancer in Scotland receive high-quality, well-co-ordinated care. Good progress has been made in providing information for patients and involving them in the decisions about their care, and specialist nurses are making a real difference to patients and their families. However, we have identified five areas that need to be addressed as part of the further development of bowel cancer services in Scotland. Those areas relate to budgets and value for money, waiting times and service capacity, the referral and diagnostic process, the quality of clinical care and, finally, bowel cancer screening. I will outline the main issues in relation to the first two of those areas and Barbara Hurst will briefly take members through the other three.

On expenditure and value for money, although the future direction of bowel cancer services in

Scotland is now clear, a better understanding of how much is spent on cancer services is required and more emphasis is needed on securing better value for money from what we might call mainstream cancer services. Our report highlights the fact that the Health Department is currently unable to identify the proportion of the total NHS Scotland spend that is dedicated to cancer care. Similarly, the department is unable to identify the balance of spend across prevention, detection and treatment.

That said, we must acknowledge the difficulties of clearly separating out resources for cancer treatment from other activity such as that which takes place during the early diagnostic and screening stages. After all, people present with symptoms that might lead to different diagnoses. However, if there is no reliable information, it is very difficult to demonstrate that resources are being deployed well to get value for money.

Our report cites a figure of £460 million as the amount that was spent on cancer care in 2003-04. We cannot positively assure members that that number is accurate or entirely reliable, because it is based on ISD Scotland estimates and calculated using a complex range of data. However, we felt obliged to attempt to give some ballpark figure for cancer services spending in Scotland.

Our report recognises that the regional cancer advisory groups have all made good use of the new money that has been invested to support the delivery of the cancer in Scotland strategy. However, the money that they are using equates to only around 5 per cent of the total cancer spend. In our opinion, the agenda for the future will increasingly depend on securing more efficient and effective use of the £460 million that has been invested in mainstream cancer services.

There might be inherent tensions between the different models of management accountability that are used by the NHS boards and the cancer networks. We have attempted to summarise those tensions in exhibit 6 on page 12 and exhibit 7 on page 13, which lay out the management of the networks. I should say that, by cancer networks, I mean the regional cancer advisory groups and their managed clinical networks, which cover specific cancers such as bowel, breast and lung cancer.

NHS boards have a direct line of accountability to the Health Department but, as the diagrams attempt to show, their relationships with the advisory groups and the clinical networks are based on negotiation and influence. The main point is that the networks do not have direct responsibility for or authority over the use that is made of mainstream cancer services resources. However, efficient patient-centred services will be achieved only through redesigning existing mainstream cancer services. As a result, we feel that there might be a challenge in ensuring the delivery of mainstream services through such slightly arm's-length networks.

The second issue that we have highlighted is waiting times and service capacity. It is very clear that performance is improving, but it is also clear that many patients are waiting too long for diagnosis and treatment. Between July 2004 and September 2004, only six out of 10 patients who had been referred urgently for suspected bowel cancer started treatment within the Health Department's two-month target. If current trends continue, it is unlikely that the target of 100 per cent of urgent referrals starting treatment within two months will be met by the end of 2005.

Much work is taking place throughout Scotland to streamline the process of care; to target finite resources more effectively; and to make better use of technology. Although that is welcome, we should point out that one of the main barriers to improving waiting times performance is the availability of qualified staff such as endoscopists, radiologists and radiographers to undertake diagnostic testing. We suggest that urgent action is needed to train more staff to carry out diagnostic testing. Although endoscopy suites are used to diagnose bowel cancer, many of them are not being used to full capacity. Members will see in exhibit 32 on page 49 an attempt to show the number of endoscopy sessions throughout Scotland that are not being fully used. We have estimated that the unused capacity, which we have been told is due mainly to staffing constraints, amounts to about 30,000 additional endoscopy examinations that could be undertaken annually in Scotland. Moreover, because of the shortage of radiologists, some NHS boards are being forced to employ staff on short-term contracts or as locums from abroad.

Funding has been provided in England for three national and seven regional endoscopy training centres. However, very few such resources exist in Scotland and we feel that action is needed immediately in that area.

At this point, I will hand over to Barbara Hurst, who will take members briefly through the other issues.

Barbara Hurst (Audit Scotland): On referral and diagnostics, most of the delays between the onset and the treatment of symptoms happen outside the hospital. For example, people present late to general practitioners or GPs try to manage the symptoms within their own care instead of referring those patients on. It is important to remember that point, because the action that people should take if they have such symptoms is very much a public awareness issue.

We should also remember that, on average, a GP is likely to see only one person a year with bowel cancer, although he or she will see many people who present with similar symptoms. As the condition is quite difficult to manage within primary care, we are keen to use the report and discussions with clinicians to promote the need for better partnership working between primary and secondary care to ensure that people are identified early and are referred to the right part of the system.

As far as diagnosis is concerned, a developing body of evidence suggests that different tests should be targeted at people according to risk. As a result, expensive and time-consuming tests such as colonoscopies should be targeted at patients with higher-risk symptoms. After a detailed examination of the issue, we have found that a lot of work on developing diagnostic risk-based models is coming to fruition in Scotland. However, when we carried out the fieldwork for this report, fewer than one in five of cancer services had established such diagnostic pathways. I expect that figure to be a bit higher now, because a lot of activity was taking place when we were carrying out the fieldwork.

As well as looking at the processes of the service, we examined some quality indicators simply by following up the existing NHS Quality Improvement Scotland standards for bowel cancer services. I believe that QIS considered the matter in 2002, and this report presented an opportunity to find whether any progress had been made. In general, we found that there had been quite good progress and quite high levels of compliance. However, a few standards are no longer up to date and need reviewing.

There was certainly evidence that some clinicians are not recording everything about procedures in patients' case notes. That needs to be corrected, and we have flagged the matter up with local health boards. Furthermore, there was non-compliance in a few services, which is something that we might want to return to in our discussion. For example, none of the sites was complying with the standard for chest X-rays or scans before treatment. That said, although there is still room for progress, quite a lot of good work has been carried out in that area.

The roll-out of national bowel cancer screening, which is expected to save as many as 150 lives a year, is likely to happen over the next four to five years. However, unless action is taken now to find out how some of those services could be managed better, that measure is likely to put some pressure on existing services.

We need to ensure that there is equity of access to routes into the diagnostic tests for patients from the screening programme and patients who present with symptoms.

I have provided a general overview. We are happy to take any questions that members want to throw at us.

10:30

Susan Deacon: I want to ask some broader, first-principles questions about the report before Audit Scotland staff and colleagues go into the specifics, which are fascinating and enlightening.

My first question is about Audit Scotland's role in producing this kind of report. Why did you select bowel cancer services, rather than another service or cancer services more generally? Why did you take this approach to an area of clinical services? The question that is screaming to be asked concerns the relationship with QIS, which was not mentioned until the latter stages of Barbara Hurst's comments. It strikes me that an awful lot of the analysis and observations in the report fall much more naturally into the areas of responsibility of QIS. The Auditor General knows that I am anxious about the clutter of regulatory furniture across Scotland, but I am always reassured to some extent when I hear that there has been co-operation between different bodies to ensure that there is not duplication of effort at either local or national level and that bodies have made an effort to complement one another's work. I hope that the Auditor General can give me that assurance and explain how he sees Audit Scotland's role in this area.

Frankly, I think that for a large number of your observations, you could have deleted "bowel cancer services" and inserted dozens of others. There are issues regarding spreading of best practice, capacity gaps that cause delays for patients, the role of specialist nurses and better monitoring of spend—the list is almost endless. What do you intend to do with some of the observations that have much wider resonance? Will they feed into some of the overview reports that you publish and that the committee considers?

Mr Black: I will deal first with your question about the relationship between the role that Audit Scotland plays and the role that inspectors, regulators and specialist bodies play. It is very clear to me—and I know to my Audit Scotland colleagues—that there is complementarity between the role that Audit Scotland plays and the role that QIS, Her Majesty's Inspectorate of Education, Her Majesty's inspectorate of constabulary for Scotland and the Scottish Commission for the Regulation of Care play. Those bodies, which I will call broadly inspectors

and regulators, tend to approach issues from the perspective of professional standards.

QIS is a good example. It is the body that concentrates on developing clinical best practice, getting that accepted by clinicians, recommending it and overseeing whether it is applied effectively. Similarly, Her Majesty's Inspectorate of Education examines what is happening in schools and so on. We complement that work by examining in the round the systems that exist to support clinicians in their activity or teachers in the classroom. We tend to take a systems approach to such matters. To the best of my knowledge, QIS does not have the capacity to do that. I hope that we have demonstrated in this report that we can bring a different dimension to issues, compared with bodies that deal purely with clinical standards.

Bodies such as QIS have a huge agenda to cover, so we have an understanding with QIS that from time to time we will revisit some of the major issues of clinical standards, to see how effectively they are being implemented and whether, to the best of our ability, we are generally finding value for money in how standards are being implemented.

The starting point for this study was a discussion that I had some years ago with Lord Naren Patel, who is the chair of QIS. We accepted in principle that we could move along this line and that what we would be doing would support QIS. That subsequently led to work between QIS and Barbara Hurst's team to develop a memorandum of understanding, which is now pretty well in place. We are comfortable with the complementarity of roles.

Ultimately, the test is the quality of the pudding. I am satisfied that this is a strong piece of work that provides important evidence on how the cancer care strategy is being implemented in Scotland. As we say in the report, there is a lot of very good work going on. However, I would like to think that this evidence base will be useful to those who are implementing the strategy in future.

Barbara Hurst or Caroline Gardner might wish to add something.

Barbara Hurst: To go back to the first question, on why we selected bowel cancer services, I feel strongly that we should be looking at clinical areas because that is where the big money is in the health service. Although there are a number of areas that we could examine, the clinical priorities are an obvious one. Of the three clinical priorities, Audit Scotland had previously done some work on mental health issues and a lot of work was going on anyway on coronary heart disease. That left us with the issue of cancer. We knew that work was being done on breast cancer. Bowel cancer looked like an area where there was something of a Cinderella service, but it also looked like one where we could make recommendations that would add value, which is why we ended up selecting bowel cancer. I am glad that we did so because the report has fed into the present climate of raising awareness about bowel cancer—obviously, however, we did not know that when we selected that area.

As the Auditor General said, QIS is very much focused on clinical professional standards. We had a discussion with QIS very early on and said that we wanted to look at the whole service; clearly, an important part of that is the clinical standard of service. We agreed with QIS that instead of its doing a follow-up, we would incorporate that follow-up in our own piece of work. I hope that that reassures the committee about joining up regulation, inspection and audit.

On added value, nobody had previously looked at any of the capacity issues in this area. Although the report simply opens up debate on that, it makes an important contribution. We tried to look at the whole patient journey rather than just what happens to the individual in the hospital. One could argue that we could have done more at the primary care end, but the report was an ambitious project in any case.

Finally, I will pick up on Susan Deacon's point that we could have dealt with various other issues. We have had various discussions in the committee about different issues of capacity and performance management, and we have already started thinking about our next overview report for the committee. There are some interesting issues with regard to the accountability of the managed clinical networks, alongside the health boards and the department, which we might try to make one of the themes that we look at in more detail in the overview report.

I am sorry if I was a bit long-winded, but I wanted to pick up on the various points raised by the member.

Susan Deacon: That was very helpful.

Margaret Jamieson: I found the whole report very interesting. The part of it that underlines some of the issues that have arisen in other reports by Audit Scotland concerns the relationship between QIS and the centre for change and innovation. Barbara Hurst said that QIS develops professional and clinical standards. In an ideal world, we would expect those standards to be replicated in every hospital in Scotland, but the report tells us that that is not the case. Why do we have a centre for change and innovation if it is not driving changes and ensuring that they are in place, which would benefit patients? There would not then be the wide discrepancy that the report highlights.

What differences exist in the use of specialist endoscopy nurses? In my health board area, significant investment has been made in the training of nurses, to ensure that they can undertake certain levels of endoscopy without the presence of a consultant.

My final question relates to the variation in referrals by general practitioners. Does that variation occur within individual practices and health board areas, or are some areas better than others? Is standardisation of referral possible, given that we now have the general medical services contract and the new community health partnerships? I am sorry that my questions relate to different bits of the report, but I believe that this issue needs to be tackled in a joined-up way, which has not happened before.

Barbara Hurst: I will try to deal with the questions that you have put. You will have to come back if I miss out any of them.

The centre for change and innovation has done many individual bits of work on these issues with different boards. In particular, it has pushed hard on nurse endoscopists. If you want to probe more, you will need to direct questions at the Health Department. There is much evidence that nurse endoscopists can provide high-quality care. The Auditor General alluded to that in his presentation to the committee. We in Scotland are a little way behind England, which has pushed ahead on developing the role of nurse endoscopists. We wanted to flag up the issue because, although in Scotland there has been a relatively big increase in the number of such nurses, it is not on the same scale as the increase in England and the same formal training programme has not been put in place. We think that the department needs to look at that, especially given the pressures that the roll-out of screening may place on it.

You asked about the variation in primary care referral and the GMS contract. I think that the GMS contract does not include any specific provisions relating to bowel cancer. I am not sure whether it includes provisions relating to other cancers. In our view, that does not mean that something should not happen to improve the referral processes. This sounds very processy, but we think that it is crucial that boards and all practices should agree referral protocols, so that there is standardisation of the types of referral information that are included. Such protocols would ensure that, once someone was referred to the secondary care service, they did not get lost and there was not a paper chase because they had been sent to the wrong place. That is why we pushed standardisation strongly. The protocols would have to apply to all GP practices and secondary care providers in an area.

Mrs Mulligan: I was interested to hear the general response that you gave to Susan Deacon's questions, but I want to concentrate on screening, which Barbara Hurst mentioned. Given the trials that have been run, would you say a little more about the usefulness of screening in picking up cases at an early stage, which is obviously important to people. You said that there would be a five-year roll-out of the programme. Five years seems an awfully long time for something that has been trialled already. Was the five-year period decided on because there is not enough staff or equipment? What are the reasons for it?

You talked about how you bring together those who come through the screening programme and those who are referred by their GP. Are there different pathways? Are there problems in bringing people into the programme because of the way in which they enter it? How can we co-ordinate the two groups so that everybody receives the kind of service that they want?

10:45

Barbara Hurst: The screening programme could be a valuable exercise. It is likely to pick up more people than any of the other screenings for cancers. We are not saying that it is not an effective use of resources. Early evidence suggests that the pilots are successful in that sense.

The roll-out is phased and I do not think that we have an end date yet, so I generously gave a four to five-year roll-out period. The programme should be in place throughout Scotland by the end of 2009. You might want to check that with the Health Department if you decide to take this further.

You asked about accessing the service from the screening route and the GP referral route. In the screening, if someone is picked up in the initial blood test as needing to go for more screening, they go straight to having a colonoscopy, which is almost the gold-standard diagnostic test. If someone comes in through the GP referral route, they might have a range of tests. The health service needs to consider that issue, which probably links in with the diagnostic referral assessments to determine whether someone is high risk. Clearly if someone has come through the screening, they are at risk, but they might be no more at risk than somebody who has come in and has symptoms already.

Mr Welsh: On endoscopies, you pointed to a lack of diagnostic testing staff, allied to unused capacity. How long does it take to recruit and train diagnostic staff and what facilities and funding are available now for training? I think that you said that there was none in Scotland.

Barbara Hurst: We have around 20 endoscopy nurses already in Scotland. Given that nurses are highly trained anyway, they do not need a whole new training programme. I will just check with my colleague Jillian Matthew whether she knows the timescale for the training. We think that it might be a year, but I will get back to you with that information, in case that is wrong.

Mr Welsh: I was just asking about the practicality of training. If there is a need to take up unused capacity, how would it be done and what resources would be required? If I caught it correctly, you said that there were seven national and three regional endoscopy training centres in England. What is our equivalent in Scotland? What sort of training is involved?

Barbara Hurst: We do not have any such training centres—that is the issue for Scotland. If the health service is serious about developing the role for nurses, a formal programme for them has to be put in place.

Mr Black: As we say in the report, the only specialist training currently available is on the nurse endoscopist course at Glasgow Caledonian University. That is not going to meet the need in Scotland.

Mr Welsh: Perhaps I did not make my original question clear. It was about training centres rather than nurses. That key issue has to be addressed.

George Lyon: At paragraph 27 of the key messages report, you list three reasons why referrals cause delays. First, you say that the referrals system is a key reason for delays. What is being done to improve the system? Secondly, you say that

"'named' referrals to individual consultants"

cause delays. Why are such referrals a problem? Thirdly, you refer to

"unclear referral information from GPs".

How is such information causing delays?

At paragraph 31, you say:

"Big challenges lie ahead in meeting the 2005 waiting times target for the diagnosis and treatment of urgent bowel cancer patients and implementing national bowel screening".

Given that the Executive has set out a clear agenda, why are there no training centres in Scotland? Did the Health Department explain why the issue has not yet been tackled?

Barbara Hurst: Our first point about delays to do with referrals partly links back to discussions that the committee has had about the use of information technology and electronic records. A paper-based system might be efficient, but it is slower than an electronic system because paper must be shifted around. We were making the point that the use of paper builds a delay into the system.

George Lyon: What is being done to improve the situation?

Barbara Hurst: We did not consider IT in detail. I will work through our list and say how referrals protocols should help. Named referrals to individual consultants are common practice, but if most referrals are to a single consultant, there is a risk that differences in waiting times will build up, depending on the consultant to whom a patient is referred. One way of dealing with the problem is for consultants to share referrals.

George Lyon: What is currently preventing that from happening?

Barbara Hurst: Partly the culture. There has always been a tradition of direct referral to an individual consultant, although that is breaking down to some extent and the culture is changing.

Unclear referral information causes delays. Given that the symptoms can indicate not just bowel cancer but a range of conditions, the more specific the referral information is about the symptoms, the more likely the referral is to reach the right part of the secondary care system. If a general practitioner does not provide clear and detailed information with a referral, the patient can easily be sent to a more generalist part of the system for tests, because the urgency of the referral is not realised. The patient might see a gastroenterologist first and then have to be referred to the cancer service. We tried to flag up areas that would be simple to tackle and which could affect the administrative—

George Lyon: Are you talking about referrals from GPs?

Barbara Hurst: Yes, referrals from the GP to the hospital.

I think that I missed one of your questions.

George Lyon: Given that the Executive is prioritising the introduction of screening, and given the current problems with diagnosis, why are there no training centres in Scotland? Did you ask the NHS about that?

Barbara Hurst: I do not have an answer to your question—perhaps you should ask the Health Department.

Susan Deacon: You mentioned the patient feedback that you sought and you said that you plan to expand that approach—you have said so previously, too. Have you considered patient information on bowel cancer? Does QIS or another organisation provide such information? I always think that patient information is important but, given the connection between late

presentation and people's anxieties and embarrassment about going to their doctor with symptoms, it strikes me that it is particularly significant in this area that people should get to know what is involved in the procedures and in the preparation for the procedures. Did you examine that area?

Barbara Hurst: In part. We looked at the written and verbal information and the support that patients who are already in the system get, specifically from specialist nurses. There was a big vote of confidence in the role of such nurses in helping people through a very difficult process and in enabling them to understand what was happening to them. What we did not look at was the information that is available to people before they come into the system. That would be an interesting issue to take up.

On developing our work around patients, it is much easier to access users of services in community care because the same ethical issues do not arise there. Good links into voluntary sector organisations give us access to people, but it is harder to access people in the health service. We conducted a detailed piece of qualitative research with a small number of patients, but we need to investigate how we can get ethics approval so that we can widen the base of patients. However, I think that we might want to examine the issue of patient information generally as a stand-alone study.

George Lyon: Paragraph 32 in the key messages document states what the agenda for the future should include. We have dealt with the first four points. The fifth one talks about

"improving the routine management information available on the cost and performance of bowel cancer services".

How would that be done and who would lead the work, given the complicated nature of the management and the systems that are in place?

Barbara Hurst: In a sense that is a standard recommendation for us, but it is very important that if someone manages a service, they understand it. To understand it, they need to know how much it costs, what they are getting for their money, what the quality of the service is and whether patients are satisfied.

George Lyon: How many of those pieces of information do we currently have?

Barbara Hurst: Some of the information in the report is new information about capacity planning, so that is a gap, and another gap is in the detail about how the money is being spent. Some qualitative work on patients' views has been done, and that could be developed.

I suppose that what I am saying in essence is that quite a lot of information still needs to be examined if the service is to be managed properly. To be fair, the regional networks are doing a very good job in developing clinical audit work around these services. We would not have been able to examine the performance against the QIS standards had the networks not been supportive and co-operative in helping us to do that. We also got the waiting times information from that level within the service.

A lot of work is going on, but it needs to be pulled together properly so that we can look at the whole service and not just bits of it.

George Lyon: Who would be responsible for that?

Barbara Hurst: My view is that the Health Department should give a lead and that, along with the health boards, the local cancer networks should look at the matter in more detail.

The Convener: As there are no further questions, I thank Barbara Hurst and Jillian Matthew, as well as the Auditor General, for giving us a detailed briefing on the report on bowel cancer services.

That concludes item 3. We have agreed to take items 4, 5 and 6 in private, so we will move into private. We will take a short comfort break for 10 minutes while the public gallery is cleared.

10:59

Meeting suspended until 11:14 and thereafter continued in private until 12:25.

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