AUDIT COMMITTEE

Tuesday 20 September 2005

Session 2

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AUDIT COMMITTEE
14th 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)
Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Mrs Mary Mulligan (Linlithgow) (Lab)
Eleanor Scott (Highlands and Islands) (Green)
*Margaret Smith (Edinburgh West) (LD)

COMMITTEE SUBSTITUTES

Chris Ballance (South of Scotland) (Green)
Marlyn Glen (North East Scotland) (Lab)
Mr John Swinney (North Tayside) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Caroline Gardner (Audit Scotland)
Barbara Hurst (Audit Scotland)
Bob Leishman (Audit Scotland)
Tricia Meldrum (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

Jill Alexander (Scottish Executive Health Department)
Alistair Brown (Scottish Executive Health Department)
Julie McKinney (Scottish Executive Health Department)
Mike Palmer (Scottish Executive Health Department)
Dr Kevin Woods (Scottish Executive Health Department and NHS Scotland)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Clare O'Neill

LOCATION

Committee Room 1

Scottish Parliament

Audit Committee

Tuesday 20 September 2005

[THE CONVENER *opened the meeting in private at 09:32*]

09:49

Meeting suspended until 09:50 and continued in public thereafter.

Items in Private

The Convener (Mr Brian Monteith): I welcome our witnesses and the members of the public and the media who have joined us. I make the usual announcement about ensuring that pagers and mobile phones are switched off so that they do not interfere with the public address system. We have apologies from Eleanor Scott and Margaret Jamieson.

Before we take evidence from Dr Woods and his team, we must deal with item 2 on the agenda, which is to seek the committee's agreement to take in private agenda items 7, 8, 9 and 10. Item 8 is consideration of the committee's approach to a number of Auditor General for Scotland reports, item 9 is consideration of a draft committee report on three further education section 22 reports, item 10 is consideration of a draft committee report on bowel cancer services and item 7 is consideration of the evidence that we will have heard from Dr Woods and his team. Do members agree to take those items in private?

Members *indicated agreement*.

"Overview of the financial performance of the NHS in Scotland 2003/04"

"The 2003/04 Audit of Argyll and Clyde Health Board"

09:52

The Convener: I am pleased to welcome Dr Kevin Woods and his team. Dr Woods has asked to make a statement to us about reports on Argyll and Clyde NHS Board and the financial state of management and services in the national health service. I invite Dr Woods to introduce his team. After his statement, members can ask questions.

Dr Kevin Woods (Scottish Executive Health Department and NHS Scotland): Good morning, everyone. Thank you for giving me the opportunity to make an opening statement. I will introduce my team. On my extreme right is Julie McKinney, who is the finance manager for the health boards in the west of Scotland; next to her, on my right, is Alistair Brown, who is head of the Executive's performance management division; Mike Palmer looks after a number of human resources issues that are of particular interest to the committee; and Jill Alexander is head of our analytical services division and has been leading our work on the health care statistics review. I hope that they will be able to give committee members detailed answers to their questions.

I thought that the committee might find it helpful for me to make a short statement covering some key points that will be relevant to today's discussion. Given the breadth of the issues with which the overview report and the report on matters in Argyll and Clyde NHS Board deal, my statement may take me a little longer than normal, but I hope that the committee will find it helpful.

First, members might be interested to hear about our plans for improving delivery performance across the Health Department, in which I have worked for nine months. Very soon after my arrival, I concluded that we needed to improve our ability to deliver on key objectives across the health portfolio. I felt that it was important that we could reassure the Minister for Health and Community Care and the public that the Health Department was doing everything that it could to ensure that important operational standards and key targets were being met. In a nutshell, I have agreed with ministers that the department needs to focus on a core set of clearly defined objectives and targets. We must align our resources to support the delivery of those targets, ensure that health boards have made plans that

show how they will deliver their share of those targets—if necessary, we will intervene to support the improvement of a board's performance when there has been significant variance from the plan—and check that our staff have the right skills and tools to enable them to carry out those tasks effectively and confidently.

As the committee will be aware, on 29 July, the Minister for Health and Community Care announced that the department has decided to establish a new delivery group and an advertisement for the post of director of delivery has recently been placed in the national press. We are currently taking forward detailed arrangements to get that group up and running.

All of that will be supported by a new emphasis on delivery across the department. We are trying to promote a delivery ethos—that is the key word for me—that will inform the work that we do in all aspects of our activities.

I hope that I have demonstrated clearly our determination further to improve the performance of the department and the NHS in Scotland. I would be happy to keep the committee informed of our progress.

The committee has expressed an interest in the review of health care statistics. As you know, that was a strategic review and the report establishes the current position in terms of data availability and appropriateness, sets out the context for the consideration of future requirements and proposes a range of recommended actions covering data needs, data collection and so on. The report is currently being considered alongside our plans for delivery, which I have just outlined, and, importantly, the findings of Professor David Kerr's review. Once we have completed those considerations, the report will be made widely available.

In the meantime, however, a number of actions are already being taken, such as the development of a regular measure of access to accident and emergency services, the development of wider measures of activity in the primary care sector and the consideration of a more orderly process of releasing new statistics. We will be happy to elaborate on that if the committee wishes.

I know that the committee has had an interest in productivity in the health care sector. That is, obviously, a complex subject, although it is referred to as a simple ratio of activity in the NHS to increased levels of expenditure. Previously in this committee, we have discussed the measurement of activity and cost. However, I must say that the effective use of the health service cannot be captured by such a simple ratio. We must also take account of quality and effectiveness, measured in terms of outcomes to patients.

We had a good example of that in recent weeks, with the announcement that a new drug is to be used to help breast cancer patients. The drug is expected to have a significant impact on the number of people who survive breast cancer and on prolonging life. In other words, that will be a higher quality outcome for patients. However, it will cost the health service much more per patient. If we were to use the simple approach of assessing the change in terms of activity divided by expenditure, that might lead us to the conclusion that there had, somehow, been a drop in productivity, as measured in cost-efficiency terms. However, as the committee will appreciate, there are significant quality and cost-effectiveness gains from such an approach. Not long ago, I was here talking about our plans to invest in bowel cancer screening services, where similar considerations apply.

Of course, we are not complacent about the need to improve cost efficiency and are seeking to do so, not least through our efficient government initiatives. However, we should not lose sight of the improvements in outcomes that we have had in Scotland in recent years. For example, between 1997 and 2003, there was a 30 per cent reduction in deaths from coronary heart disease in people under 75, a 23 per cent reduction in deaths from stroke in people under 75 and a 24 per cent reduction in teenage pregnancies.

It is important to consider quality and outcome in relation to the use of resources as well as broad levels of activity.

I know that the committee has focused on the introduction of new pay arrangements and the resources that are associated with them. It might be helpful if I were to give you an update on that situation.

10:00

On 1 July this year, I issued guidance to the health service on the realisation of benefits from pay modernisation—members will have seen the Executive letter about that. The guidance reaffirms the role of the new pay systems as key tools to lever in changes required to meet our service priorities, but it also asks boards to draw up benefits delivery plans and to demonstrate clearly how they use pay modernisation to enable concrete and measurable improvements to patient services. Those plans are now being finalised and they will be monitored and performance managed as part of the delivery focus that I mentioned earlier.

I will briefly update the committee on how we are progressing with agenda for change, which entails the evaluation of over 130,000 jobs in the health service in Scotland. It has been recognised by all

parties to the deal throughout the United Kingdom that the original timetable was perhaps too ambitious and that the original timescale needs to be extended.

The minister and I have been exploring the matter with all NHS boards during the annual review process, which as members know, the minister has been leading this year. We have learned at first hand of the tremendous efforts that are being made by staff and managers to undertake this major exercise as swiftly as possible. The message that we have from our trade union partners is that we need to get the task right rather than to rush it. At the end of August, about 45 per cent of all NHS staff in Scotland were matched to the new evaluation arrangements.

The committee might find it helpful to be updated on what has been happening in the Argyll and Clyde area. Progress has been made since the minister's announcement to Parliament on 19 May of his intention to dissolve the board and consult on new boundaries. I am conscious that members know the background, so I will not go over it. However, when I previously gave evidence to the committee, I said that reaching agreement with NHS Argyll and Clyde on a financial recovery plan was a priority. I am pleased to say that that was achieved soon after my appearance before the committee and the board remains on track to deliver against that plan, although in such a large-scale recovery plan there are, inevitably, risks that need to be carefully assessed and managed.

As the minister said in May, we cannot guarantee that there will be no impact on patient services as a result of implementing the financial recovery plan, but we are clear that any impact will be kept to the minimum, consistent with an orderly return to financial balance.

As members know, the minister's conclusion was that there was no realistic prospect of the board repaying the accumulated deficit. He also concluded that there were underlying difficulties in planning and delivering sustainable, affordable, high quality health care services given the geography of Argyll and Clyde. The area is divided by the river Clyde and there are disparate demands for services in rural Argyll and urban Inverclyde and Renfrew. There is a natural patient flow west to east into Glasgow. We concluded that all that put substantial difficulties in the way of coherent planning of health care services.

It was for that reason that the minister announced on 19 May that he would dissolve the board and consult on redrawing the boundaries of Greater Glasgow NHS Board and Highland NHS Board to take over the planning and delivery of services in the area. At the same time, he announced that the Executive would provide up to £80 million from central funds and from end-year flexibility allocations to write off the accumulated deficit.

The public consultation was launched on 8 August and runs until early November. The minister will respond to the consultation as soon as possible thereafter. On the assumption that he confirms his decision to dissolve the existing board, formal consultation will be required with affected staff and orders will require to be made and submitted to the Parliament for approval.

The three boards are already working closely together to plan the integration of services and the dissolution of Argyll and Clyde NHS Board. Plans are being overseen by the board chairs. A project team is in place with proper procedures for assessing and managing risks and reporting progress and I meet the chief executives regularly to satisfy myself that work is going ahead and to plan.

I recently met a group of senior clinicians from NHS Argyll and Clyde to discuss their perspectives. It is very important that the clinicians are involved with these changes, as clinical services must be maintained for all residents and plans for integration must take account of important clinical issues.

I am conscious that I have covered a great deal of ground, but I hope that my summary will help the committee in reviewing the progress that we have made on the considerations in both the committee's reports.

The Convener: We thank you for covering all that ground. I am sure that that has been helpful to committee members. It is my intention to take questions from committee members in two groups: one on NHS Argyll and Clyde and one on the overview. We will start with questions on NHS Argyll and Clyde.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): There was one overarching question in my mind when the response to our report was published. In the many months during which we considered the issue, and during the extensive evidence that we took both from representatives from the board and from the Scottish Executive Health Department, at no time was structural reform, let alone abolition, advocated as a way of addressing the situation that the board faced. Similarly, in the 140-page report that the committee published, at no time did we conclude that structural reform, let alone abolition, of the board was a solution. Can you advise us why the Executive concluded that that was the right way forward?

Dr Woods: The scale of the problems in NHS Argyll and Clyde is so considerable that it was necessary to take a fundamental look at the way

forward. Although I cannot remember a precise occasion, I think that the minister made it plain several times that he had not ruled out any option in relation to the future of the board. He concluded that the board was geographically unsustainable. That is reflected in some of the history of the past five or six years in NHS Argyll and Clyde. Some of the things to which I referred in my opening statement—the difference in circumstances north and south of the river, and the distinction between urban Paisley and Inverclyde and rural Argyll and Clyde—meant that the board simply was not going to be sustainable in the longer term. For that reason, the minister believed that it was desirable to start again and look at some of those issues on a larger, regional scale. In general terms, NHS Scotland is trying to increase the effectiveness of its regional planning arrangements. We think that that is important. It was on that basis—the unsustainable nature of the geographical entity called Argyll and Clyde NHS Board—that ministers decided to dissolve the board and consult on new boundaries.

Susan Deacon: In the light of that response, would it be fair to say that that was a political decision? As the accountable officer for the purposes of the Audit Committee, do you believe that that was the correct decision, as far as value for money is concerned?

Dr Woods: Yes. I believe that, in the circumstances that NHS Argyll and Clyde faces—which are unprecedented—and given its history, it has been necessary to wipe the slate clean and move on.

Susan Deacon: You said earlier that your emphasis will increasingly be on quality and outcomes. I am sure that the committee agrees with that. It is striking that Argyll and Clyde NHS Board has performed well in recent reports, with achievements such as the reduction in waiting times. The committee identified several areas in which the board was starting substantially to turn the corner, in terms of both financial and service performance. What message do you think that the subsequent decision to dissolve the board sends out to managers in NHS Scotland, given the fact that the management team in NHS Argyll and Clyde was clearly beginning to deliver results?

Dr Woods: Both the minister and I have acknowledged the progress that has been made in NHS Argyll and Clyde on several issues. We recognise the very testing situation that the current management team in NHS Argyll and Clyde have been in, and we acknowledge the contribution that they have made. We are not saying that they have failed in any way; we are saying that, if we are to move on and develop services for people in that part of Scotland, we must have a new geographical and organisational set of arrangements. I am pleased to say that the senior team in Argyll and Clyde is working productively with colleagues in Highland NHS Board and Greater Glasgow NHS Board to make progress. That is the focus of our energies.

Susan Deacon: I do not expect you to be specific about individuals, but what steps have been taken to ensure that the skills of the management team in Argyll and Clyde will be retained and used effectively in NHS Scotland in the future?

Dr Woods: It is obviously not possible to talk about individuals. All such changes must be conducted in accordance with our policies on organisational change—I am sure that you will be familiar with the details of that. We are anxious to retain the skills of talented people throughout NHS Scotland. The focus of our energies is on bringing people together to work through the details of how we make progress.

The Convener: Mary Mulligan has a related question.

Mrs Mary Mulligan (Linlithgow) (Lab): I understand the direction of Susan Deacon's questions. In response to our report, even the Health Department agreed that the new management team has made good progress and that corporate organisation was continuing to provide a service in the most difficult circumstances. Your response seems to be that the only reason for change is geography. If so, what procedures are you putting in place to ensure that the parts of Argyll and Clyde that are to be matched with Highland NHS Board do not have the same kind of difficulties, especially given that Highland NHS Board is already trying to marry quite disparate geographic areas? What lessons have been learned about geography that will ensure that we do not find ourselves in the same situation again?

Dr Woods: You are right to point to difficulties in rural and remote areas, which is a subject that was considered at some length as part of Professor David Kerr's review and one in which I am taking an increasing interest. The particular issue to which you refer may be the arrangements for Fort William and Oban. I intend to visit Oban to have a look at some of the issues closer to the ground, although unfortunately it was not possible for me to get there for a recently planned engagement.

If we can, we must find ways of making services in remote and rural areas more sustainable. For instance, we need to consider the whole basis on which medical staff are trained. I recently had an interesting discussion with Professor Sim from the Western Isles, who is a particular authority on the issue. We discussed how we might approach the

training of junior medical staff to produce a larger pool of consultants who have the expertise that is needed in the circumstances of remote and rural hospitals. I am sure that we will have more to say on those issues in our response to the Kerr review, as we are considering them closely.

Mrs Mulligan: It will be interesting to see how that develops. I hope that people in the former Argyll and Clyde NHS Board area do not feel removed from Inverness, which is where the centre of their health board will be. The other side of the question is how we ensure that the areas that become part of Greater Glasgow NHS Board are not overwhelmed by the severe challenges in Glasgow. Whenever we look at the health figures, Glasgow's needs and requirements are at the forefront. How can we reassure people that that will not become a problem for them?

10:15

Dr Woods: One important way of providing such reassurance that has not been mentioned is our plan to introduce community health partnerships throughout Scotland. This innovation in our organisation is intended to provide a local focus; to devolve management of and responsibility for a large range of services; and to work in concert with colleagues in partner organisations. Making a success of community health partnerships is the key way forward in ensuring that we have a local identity within a large system to address coherently planning issues that might span large geographical areas. Indeed, later this week, the Minister for Health and Community Care will make a speech on our plans for community health partnerships.

Mrs Mulligan: That response is quite positive. However, the success of CHPs will be ensured only if we work in partnership with local authorities. One constant concern about Argyll and Clyde NHS Board was that it had to work with five different local authorities to deliver its community services in particular. What has been done so far to develop better relationships with local authorities and ensure that CHPs are given a good opportunity to become productive?

Dr Woods: I am not deeply familiar with the dialogue that is going on in Argyll and Clyde. However, it is an important dialogue that needs to get right issues such as the financial recovery plan and the non-acute clinical strategy. I understand that those discussions are under way.

In other parts of Scotland—I think that this is true of Glasgow—a number of CHP models have been developed that feature very close working with local authority partners and demonstrate a genuine willingness to engage on a joint journey to improve services for patients. We see the benefits of such an approach and, indeed, want it to be introduced everywhere.

Margaret Smith (Edinburgh West) (LD): This committee's report on Argyll and Clyde was quite critical of the fact that the accountability review process had not examined key strategic issues. In your response, you said that the committee's points in that respect would be taken on board in the 2005 reviews, which would be headed up by the minister himself. How were the committee's comments taken into account in this year's annual review?

Dr Woods: As you have pointed out, this year's annual reviews have been conducted rather differently. However, there is one similarity with the previous process. The annual review provides a particular focus for a dialogue with boards. Throughout the year, a dialogue takes place on a wide range of issues—in other words, it is a continuous process. My earlier comments about the delivery group are intended to signal the fact that we think that we can do better in that respect—sharpen up that dialogue and be clearer that what we have agreed with boards will be achieved.

Nonetheless, we have proceeded through this year's annual review by focusing on a common agenda and identifying areas such as health improvement, improved access and efficiency and productivity that we feel are strategically very important and that have been of concern to the committee. We have also looked at the boards' financial position to satisfy ourselves that they are on track to live within the available resources and that, if they have an accumulated deficit, they have a recovery programme that can be delivered. We are aware that we can build on all that work—and we will do so.

I hope that the committee will not mind my making an related point, but your report expressed concern about how the department received and analysed boards' financial plans. I am pleased to say that we have spent considerable time revising our internal protocols for that. Julie McKinney may wish to elaborate on this, but within the department there is now a process of detailed examination and escalation, if we have concerns about matters. We are also looking closely at the skill mix within our finance team to ensure that we have appropriately qualified people.

We have been doing a range of tasks in a dynamic and continuous process of performance management, in which the annual review meetings deal with a particular point in time. The annual reviews have gone well and there has been a great deal of public and media interest in them. People who attended them saw the minister conduct the accountability process in an open and public way, which is healthy.

Margaret Smith: Can we hear from Ms McKinney?

The Convener: The line of questioning that I was going to follow up was to point to paragraph 35 on page 11 of our report on Argyll and Clyde—point 10 of your response—which raises the issue of capacity in the department to look at the financial analysis. I would certainly welcome any further detail that Dr Woods or Julie McKinney can give.

Dr Woods: I will set the context before Julie speaks. The key feature that we require from each board is a five-year financial strategy. That document is the starting point for our analysis. I will let Julie elaborate.

Julie McKinney (Scottish Executive Health Department: In July this year, we produced a formal protocol for the review and analysis of all NHS boards' financial plans and monitoring returns, which sets down in writing the department's procedures for receiving, reviewing and approving financial plans. We can make a copy of it available to the committee, if members would like to see it.

The protocol sets down all our procedures, including those that we would take with boards that achieve financial balance and, more important, those that we would take with boards that are in financial difficulties. It is important that the protocol also sets down the requirement for us to agree in writing the financial plans that boards submit each year. We obviously had difficulty in that area with NHS Argyll and Clyde.

Dr Woods: I have the protocol document here.

The Convener: It would be good if you could leave it with the clerks.

Dr Woods: We will send it to you properly, if that is okay.

The Convener: That is fine.

Mr Andrew Welsh (Angus) (SNP): I want to go back to Dr Woods's remarks about rural services in Argyll and Clyde. If rural service provision is the problem, is there a model elsewhere in Scotland that you can follow, or is your solution for Argyll and Clyde unique?

Dr Woods: Services in remote and rural areas have many problems in common. For example, there are circumstances that are particular to the islands. In recent years, more collective work has been done and successful models have been deployed in several places. I recall that the hospital in Stranraer, for example, went through a difficult period. However, arrangements were made in Dumfries and Galloway that seem to be working productively and which have enabled a range of important services to be delivered locally in Stranraer rather than in Dumfries. That is what we are exploring in the context of our response to Professor David Kerr's report. Members will remember that there was an initiative some years ago called RARARI, which was the remote and rural areas—I cannot remember the rest.

Alistair Brown (Scottish Executive Health Department): Resource initiative.

Dr Woods: Thank you.

Mr Welsh: I hate acronyms.

Dr Woods: I hate them, particularly when I cannot remember what one stands for halfway through describing it. However, that initiative stimulated a lot of good work. Indeed, I think that the appointment of Professor Sim came on the back of it. Our intention is to try to progress such an approach in a number of other places. Telemedicine, for example, may well have a great deal to contribute. The minister and I went to each of the island groups this summer to conduct annual reviews and we saw some of the initiatives that have been pursued.

The other feature that we often see is organisations that are developing extended practitioner roles, with other professional groups, such as doctors, taking on additional responsibilities. A range of models, rather than a single solution, might be deployed. The mix that is used will depend on local circumstances.

Mr Welsh: Thank you for that clarification.

On the financial recovery plan, the Executive's response says:

"Despite the terms of the financial recovery plan, there remains a significant risk to delivery."

A plan is a plan, but monitoring the delivery of a plan is what really counts, especially when it is described as being at "significant risk" before it is even implemented. Given those caveats, how confident are you that the recovery plan will be delivered?

Dr Woods: We have recently discussed the plan with NHS Argyll and Clyde. From those discussions, I understand that in broad terms this year's plan is on track. We are confident that it will be delivered. Inherent in such a plan are risks about the timing of arrangements, particularly if they involve property transactions, because one cannot be entirely sure about some of those timings. I understand that the board is on track this year and that it is taking the steps that it planned to take. It is in productive discussions with its partners on those matters.

Some risks next year will have to be anticipated and carefully managed. All that I am trying to say to the committee in the response and here today is that, in so far as it is humanly possible to manage

such a large-scale set of changes, we believe that the board is on course. However, I do not wish to mislead the committee into thinking that the plan is risk free, because it is not. We are trying to identify and manage the risks.

Mr Welsh: The plan is obviously not risk free. How closely do you monitor the position? Does that happen monthly? How quickly could you spot whether a plan was off course?

Dr Woods: We monitor such matters monthly. Julie McKinney and other colleagues met the board just last week.

As for other boards, in which I know the committee has had an interest, I spoke in the past few days to the chief executives of Lanarkshire NHS Board and Grampian NHS Board because I wanted to satisfy myself about their positions, in addition to the monitoring that continues. I am pleased to say that they are where we expect them to be. We keep a close eye on such matters.

Mr Welsh: You said that the impact on patients would be minimal and that you would seek to minimise any impact on patient services. How will that be achieved?

Dr Woods: We are trying to signal that, with such a large-scale set of changes, some alteration in how services are operated and designed is inevitable. We simply want to do our utmost to ensure that impacts on patients come last and that savings behind the scenes are achieved first.

The committee will be aware from previous evidence that, in Argyll and Clyde, much work has been done behind the scenes and a process has been agreed with trade unions whereby several staff are taking voluntary early retirement. We are trying to preserve and redesign services while making savings in non-patient areas wherever possible. We say merely that, given the unprecedented scale of what has happened in Argyll and Clyde, one must be alive to the fact that the current pattern of patient services cannot be set in aspic. However, we want to ensure that services remain effective for the patient.

Mr Welsh: To measure such matters, it would be inadequate and simplistic simply to measure activity and expenditure. More subtle methods could be used, such as the measurement of quality. However, how to measure quality gains is a problem. I have seen that performance indicators in local government have an in-built problem. I remember that somebody in my local parks department said, “In the past, we used to cut the grass. Now all that we seem to do is measure it.” Are you aware of those problems when you consider how to measure quality? If you do not get that right, patient services will be affected.

10:30

Dr Woods: I agree. Quality measurement is especially difficult. The point that I was trying to make to the committee was that it has to be factored into our considerations of how health service resources are being used. When we consider outcome indicators, which are the true measure of quality, we are very much on track in Scotland. When I spoke about cancer services previously, I reported that we are on track to achieve our target.

On the other hand, there are a number of intermediate measures of quality, or process measures. Some of the work that is done by NHS Quality Improvement Scotland—NHS QIS—is leading the way; a series of standards is in place. To refer back to my previous evidence to the committee, we are pleased that all our cancer services in Scotland now meet the accreditation standards, which are measures of process quality, if you like, that have to be achieved in those important clinical services.

The more general problem of measuring quality and outcomes in national statistics is something that the Atkinson review—a review of United Kingdom statistics—is considering. Jill Alexander might want to elaborate on that, but it is a complex intellectual problem.

Mr Welsh: I wish you well, not only on measurement but on delivery.

The Convener: Are members content to move on from questions on Argyll and Clyde?

Members *indicated agreement*.

The Convener: Given that Andrew Welsh has raised the question of information, I would like to give Susan Deacon the opportunity to move into that area. It is a line of questioning in which she was interested, so we might as well continue the discussion.

Susan Deacon: Dr Woods, you will be aware that the committee has taken what I suspect is an unhealthy interest in the issue of information over an unhealthy period, but for good reason, because we are greatly concerned by the absence of a clear picture of performance in the NHS in Scotland. As the convener said at our previous meeting, we all genuinely welcomed the directness of your response to our financial overview report and the fact that you agreed that improvements were needed in certain areas. Management information was one such area. However, for all I hear the assurances that work is under way, it strikes me that—dare I say it?—given your formal role, and that of Alistair Brown, in the Health Department, you have between you a decade’s experience of heading up the performance management function in the

department. Why is management information proving such a profoundly difficult area? Why is it that time and time again, successive health ministers and First Ministers have to put all sorts of caveats on, and give all sorts of explanations for, the published statistics because those statistics simply do not tell the story of what is happening in the NHS in Scotland today?

Dr Woods: The committee's interest in those matters is welcome and right; I do not contest that at all. We acknowledge that, over a period, a number of our data sets have not developed and kept pace, particularly with some of the changes in care delivery settings. We are trying to recover that ground. However, we have a great deal of good information about what happens in our health service. If you will permit me, I would like to put on record the fact that ISD Scotland—the information and statistics division—has an international reputation for the quality of the statistical information that it produces. It is able to do things that are the envy of other countries in the UK, in terms of record linkage and its work on outcomes. We need to remember that important context. However, we acknowledge that we need to do better in some of those areas to keep pace with developments in health care and in care delivery settings. That is what the strategic review has set out to do. I previously indicated that I would be happy to talk to the committee at some length about what is going on in the review. What I should perhaps do now is pause and invite Jill Alexander to give you an update on where that work has got to and what the thinking is around it.

Jill Alexander (Scottish Executive Health Department): There is a draft report on the strategic statistics review. Over the course of the past year, when we carried out the review, a number of major changes were made, which expanded the review's remit in the context of our consideration of the kind of information that we need for the future. That had a huge impact on how we thought about the review. As Dr Woods said, the final report considers a number of different areas. We started off thinking mostly about data needs, but the report covers the way in which we collect, present and give access to information. It covers a broad range of issues; there are approaching 40 recommendations in total.

To test the recommendations before they were included in the draft report, we conducted a fairly detailed second-stage consultation with a number of organisations, such as health boards, local authorities and Audit Scotland. We got a positive response to the recommendations and took on board a number of additional recommendations that came out in the discussions. The recommendations have therefore been aired fairly broadly.

There is a range of types of recommendation. Recommendations that you would expect us to take forward quickly—Dr Woods said that we are making progress on some of them—include those on getting better information more quickly about access to A and E services. We carried out a census last week on allied health professional activity. We are considering the kind of information that we can get out of the new quality and outcomes framework and how to get better information from primary care on how long-term and chronic illness is managed. Those things have to happen quickly; we cannot wait for full consideration of the report alongside the other activities of developing the delivery service in the department and considering the implications of the Kerr report.

Although there is a range of important and exciting recommendations, the report has not stopped there. We have explored the context in a lot more detail, which I think will be extremely helpful in getting other people's feedback. We have developed a new flow diagram, which shows how we understand activity, resources and the workforce to be flowing through the system, what the relationships are and where the bottlenecks are likely to appear. That is an important new development.

We have also taken the first steps towards developing an information framework, which we discussed at some length with colleagues at Audit Scotland. We are mapping out what we need to understand about health and care services in order properly to monitor and improve delivery over the longer term. I am happy to answer more detailed questions.

Dr Woods: I would like to add a word or two in response to Susan Deacon's question about the context of performance management. As well as conducting the statistics review, we are giving a lot of thought to the key data that we need for in-year monitoring of performance. The delivery group is taking that work forward—I did not want to lose that point.

More generally, we are adding to our information on performance in key areas. We are introducing a workforce information system, known as SWISS, which will enable us to get much better information on a range of workforce issues, including absence, which is important to us. The benefits realisation Health Department letter on pay modernisation will yield additional management information on performance for us.

The QOF in primary care has taken us to a different place in our understanding of what is going on in general practice. The recently published NHS workforce plan, which we are developing at local, regional and national level, will add to our overall knowledge for performance

management purposes. Mike Palmer might want to say a bit about the QOF in particular.

Mike Palmer (Scottish Executive Health Department): The QOF represents an absolute revolution in the amount of information that we now have on the activity that is going on in general practitioners' practices throughout Scotland and the United Kingdom. As far as we know, this is the first time that any country has attempted to establish a quality and outcomes framework in which information is systematically assessed, evaluated and collected in this way across a country the size of the UK. In Scotland, we were able to publish our data ahead of any other country in the UK, earlier this year. The exercise was an incredibly rich source of information, which local health boards were able to use to enable them to be more transparent for their patient communities on the activity and performance of GP practices in those communities. There was a lot of generally constructive and positive press response to the information that came out.

The other positive thing about the QOF is the fact that all parties—the profession, the Government and health boards—accept that it is a journey of continuous improvement. We will build on and develop the QOF. We will continuously improve and enhance the performance of GP practices by looking at the year-on-year information that we get back, reflecting on it, reviewing it and ensuring that we raise standards for everybody on the back of the information that we get.

Susan Deacon: You have outlined to us that a huge process is under way to make improvements across a range of areas. I am sure that the fully-fledged anoraks on the committee will be keen to explore the detail of that process further when we meet informally. When will the general public be able to get a clearer picture of performance in the NHS in Scotland—especially in the key area of waiting—in terms that they can understand? [*Interruption.*]

Dr Woods: I have just received a note—I am not sure why or where it came from.

We publish a great deal of data on the ISD website on waiting time performance. We publish quarterly all the important information that we have—which, incidentally, shows that we have a very good record in Scotland, over recent years, in relation to decreasing waiting times. We make a great deal of those data available. Could we do more to make them accessible to the public? I would be happy to consider that, but there is no shortage of published data.

Susan Deacon: With respect, there surely is a shortage of data. Every time that the issue is debated in the public domain, whether in the Parliament or among the wider public, qualifications and caveats have to be placed on the data, not least because it is acknowledged that there is insufficient information on performance and the delivery of services outside hospital settings—in primary care settings, nurse-led clinics and so on. As a consequence, the public are unable to get a clear picture of performance in that key area; they see the statistics that are published only on one area of activity. I see that you are nodding. There is general agreement about what the problem is, which returns me to my question. How and when will we see an improvement in that area, so that all concerned can get a clear picture of performance?

Dr Woods: I may have misunderstood the direction in which you were going; I apologise if I did. That is where our work on data deficit is very important. In September last year, we started to publish information on out-patient activity, where so much work goes on, for the first time. Perhaps Jill Alexander can say a bit more about the data in primary care on allied health professionals, nurse-led clinics and so on. I think that that would be of interest to the committee.

10:45

Jill Alexander: We are talking about recent developments from the past year. ISD presents them as developmental data sets, which is why we are not seeing the whole picture yet. As the committee is aware, there are still gaps that we need to fill. Over the past year, major progress has been made and we now have information on nurse-led clinics, one-stop clinics, AHP activity, out-patient procedures and so on. The data still need to be fully tested, but already they are showing that major activity is taking place in non-acute environments.

We need to keep working with ISD to understand exactly how best to present the information. That is partly covered by the recommendations from the statistics review. The complete story has not been put together yet, for the developmental reasons that I outlined.

The Convener: Before I call Andrew Welsh, I have a question for Dr Woods. You mentioned the QOF, and we heard the explanation for that acronym. However, you also mentioned SWISS. Is that an acronym too?

Dr Woods: It is the Scottish workforce information system. [*Interruption.*] My colleague is reminding me that it is the Scottish workforce information standard system.

The Convener: Thank you. I am sure that that is accurate.

Dr Woods: I am sure that we have a whole department to dream up these names.

The Convener: Indeed.

Mr Welsh: Accepting that non-recurring resources can be used in some limited circumstances, surely they can be used to balance base budgets but not to balance the books. In your response to the committee's report, you said:

"We agree that the use of non recurring resources to meet recurring expenditure is inappropriate".

How many boards are likely to be in that category? What assurances can you give that the practice will stop?

Dr Woods: What is the recommendation number?

Mr Welsh: It is recommendation 8, on page 31.

The Convener: It is on page 3 of your response, Dr Woods.

Dr Woods: Where we agree very much with the committee is that no board should sustain its on-going position by relying on non-recurring moneys. We are very clear about that. However, non-recurring resources are a fact of financial life and can be useful and important, but they should be used only for non-recurring purposes, and not for sustaining services in the long term. That is why we tried to introduce into our financial monitoring arrangements a more transparent way of tracking the use of non-recurring resources. I have been pursuing the subject with chief executives in the NHS, and we have now built such tracking into our monitoring.

Because of the way in which the accounts are done, there are some limitations to the information that we can display at the national level. I defer to my accountancy colleagues to guide me on that. We are clear that boards need to be much more transparent in their use of non-recurring moneys, about which we have made some recommendations. We are also clear that non-recurring resources should not be used to sustain a board's long-term position and that boards should be open about and minimise their use of non-recurring resources. However, non-recurring resources arise and can be useful for progressing things. I am not sure whether Julie McKinney wants to add anything on the subject.

Mr Welsh: Given that you now have monthly statistics, can you tell us what the current state of play is?

Dr Woods: I am sorry—could you repeat that?

Mr Welsh: Given that statistics that show a detailed analysis of recurring and non-recurring resources and expenditure are now returned monthly, can you tell us what the current situation looks like?

Dr Woods: Board by board? I am not sure that I have the information to hand.

Mr Welsh: We want to know where the problems are.

Dr Woods: I am sure that we could send the information to the committee.

The Convener: That is fine.

Mr Welsh: The Executive's response refers to the format of the accounts. At first glance, it looks as if the way in which the Scottish Executive keeps its accounts is not suited to the disclosure of the use of non-recurring funding nationally. Is the problem really insuperable?

Dr Woods: Again, I defer to my accountancy colleague on the subject.

Mr Welsh: The comment is on page 3 of the response.

Dr Woods: Yes—recommendation 10.

Julie McKinney: The format of the annual accounts of NHS boards is dictated by the resource accounting manual, which is issued by Her Majesty's Treasury and adopted by most Scottish public bodies. That format discloses some forms of non-recurring resources, for example, profits and disposal of fixed assets, but not necessarily all. That is why we have a specific form with our monitoring returns that we get from boards each month that will identify all sources of non-recurring income and how that income is spent. We are tracking that much more clearly as of this year.

The Convener: Is that a minimum standard that you can add to and develop?

Julie McKinney: Yes. The information is available to the board, the department and Audit Scotland, but it is not necessarily disclosed in the annual accounts.

Mr Welsh: Why not?

Julie McKinney: Because the format of the annual accounts is prescribed by the Scottish Executive and, ultimately, the Treasury.

Dr Woods: We are trying to ensure that that information is published and made available locally. That will enable people to find out about non-recurring spending, even if the information is not in the national accounts. I think that that deals with one of the concerns that the committee has expressed on previous occasions.

Margaret Smith: I want to ask about the HDL that you sent out on 1 July, which dealt with the benefits of pay modernisation. It says that the pay modernisation benefits delivery plans that will inform us of the progress that has been made should be available by 30 September. I know that you said that the plans are being finalised, but when will they be available?

Dr Woods: Mike Palmer will answer that question in detail, but the short answer is that the plans will be ready by the due date.

Mike Palmer: We are confident that the plans will be delivered by the due date. We asked for draft plans to be sent to us last month so that we could have a look at how the boards were doing and could help them out if they had any difficulties with responding to our requests. We have seen the draft plans and have made some comments that we hope were helpful and constructive. We have identified areas in the plans that we think could be developed to enhance their content and demonstrate benefits more concretely. We are confident that the boards will take on board our comments and submit their finalised plans by the end of this month.

Margaret Smith: I think that you said that there had been some slippage in the timetable for the agenda for change. What is the likely timetable and how will that impact on the monitoring of the plans?

Dr Woods: We got a clear message from the trade union representatives that people wanted to get the agenda for change right, even if that took a bit longer. During the annual review process, the minister and I meet our local area partnership forum, which brings together all the staff-side representatives with management. It was in those meetings that that representation was made, and we have been happy to take that view on board.

The problem is not unique to Scotland; it is apparent in the other United Kingdom countries. Dealing with such a large number of job evaluations and job matching exercises takes a little bit of time.

We do not want the process to drag on and we are trying to decide what the outer limit should be. The minister has not yet made a final announcement about that, but I think that we are looking at the end of the calendar year or perhaps slightly later.

The fact that the agenda for change is in progress makes it difficult to talk about benefits realisation. In many respects, although the benefits realisation HDL is about the agenda for change, it is also about acknowledging some of the contracts that have already been announced and implemented, such as the new GMS and consultant contracts.

Margaret Smith: I will pick up on an issue that has an impact on the accounts, but which is fundamental to policy. How will you monitor whether pay modernisation has delivered benefits and improvements in recruitment and retention?

Mike Palmer: We use a number of mechanisms to monitor the various impacts and factors that fall out of the new pay contracts. Each of the contracts is overseen by delivery groups that we have set up jointly with the service. A key dimension of that is that the department and the boards have joint, integrated oversight. Oversight groups examine different aspects of the benefits that we are looking to procure from the contracts. The groups constantly check and review the progress that we make against the anticipated benefits.

The consultant contract and agenda for change offer the potential to apply recruitment and retention premia to specific staff groups, if it is felt that there is a recruitment and retention issue that has not been addressed in the base salaries that have been agreed in national negotiations. That dimension is monitored constantly. For example, there is a partnership-based steering group and an employers reference group for the consultant contract. For the moment, it has been decided that there should be a moratorium on all the recruitment and retention premia because it is felt that the contract already addresses specific pay-related recruitment and retention issues in the base salary.

Similarly, the Scottish pay reference implementation group is a partnership-based oversight group that has a recruitment and retention policy that is related to agenda for change. It reviews regularly whether there is any compelling reason to discuss whether recruitment and retention premia should be applied to specific staff groups. That is an illustration of how one strand is considered; it would take me much longer to go through all the different strands that emerge from the contracts.

Margaret Smith: That is reassuring. I had heard, anecdotally, that ward sisters would do rather well out of agenda for change. I think that everyone would agree that that is a good thing. However, I had also heard that people who work in the community and who may have had to take another degree to do that might find themselves not doing quite as well. If there is a possibility that agenda for change might offer perverse incentives, whereby one set of staff is seen to do better than another, that will play a part in decisions that people make about their career paths, which could have a knock-on impact. From what you have said, I am reassured that there are people who are considering such matters.

Mike Palmer: That is the case.

11:00

Dr Woods: Agenda for change is designed to promote equal pay for work of equal value and to harmonise all terms and conditions across a variety of staff groups. We must not lose sight of the fact that that is one of its key objectives.

Mrs Mulligan: You have probably answered most of my questions on productivity, but I will press you on one final issue that you raised about balancing quality against activity. Are you confident that you can get the balance right? Secondly, given all the statistics and information that you have said you are in the process of gathering, how do you intend to show quality rather than just activity?

Dr Woods: You will know that a number of objectives under the efficient government initiative are related to productivity. We have set out clearly how the gains will be measured. One of the initiatives will be underpinned by work that is being led by our medical directors, who have confidently agreed to undertake detailed work on consultant productivity. They will keep a sharp eye on the balance between quality and productivity, but those two aspects should not be regarded as being in conflict with each other, as it is possible to achieve greater productivity and to enhance quality at the same time. That will be one of the considerations of that group.

Mike Palmer might want to update us on that work.

Mike Palmer: Dr John Browning is leading some work on consultant productivity with his medical director colleagues. We have also had discussions with the British Medical Association, which clearly has views on the issue and can make a contribution to help to ensure that the measurements that we make are sensible and take into account the complex issues around quality.

One of the issues that is being factored into the productivity measure is case complexity, which is a tremendously important dimension to take on board. If, for example, someone does 10 complex cases they may turn out more productivity than someone who does 20 straightforward hip replacements. That is the kind of clinically informed adjustment that the medical directors are working on with ISD, with input from the profession. The aim is to factor such issues into the measure to ensure that it is sensible, reflects clinical practice and reflects fairly the amount of effort and quality of work that is put in.

Mrs Mulligan: That follows on from Susan Deacon's point about making such information available in a way that we can all understand and which shows us clearly what is going on in the service.

I turn to the paragraph about incentives, on page 13 of the paper. We have talked this morning about many of the changes that are taking place in the health service, for example agenda for change and organisational changes. The committee had said that it was concerned about perverse incentives arising from those changes and improvements. The Health Department has noted the point, but it has concerns about how the health service could be incentivised to make the necessary changes. Why is it not possible to do that financially? How would you encourage people to respond to the challenges of change that are before them?

Dr Woods: What is the number of that recommendation?

Mrs Mulligan: The recommendation number is 33 and the paragraph reference number is 77. It comes under the heading "Incentives". I assume that you have the same paper as we have.

Dr Woods: Someone has found the relevant page for me. Thank you.

We believe that we have established a performance management process in Scotland that can achieve the desired results without the need to resort to market-style incentives. That is the context for the issue. We believe that our work on delivery will bring clarity to key objectives and operational standards by providing targets in areas in which we want to raise performance. Linking that work with our work on redesign, which is an important intention for the delivery group, will ensure that we go a long way towards achieving our targets. Perhaps the committee heard some of the progress that can be made by using such an approach in its previous discussion on improvement in bowel cancer services.

We should not lose sight of the fact that, the length and breadth of Scotland, we constantly see professional staff who are deeply committed to their work and who have a desire to improve services. One of the great things about the health service is the sense of vocation that exists among the staff. Our job, I believe, is to support that and to help people to make those changes.

I hope that the committee will not mind my saying that, when I went round the different health boards, I spent part of one week with an addiction service in Glasgow. I found that the staff there—both health service and social care staff—worked very hard to deliver some extremely important services to vulnerable people. The staff were full of commitment and they were bursting with enthusiasm to find new ways of doing things. In other words, whatever the incentive was, it was present and it was working. Two days later, I visited the transplant unit in Edinburgh royal infirmary, where staff showed exactly the same commitment despite the fact that they worked in a totally different kind of clinical service. The staff are deeply and professionally committed to seeking out and making improvements.

As the minister and I went round health boards to conduct this year's annual reviews, one of the

great things that we saw is the way in which people are responding to the opportunities that are provided through things such as the centre for change and innovation. People are capitalising on the support that we offer for redesign and re-engineering. We believe that our focus on delivery and our emphasis on redesign through the CCI, coupled with modernised pay contracts that enable people to be rewarded for taking on extended roles, add up to a sufficient package of incentives that will deliver real benefits to patients. We are already beginning to see those benefits.

That is what lies behind that response in our submission to the committee.

Mrs Mulligan: My hope was that the department does not just respond to information that has been gathered, but encourages staff. We have all seen examples of the enthusiasm with which NHS staff deliver the services that they provide. I am sure that all of us could replicate those examples.

Dr Woods: That is very much why we want to be able to support staff at local level. The issue comes back to community health partnerships, which provide a way of enabling people to make decisions locally that take local needs into account in considering how best to reorganise and redesign services. We very much want to support that.

Mrs Mulligan: What difference will the new employment contract that has been introduced for senior NHS managers make to that? How will the new contract improve that ability?

Dr Woods: Are you referring to the executive managers pay review?

Mrs Mulligan: I refer to the new employment contract that is mentioned in your response.

Dr Woods: I was just checking that that was what you were referring to. That review is not yet complete, so it would probably be premature to report on it. When the response mentions the department's work on tariffs and on a new employment contract for senior NHS managers, it refers to work that is on-going rather than complete.

The Convener: Susan Deacon has a question on e-procurement and related matters.

Susan Deacon: I shall raise the matter briefly, convener; I appreciate that it is a big area, but a couple of things leapt out at me from the response. The first of those things was in the section on e-pharmacy, and specifically on the information about electronic prescribing on page 2, which states:

"Electronic prescribing has been established in Ayrshire Hospital as a precursor to developing standards for electronic prescribing systems throughout NHSScotland hospitals."

Is that a new project or is it the pilot project that has been on-going for a number of years in that area?

Dr Woods: It is another acronym: HEPMA, or hospital electronic prescribing and medicines administration. It is the pilot to which you referred, which has been under development in Ayrshire for some time. The project is very complex; I think that it is covered in Audit Scotland's recent report on hospital prescribing, so no doubt we shall discuss that at a later date.

Susan Deacon: It would be helpful if future responses to the committee could attribute a timescale to such references, because it would be easy to read into that part of the response that the initiative was recent, as distinct from something that has been going on for some time. The project that I am thinking about has been discussed by the committee before and we sought in previous reports to see it being rolled out more swiftly. That clarity would be helpful.

Dr Woods: If it would be helpful, I would be happy to submit a note to the committee giving members an update on that project.

The Convener: That would be welcome.

Susan Deacon: You have previously identified, and we have welcomed, increases in funding for e-health. On page 17, the response refers to

"recognition of the need to make a step change in the development of our eHealth systems".

The previous e-health strategy, which was published by the department last year, was clear about the incremental approach that it would adopt. In our report, we quoted the phrase "incremental approach"; I do not want to sound pedantic, but is your use of the phrase "step change" an indication of just that? Are we going to see a marked acceleration in e-health? If so, when can we expect to see, for instance, the completion of the procurement process that is described over the page in your response?

Dr Woods: First, I should say that we regard e-health as strategically extremely important. There is no question about that. E-health will be central to achieving many of the things that are identified in David Kerr's report, so we accept that.

In essence, we are working in two streams. We are working on the whole issue of procurement for a single electronic patient record; our timescale for that is that, by 2008, we should have procured the system. Between now and then, however, there are a number of things that we can do to fill in important gaps and to provide some of the functionality. One example of that would be information systems to support work in accident and emergency departments; another example would be the picture archiving and

communications system, which is important to radiology and provides high quality digital images. We are also developing and rolling out the emergency care summary, which, with the patient's consent, will enable out-of-hours providers to know something about patients' basic medical conditions.

11:15

We are trying to fill important gaps in our information systems pending the procurement of the single national system to which I referred. One of the things that we are doing right now, and which will be important in the longer term, is pursuing energetically the universal use of the community health index number. If we are to use electronic information, there must be a way of uniquely identifying every person and finding their records. We have set ourselves the objective of universal use of the CHI number by June 2006.

We are operating on several interim fronts to bring appropriate functionality more quickly to a number of places. Another example is the work that has been done on strengthening the telecommunications system so that we have the wires—or, in this wireless world, the technologies—in place to carry the large volume of data that needs to be transmitted securely in a way that protects patients' interests. We are doing such things in the interim, with a view to procuring a single system later. That work is progressing.

Susan Deacon: Thank you for that clarification.

It might be helpful to the committee, and might minimise work for the department, if we had a summary of the outcomes that showed when the various service areas that you have described deliver differently for the service users or patients, or when front-line staff have those tools available to them, because some of this will affect the way in which they work. That area is of the greatest importance to us all and it would be helpful if that information could be distilled for us.

Dr Woods: I think that we can do that.

The Convener: The committee was pleased that the tone of the department's response was positive and, where necessary, frank. Indeed, of the committee's observations, conclusions and recommendations in the overview report, 19 were agreed to, 20 were noted and only two were disagreed to. In the report on Argyll and Clyde, 10 were agreed to, four were noted and there were no disagreements. The department's general tone and approach was very helpful to us in getting to the bottom of things.

Forgive me, but I will touch on one of the areas in which there was disagreement—estimating costs for pay modernisation—so that we might clarify matters. On page 4 of the annex, referring to paragraph 39 of the report, the committee was concerned that the department had

"failed to model pay modernisation costs adequately."

The department's response was to disagree and point out that the modelling was

"for the delivery of new pay systems across 150,000 staff".

Of course, we have to bear in mind the fact that there were three pay modernisations—for GPs, for agenda for change and for consultants—and that some of those groups of staff were significantly smaller. However, the department notes our conclusion, in paragraph 40, that the original cost estimates were too low and that NHS boards found them difficult to budget. Your response mentions how the boards have to have their input.

Drawing together those two points, is the problem that it was not that your pay modernisation was particularly flawed but that the local information was difficult to gather and that the boards had difficulty in helping with that modelling? If that is not the problem, what needs to be improved so that, in the future, the modelling is more accurate? I accept that, as you said, your modelling was better than that which was done anywhere else in the UK.

Dr Woods: I acknowledge, and thank you for, your comments about the clarity and style of the response that you received. It is important to us that we establish an effective dialogue with the committee, and we look forward to continuing that. What you have heard today has been offered in the same spirit, and we welcome that arrangement.

The point that we are trying to make—you covered the ground a bit in your comments—is that the process was an iterative one involving a large number of staff and that, as things eventually came to be played out, more information became available and an adjustment had to be made. In our response to recommendation 13, we tried to point out that it was a dynamic process rather than a particular moment in time and that, therefore, we were trying to work to a common understanding with boards. That is really all that we were trying to flag up in our comment about disagreement.

Mike Palmer was very much involved in the dialogue with boards over the contracts, and he may wish to elaborate on what information was available to boards and when it was made available to enable them to factor in additional costs that the modelling may not have got precisely right at a particular moment in time.

Mike Palmer: Modelling costs accurately in such a massive operation is a challenging and complex business. Even with the smaller cohorts of staff, which you mentioned, we are still talking

about thousands of people moving to a totally new pay system that has not yet gone live; therefore, we are having to make projections and assumptions. Human beings being what they are, we cannot predict how they will behave when a new pay system is delivered to them, so a lot of different variables are at work at the same time.

You are absolutely right to say that at the heart of this is the requirement to have good linkage between the departments and boards. It is essential that we build the models from the bottom up, as far as we can. Over the three pay modernisation contracts that we have developed and are now delivering, we have all gone through a learning process. It is the first time that we have remodelled pay in this way since the inception of the NHS—the first time that it has been done since the old Whitley system was introduced in 1948—so everybody has been treading on uncharted territory. We learned a wee bit from the experience of the consultant contract, which was the first cost model that we generated. From that, we learned about processes to do with dovetailing with boards, projections that could come from the bottom up, and so on. We have reflected that in our response.

On the agenda for change cost model, we feel that we have a robust process in place; however, the process is only as robust as the information that we have. It is simply not possible to predict exactly how 130,000 staff will turn out at the end of the delivery of a new pay contract and what behaviours they will display—that is, the pay bands that they may aspire to and end up in. It is also difficult to predict how health boards will respond to the different dynamics of a new pay system, in terms of how they manage it through. For example, there is a lot of potential variation in the amount of backfill that can be put in for staff gaining extra annual leave. One of the elements of agenda for change is an extra two days of annual leave for most people. Different managers in different health boards will react to that in a different way: some may wish to bring in fresh staff to backfill for the staff who are on annual leave, which will mean an extra cost; others may decide to manage the backfill differently, using their existing cohort of staff. That is a tiny example of a variable that is difficult to predict precisely.

To return to what has been said, it is important for us to work as closely as possible with the boards. On the consultant contract, we felt that the boards had the information from the original United Kingdom price framework and that they had the costings to generate costs locally. However, there was a difficult situation because we went into Scotland-level negotiations off the back of that and the boards—perhaps understandably—waited to see what those negotiations would come up with. We made it clear—and we had heads of agreement with the British Medical Association—that we would stay within our financial envelope, which we did. However, there were late dynamics in the negotiations, if I may put it that way, that created outcomes, such as the payment of back pay for the 2003-04 year, about which people were not certain until that late stage. That was simply an added dynamic and complication that boards needed to deal with. The situation is complex and challenging and we try to do the best that we can on the basis of the information that we receive.

The Convener: I thank you for your full answer. Can you assure the committee that, from the experience of things such as the consultant contract, enough weight will be given to different Scottish staffing rotas and working practices in initiatives that start as UK pay initiatives so that outcomes take account of the different ways in which we work?

Mike Palmer: Absolutely. We did not simply take the English payroll, so to speak, with the consultants and say, “We’ll take a tenth of that and that’ll be the Scottish cost.” We looked at what had been done in England and based our modelling on the Scottish profile of the consultant workforce—we took into account the specific circumstances that relate to seniority among consultants in Scotland, for example. We took a Scotland-based approach with the consultants and have done so for the other contracts; we will, indeed, continue to do so. That is a positive answer to your question.

The Convener: Fine. Thank you.

That ends our questions. We have taken a little more time than we had hoped to take. You mentioned that it is important to take time to get the right outcomes with agenda for change, but it is also important that we take time to get answers and to give you the chance to answer our questions.

I thank Dr Woods and his team for their evidence, on which the committee will deliberate later in the meeting. We look forward to continuing our positive work together.

Dr Woods: Thank you very much.

The Convener: I suspend the meeting for a comfort break. Members should be back at the table at 20 minutes to 12.

11:28

Meeting suspended.

"Moving on?"

11:41

On resuming—

The Convener: I bring the meeting back to order. For agenda item 4, I invite Barbara Hurst to give the committee a briefing on Audit Scotland's report "Moving on? An overview of delayed discharges". Under agenda item 5, Caroline Gardner will give us a briefing on Audit Scotland's report "A Scottish prescription: Managing the use of medicines in hospitals".

Barbara Hurst (Audit Scotland): "Moving on? An overview of delayed discharges" was the first report to be published over the summer; the second was the report on medicines. The report on delayed discharges was a slightly different piece of work for us. Increasingly, we have to work across organisational boundaries on health and social care issues. We want in-depth understanding of how partnerships work together, partly to ensure that we do not make simplistic recommendations in our reports and partly because of the genuine need to examine the real barriers to organisations' working well together.

As a result, we asked for a partnership in Scotland to volunteer to work with us so that we could examine the delayed discharges in that partnership's patch. The overwhelming response that we received shows the importance of the subject to partnerships. In the end, we decided to work with Tayside NHS Board because it met our key criteria: it covers a number of council areas; it is committed to making a difference on delayed discharges; and its situation is fairly typical of the picture throughout Scotland. Most important was that it already possessed good information that we could use to carry out some of our whole-systems work, which meant that we did not have to waste time collecting a lot of new information. I must put on record our gratitude to NHS Tayside for working with us in that way. Together, we built a model of the local system in Tayside so that we could examine different strategies for tackling delayed discharges.

I should point out that, because the model was built on NHS Tayside's data, its service delivery structures and assumptions about how its services interrelate, it applies as a whole only to Tayside; it cannot be taken and applied wholesale elsewhere. That said, some of our findings are applicable to the rest of Scotland. For example, we discovered that having only one or two strategies to tackle delayed discharges will not work. It is not enough simply to increase home care places or hours. Any approach to the problem needs to be more sophisticated than that.

Alongside that work, we produced a high-level report on the picture of delayed discharges throughout Scotland, which found that a lot of progress has been made. It appears that we are starting to see some success in this area. For example, from September 2000 to April 2005, the number of people who were delayed in hospitals fell by more than 50 per cent.

We also examined how the Executive sets targets and its effect on local partnerships. We felt that there was some perversity in the system in respect of the way targets were set: a target was set based on the good performance of partnerships that were performing well, which resulted in their having a more challenging target in the following year. We tried to explore some of that in the national report.

11:45

We also looked at what local partnerships were doing to evaluate systems that they were putting in place. The committee looked at putting systems in place early in order to evaluate measures of success when considering free personal care. We recommended that partnerships do the same.

We have had some interest and activity on the back of the report—we have promoted it at a couple of national conferences. We have been invited to participate in local seminars, not so that we can apply the model, but so that we can apply some of the processes and thinking behind the model. I hope that we will be able to apply that whole-systems thinking to some of our new work. We discussed out-of-hours services last week, to which that thinking is relevant, and we are starting a project on long-term conditions, to which it will apply equally.

The model is very interesting if people are anoraks like we are. We are happy to demonstrate it informally to committee members if they are interested. I will stop there and take questions.

Mrs Mulligan: On the evidence that we heard this morning, was it a formally established community health partnership in Tayside or was it part of the old way of working?

Barbara Hurst: That is an interesting question, because when we did the work, it threw up questions about the numbers of partnerships. The Tayside model pre-dated the community health partnerships. It was a delayed-discharge partnership based on the board. It was made up of three joint-future partnerships with the board and the individual councils.

Mrs Mulligan: Did a message come out of the work about how one might identify earlier the people who are most likely to be affected by delayed discharge? Is it too simplistic to say, for example, that it is more likely that those who have multiple needs will be most difficult to place? Did a pattern emerge from your work?

Barbara Hurst: It is not too simplistic to say that. A clear message emerged that older people who have a range of different needs are most likely to be difficult to place, especially older people with dementia. There are particular problems in putting in place specialist services for such people. However, there is a strong body of research that boards and their partners can use to target people who are most likely to be delayed in hospital.

Susan Deacon: First, I welcome the report. No one here is in any doubt about how critical tackling delayed discharge is to the functioning of the entire health and social care system. I was particularly heartened to hear the feedback about how the work is being used as part of a learning process. That is tremendous.

Are you connecting your approach and the work that you are engaged in with preventing unnecessary hospital admissions? There are many parallels. My second question is about targets. I note that your recommendations focus on reviewing how national targets are set. I do not want to put you in a difficult position by asking this question, but you seem to be leaning towards saying that national targets are unhelpful if local systems take ownership of driving forward improvement. What are your views on that?

Barbara Hurst: On unnecessary admissions, the answer is yes, absolutely. We have to look at the whole system and not just at the tail end of it, so we have to consider who is coming into the system and how we can stop them coming in. Partnerships are focusing strongly on that issue. There has been a lot of work on rapid response teams and setting up services before somebody has to go into hospital. I can reassure the committee on that.

We did not go as far as to say that national targets are unhelpful, but our report acknowledges that each local partnership will have issues that are particular to it. For instance, issues in the Lothians are completely different to those in Argyll and Clyde. Services will depend on the market and on how quickly alternative services can be developed. We stopped short of saying that local targets would be more helpful, but we raised the question because of the variation across the country.

Mr Welsh: Was there uniform improvement in Tayside, or did improvement vary between the different council areas?

Barbara Hurst: As far as I am aware—although I will bow to Angela Canning's superior knowledge—each council had different circumstances. The model considered the picture across NHS Tayside, but it was able to drill down into each council area. It was interesting to consider how the expected growth among the older population in each council area affected any strategies. It was possible to build up a picture of how long, if one or two particular things were done, you could stay out of trouble in terms of delayed discharges. The picture across Tayside is interesting and complex; if we expand it to cover all Scotland it becomes even more complex.

Mr Welsh: Tayside has an interesting mixture or rural and urban areas, together with a large city.

The Convener: As there are no further questions, I thank Barbara Hurst and Angela Canning for the work that they have done and for briefing the committee.

"A Scottish prescription"

11:52

The Convener: Time is of the essence, so let us move on to agenda item 5. I invite Caroline Gardner to brief us on the Audit Scotland report on medicines in hospitals.

Caroline Gardner (Audit Scotland): Thank you. As Barbara Hurst said, "A Scottish prescription" is the second report that we published during the summer recess. We considered the arrangements that NHS boards and their operating divisions have in place to manage the use of medicines. In our work, we included financial management, risk management and how pharmacy services are provided. We also considered the roles of the Scottish Executive Health Department and a range of national organisations in providing support and advice to health boards.

Spending on medicines in hospitals is rising faster than overall NHS spending. Overall hospital running costs increased by 32 per cent in the four years up to 2003-04, but spending on medicines increased by 56 per cent over the same period. A real issue of cost pressures therefore arises.

Much of the increase is for good reasons: new medicines are available or new uses have been found for existing medicines. Also, people are living longer, with a range of conditions that can be treated. All of that is good news. However, it leads to pressure on the budgets of NHS boards—especially when considered alongside the other issues that the committee has been discussing this morning. In some cases, we found a lack of information about the likely cost pressures of new medicines. That lack of information makes it difficult for NHS boards to plan and manage their hospitals' medicines budgets. We also found that boards could do more to encourage cost-effective prescribing by doctors and nurses who work in hospitals.

The increasing number and complexity of medicines then mean that it is unrealistic to expect staff who prescribe them to have all the information at their fingertips. When writing prescriptions, staff therefore need easy and quick access to the whole range of guidance—national and local—on the right drugs to use in a particular circumstance, but that is not always the case. Even where guidance is in place, it might not be supported by good education and training or, indeed, by good clinical audit, to ensure that it is being used in practice as was intended.

I will move briefly on to pharmacists. Increasingly, pharmacists are working as part of multidisciplinary clinical teams in hospitals. They are able to provide specialist knowledge directly to prescribing doctors and nurses and can provide advice on the broader care of patients. However, not all hospitals and not all specialties have access to clinical pharmacy services on the ward, in some cases because of recruitment problems. That goes back to what we said earlier about ensuring that we recruit and retain the right staff. We found that the number of vacant posts for pharmacists is currently higher than the number of pharmacists in training posts, which indicates that there is a continuing problem. When we did the work there was no national planning approach for pharmacy staff.

A recurring theme for the committee is availability of information; the situation is no different for prescribing. There is a big gap in the information that is available on how medicines are used in hospitals. One of the main problems is the lack of an electronic record that can link what is prescribed to the patient and the condition from which they are suffering. There is also no national information that would let health boards benchmark use of medicines in their hospitals and thereby identify where improvements might be possible. We think that a national hospital electronic prescribing and medicines administration system would help. The Health Department is committed to progressing that, but it has not set a timescale or roll-out plan for it.

The report includes a number of recommendations for boards, the Health Department and the other organisations that are involved. The themes that run through them are encouragement of cost-effective prescribing and ensuring that staff who prescribe have easy access to information that they need, and improvement of the available information about how medicines are used. We plan to carry out a follow-up audit in a couple of years. I will stop there, but we are happy to answer any questions.

Mrs Mulligan: I find the report really interesting, particularly given what has been said this morning about how improvements in medicines that are available can improve the quality of care, although on the other hand they generally seem to increase costs. It must be difficult for NHS boards to try to balance that in making predictions. When you were doing your work, were you aware of what advice was being given to patients about use of medicines? I am thinking in particular about patients who have been given a range of medicines without having been given much help with how to use them most effectively.

A number of people have told me that they have had problems with medicines; they have taken them back and the hospital or their GP has been able to offer them alternatives. Is any work being done to see whether there is a trend for a particular medicine, such as evidence that

particular patients do not find a medicine suitable? That would reduce use of medicines that are not effective for some people. We seem all the time to add to the medicines that are available, but we do not seem to drop those that are perhaps not so effective. What kind of research is being carried out in that respect?

Caroline Gardner: There is a lot in those questions. I will kick off and then ask Tricia Meldrum to follow up. First, on information that is available to patients, it is probably fair to say that, on the whole, less attention has been given to that in relation to patients in hospital than in relation to people who go to their GPs and receive primary care. That is partly because people tend to be in hospital for a fairly short time and prescribing for them turns over quite quickly—drugs are tried and changed quickly as the results are considered. It is also because, in general, patients in hospital are not responsible for self-administering medicines as they are at home. Tricia Meldrum might want to say more about that in a minute.

The second question was about how the health service is able to respond to information about whether patients get on or do not get on with a medicine. That is one of the things that an electronic prescribing system would be good for. At the moment, there is information about what medicines are prescribed and there is information about patients and their conditions, but there is no easy way of joining that up to see whether particular types of patient—older patients or women, for example—seem to do less well on a particular drug. That information eventually gets fed back in via research to the guidance that is available to prescribing staff, but that takes longer than if the two bits of information could be joined up more quickly and easily than happens in hospital.

12:00

Tricia Meldrum (Audit Scotland): I will talk first about the advice that patients receive about medicines. As Caroline Gardner said, that subject has perhaps not received as much attention, but it was dealt with in "The Right Medicine: A Strategy for Pharmaceutical Care in Scotland", which was published a couple of years ago. That had several objectives and recommendations about ensuring that all patients in hospital received advice from a clinical pharmacist. That involves talking to patients about their medicines and ensuring that they understand what medicines they take and why they take them. As we went round hospitals, we saw work to implement those recommendations. As Caroline Gardner said in her briefing, not all hospitals or all specialties have a clinical pharmacy service, but when one is available, that is the source of such advice and support to patients.

"The Right Medicine" also contained recommendations and targets on introducing self-administration schemes for patients so that patients can take their own medicines when that is appropriate. That involves changes in the organisation of how medicines are supplied, ensuring that lockable lockers are by patients' bedsides and that they have their medicines, and educating patients to use their medicines. National and local work is being undertaken to develop those schemes.

As for medicines not working or producing unintended or unknown side-effects for patients, we have talked about the national reporting scheme to the Committee on Safety of Medicines. That is a UK scheme, but there is a centre in Edinburgh. All prescribers and staff who work with medicines are encouraged to fill in a report card whenever they encounter an adverse reaction to a medicine and to send that to the centre, which can collate the information, examine difficulties and give feedback.

Mrs Mulligan: That is interesting.

Susan Deacon: The report sets out much that is interesting about sharing of information across boundaries, whether in primary care and hospitals generally or in emergency care settings. To what extent do cultural and attitudinal barriers to that continue to exist, or are we now overcoming the technical obstacles to full sharing? Historically, the former was fairly significant, because different professional groupings were unwilling to share data and so on. However, I sense that the world has moved on a bit. You will have a better sense of that than any of us—certainly better than I have.

Tricia Meldrum: The experience of the audit was that issues related not to culture and attitudes but to the practicalities of sharing information. My impression is that there is willingness to share information and an appreciation of the importance of full information about what has happened in primary care when a patient enters hospital. People in hospital are very aware that it is not in a patient's best interests for that information not to return to primary care on discharge, in order to support continuity of care. I was aware not of cultural difficulties, but of difficulties just with the mechanics of conveying information to people.

Susan Deacon: That is helpful. Do you have a sense—I use that word again—of whether such change and wider implementation of the national pharmaceutical strategy and so on have provided as much emphasis and impetus as have other forms of change and reform in the NHS?

Tricia Meldrum: It varies—there is variation in whether the national pharmaceutical strategy is on NHS boards' agendas and in the level that it has reached on boards' agendas. One

recommendation in our report concerns where pharmacy sits in organisations. Pharmacy involves big financial risks and big clinical risks to patients, but pharmacy managers may not be at the appropriate level in organisations to put such issues on the agenda and to explore them fully in order to ensure that board members and other senior managers are aware of the issues and how to follow them through.

Susan Deacon: What about within the health department?

Tricia Meldrum: We talked about the national pharmaceutical strategy and we are aware that there is monitoring of the strategy, so there is something in place that is being followed up. We talked to the Health Department about information management and technology issues. There are some concerns there that although those issues are a priority there is not yet a project plan or any timescale. We want to see some action on that to get it moving forward.

Susan Deacon: The issue of timescales comes through time and again.

Margaret Smith: We heard a bit about HEPMA this morning. Dr Woods said that there had been a pilot in Ayrshire—"for some time" was his phraseology—and that it was a complex issue. Do you share that view? Do you have any concerns that HEPMA will not be delivered because of its complexity? Do you have any general thoughts on it? It seems that it could be quite effective in picking up on some of the points in the report, but is taking time in coming to fruition.

Tricia Meldrum: There are complexities. We went to Ayrshire and talked to managers there who had been involved in HEPMA. They were very clear on the various processes that have to be gone through and they were clear that it is not a quick fix. We talked earlier about culture, and about staff being signed up to the new way of working. However, there are also practical issues, such as having a national drug dictionary so that all systems are populated with the same information about medicines. That has been agreed only recently on a UK-wide basis.

There are issues to do with using the CHI number, which Kevin Woods mentioned, as the national identifier. That has to be in place before we will be in a position to roll out a national system. There are some practical stumbling blocks and some cultural issues. We accept that HEPMA is complex, but Ayr hospital has been progressing it and working with its suppliers for about the past seven years, with some support from the department. It can be done, so we are asking for more clarity about when that will happen nationally.

Mrs Mulligan: I notice in the briefing a comment about a shortage of pharmacy staff, which I think Caroline Gardner also referred to. Did you get a sense that that issue had been recognised and that people are trying to address it, or is it something that we need to flag up and hear the department's response to?

Caroline Gardner: When we carried out the work, there was no national workforce planning for pharmacy staff. It is probably fair to say that attention had been focused more on groups such as doctors and nurses, where the shortage was more apparent and had had a more immediate effect on patient care. Since the report has been published, the national workforce strategy has been published; it picks up on pharmacy staff as well. However, there are some long-term issues about getting the right number of staff with the right calibre of qualifications—as Tricia Meldrum described—on wards, with patients and as part of the clinical team. There is a catch-up job to be done.

Tricia Meldrum: We should recognise what has been happening locally, where pharmacy managers have been looking quite hard at redesign. They have been considering whether pharmacy technicians can increasingly be given extended roles in order to free up pharmacist time so that pharmacists can do more clinical work. There is quite a lot of work going on at local level to identify the issues and to try to address them.

The Convener: Those were all our questions on the report. We will deliberate on the report later. I thank Caroline Gardner and Tricia Meldrum for that full briefing on medicines and hospitals.

"The 2004/05 Audit of the Scottish Prison Service"

12:09

The Convener: Item 6 is a section 22 report on the Scottish Prison Service. I invite Caroline Gardner to speak to us on that, with assistance from Bob Leishman.

Caroline Gardner: Given the time constraints, I will try to be brief. However, it is worth setting out some of the background to the report.

Last year, the Auditor General for Scotland issued a section 22 report on the 2003-04 accounts of the Scottish Prison Service to bring to the committee's attention the creation of a provision and a contingent liability to reflect the potential costs of settling court cases arising from prison conditions. This 2004-05 section 22 report updates the position and details some recent developments.

By way of background, I point out that, in April 2004, Lord Bonomy issued his judgment in the case of Robert Napier v the Scottish ministers. The judgment, which was upheld on appeal, described the triple vices of prison conditions: slopping out, overcrowding and poor regime. Lord Bonomy found that the Scottish Prison Service had acted in a manner incompatible with article 3 of the European convention on human rights and that, as a result, Mr Napier had suffered loss, injury and damage. The court awarded Mr Napier damages of £2,000 plus interest because his eczema had been exacerbated by having to spend long periods in a shared cell in which he had to slop out.

Immediately on that judgment, the SPS created in its 2003-04 accounts a provision of £26 million to reflect its possible liabilities from other court cases brought by prisoners who had been held in conditions similar to those that Mr Napier was held in. At the same time, it created a contingent liability of £136 million in respect of other cases that might arise in connection with the ECHR. However, I stress that merely being held in conditions affected by the so-called triple vices does not automatically mean that a prisoner is eligible for compensation. In each case, the prisoner has to demonstrate that the conditions in which he was held had some negative effect on him that breached his human rights.

The SPS's 2004-05 accounts show that the provision has been increased by £18 million to £44 million. However, the contingent liability has been reduced by £112 million to £24 million. Although the underlying circumstances have not altered significantly, the changes reflect the fact that the SPS now has better information on the number of prisoners who are likely to be involved and the possible value of any settlement.

I point out also that, in settling the case against Mr Napier, the SPS incurred costs of £1.5 million, including almost £1 million in respect of the legal aid that Mr Napier received in bringing his action. This case illustrates the potential for a significant amount of public money to be spent as a result of decisions that different parts of the justice system have taken about the same case. Given that that raises issues for the wider justice system, the SPS has agreed to discuss with the Scottish Executive Justice Department the best way of resolving similar actions that might be brought by prisoners.

Scottish ministers have now proposed a scheme for settling out of court cases of personal injury that have been caused or exacerbated by slopping out. The SPS considers that settlement costs through its alternative dispute resolution scheme could be substantially lower than the cost of pursuing such cases through the courts. It is also developing a strategy to deal with other compensation claims that have different characteristics from those of the Napier case.

I am sorry that so much information underlies this relatively short section 22 report, but I thought that I should clarify the background to it. We will do our best to answer members' questions.

The Convener: I do not think that you could have briefed us on this section 22 report in any other way. All the information that you have highlighted is highly pertinent.

Margaret Smith: On alternative dispute resolution—and forgive me if I am straying beyond this section 22 report—

The Convener: Please try not to.

Margaret Smith: When I was a member of the Justice 1 Committee, the committee received evidence on alternative dispute resolution. I know that the European Union had been considering whether to make such schemes statutory; however, people have backed off from such a move.

The Justice 1 Committee found that Governments elsewhere—including the United Kingdom Government—were making much more use of ADR than the Scottish Executive seemed to be making. In fact, at the time, our committee suggested that the Executive should consider whether making greater use of such schemes, particularly in the NHS, would save money, because the cases were less likely to end up in protracted court proceedings. Has the Scottish Executive been using ADR to its fullest extent? It is now being used in the Scottish Prison Service, so there is a sense that the Executive is moving

towards its use, but there is perhaps a wider issue. I do not think that the Executive has embraced ADR fully, although it produces almost a win-win situation as it avoids the need to finance many of the disputes in which people find themselves with major bodies such as the Scottish Prison Service and the NHS.

There was a question in there, but there was a comment as well.

12:15

Caroline Gardner: I think that I recognise the question. You may know more about this from the work of the Justice 1 Committee than we know from the work that we have done on the issue. Having said that, we understand that there has been little take-up, to date, of the alternative dispute resolution procedure that has been launched in the SPS, as it is a recent initiative.

This is obviously a sensitive area. Nobody is looking to limit people's rights to take legal action when they feel that they have been damaged; on the other hand, if it is possible to avoid claims being raised unnecessarily by having another way of resolving the dispute, that must be in everybody's interest, as you say. The point was raised in the section 22 report because of the potential for the procedure to be used not only within the justice system, which is where it started out, but in other areas where it may be appropriate. The health service is the obvious example of a body against which cases are sometimes raised that could have been avoided by better handling of a situation earlier on. Overall, the question that you may want to ask of the Executive, in some form, is how it is taking the matter forward.

Mr Welsh: The last sentence in paragraph 9 of the Auditor General's report states:

"Except for HMP Peterhead, where Ministers are considering options, it is expected that slopping-out will be completely eradicated one year after completion of both the two new prisons that the Scottish Prison Service plans to procure (subject to prisoner numbers)."

It says, "plans to procure". What sort of dates are attached to that?

Caroline Gardner: There are plans in hand to procure two new prisons to relieve some of the pressure on prison numbers. I am not sure what the latest dates for that are—perhaps Bob Leishman can help out.

Bob Leishman (Audit Scotland): I do not think that we have specific dates yet. Both contracts are about to go out to tender.

Mr Welsh: This is just whimsy, but how much does a new prison cost?

Bob Leishman: We will find out when we get the tenders.

Mr Welsh: Point taken.

The Convener: The committee is interested in value for money. At first glance, some members might be concerned that incurring legal costs of £1.5 million in defending an action that resulted in an award of £2,000 is somewhat out of kilter. However, I imagine that the £1.5 million was really incurred in trying to avert a potential liability of £44 million, which has now been allowed for. How the matter proceeds will still be of interest to the committee. In moving to ADR to reduce legal costs, which makes sense, it will be important to see the reduction in legal costs that can be obtained relative to the actual liabilities that are given out.

The judgment call that was made was obviously a policy decision and is not for the committee to go into; nonetheless, it will be interesting to see whether ADR brings any savings and whether there are lessons for other departments in it. I do not think that we should get into the question of whether or not the initial outlays were appropriate.

Susan Deacon: Andrew Welsh has raised the question of developments in the prison estate, and the Peterhead question is mentioned in the final paragraph of the Auditor General's report. What legitimate interest does the committee have in decisions about the estate? There is an issue because the longer that it takes to effect change in that area, the more cases there will be to resolve in future—potentially, at least.

The Convener: I think that that is a question for me rather than for Caroline Gardner. The extent to which the liabilities will be removed by the introduction of the new prisons is difficult to pin down. Tenders are going out for up to two prisons but, in the end, only one might be provided. From the evidence, it seems that progress is being made at a number of prisons. Therefore, the question is a bit like asking, "How long is a piece of string?" It will be easier for us to see where we are when we come to consider the issue again, possibly in a year's time. By that time, a section 22 report might not be required because all the matters will have been cleared up, but as the reports are laid before Parliament, we can either have the matter as an agenda item or Audit Scotland can write to us to update us on it. Certainly, if members want to be updated on that, we can ask for that.

Mr Welsh: It would certainly be interesting. Unless it is solved, the problem will continue. Either the slopping-out situation is resolved or there will be further out-of-court settlements and so on. According to paragraph 9 of the report, slopping out will not be ended until the new

prisons are completed, so the problem is a continuing one.

The Convener: The existing prison estate can be changed but we cannot get an answer to our question yet, in as much as further new prisons are required.

Caroline Gardner: The risk of claims comes in situations in which the two conditions—shared cells and slopping out—are met. According to the Scottish Prison Service, there is now no shared use of slopping-out accommodation in the prison estate. Ending slopping out relies on building new prisons because of the obvious physical limitations of the current estate. A step in the right direction has been made, but the work is not complete.

The Convener: We will discuss these matters further under agenda item 8. Are there any other points that need to be made at this point?

Mrs Mulligan: Caroline Gardner said that two conditions had to be met and that one of them was overcrowding. How do we get a feel for whether policies that are designed to reduce the number of prisoners are reducing overcrowding?

The Convener: You used the word "policies"; that is the difficulty. We must consider the effect of changes in policy after the fact. Given that the Sentencing Commission is yet to deliver its report, there might be changes in policy, which will have an impact, but that is not for us to determine. We can consider the management of policies after they have been changed.

Mrs Mulligan: I am just not sure how we would measure people not ending up in prison in a way that will enable us to decide whether those policies have had an impact.

The Convener: Caroline Gardner might want to help me out here, but it strikes me that, in the comparison between this year's section 22 report and the previous report, there has been a change in liabilities, both real and contingent. That shows that there is a movement, either in the effect of policy or in the degree of accuracy with which the information and numbers are understood. I would expect that, next year, there will be a fine tuning of the current situation or, possibly, a change in the situation because of changes in policies relating to bail conditions and so on.

Caroline Gardner: That is right. All that I can say on the bigger picture is that, earlier in the year, we produced a report on preventing reoffending, which obviously relates to the question of managing prisoner numbers. At some point, the committee might also want to explore the question of capital planning for the prison estate. I would think that the committee would want to use each issue as a way in to the policy question of the number of prisoners, which is a matter for Scottish ministers rather than for this committee or Audit Scotland.

Susan Deacon: I reinforce that point. It is important that we distinguish between our self-denying ordinance not to seek to determine the policy or express views on it and the Audit Committee's pivotal role in making the linkages in thinking and debate between various policies and the resource questions that we are concerned with. Frankly, those issues are considered in compartments far too often. We in the Parliament are quite capable of having debates in which we focus solely on the issue before us and talk about knock-on resource implications only when we must consider issues through an audit prism.

I feel quite strongly that this is an area in which it is perfectly legitimate that we should flag up the linkages between the policy areas and the areas that we and Audit Scotland are concerned with, while not expressing an opinion about the direction of travel in the various policy areas.

The Convener: The difficulty at this point is that we are straying into agenda item 8. I would like to compartmentalise our discussion so that we can focus more clearly.

Mr Welsh: We cannot deal with policy; only ministers can clarify their policy decisions. However, unless those decisions—whatever they might be—are taken, there will be an on-going case to answer in respect of the effect of the continuing situation on the public purse. It might be useful if we could find out from ministers what action they propose to take.

The Convener: We can go on to discuss that under agenda item 8. If there are no questions that are pertinent to our finding out the information that we require to enable us to discuss matters further, we will move into private session. I thank Caroline Gardner and Bob Leishman for their attendance.

12:26

Meeting continued in private until 13:02.

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