AUDIT COMMITTEE

Tuesday 13 December 2005

Session 2

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AUDIT COMMITTEE
18th Meeting 2005, Session 2

CONVENER

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

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)
Mr David Davidson (North East Scotland) (Con)
Marlyn Glen (North East Scotland) (Lab)
Mr John Swinney (North Tayside) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Angela Cullen (Audit Scotland)
Caroline Gardner (Audit Scotland)
Barbara Hurst (Audit Scotland)
Arwel Roberts (Audit Scotland)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Clare O'Neill

LOCATION

Committee Room 4

Scottish Parliament

Audit Committee

Tuesday 13 December 2005

[THE CONVENER *opened the meeting at 10:01*]

Items in Private

The Convener (Mr Brian Monteith): I welcome committee members, representatives of Audit Scotland and the Auditor General for Scotland, as well as our visitors from the Wales Audit Office, Gillian Body and Paul Dimblebee. Gillian is the assistant auditor general for Wales and Paul is the studies director.

I make the usual announcement about pagers and mobile phones being switched off. We have received apologies from Andrew Welsh and Susan Deacon, who cannot attend today's meeting, but we are still quorate; three is the requirement, so we are more than quorate.

Under item 1, I seek the committee's agreement to take in private agenda items 5, 6 and 7. Item 5 is consideration of arrangements for oral evidence as part of our consideration of the report "Overview of the water industry in Scotland". Under item 6, the committee will consider its approach to reports by the Auditor General for Scotland, including two section 22 reports and the report entitled "Overview of the performance of the NHS in Scotland 2004/05". Under item 7, the committee will consider reports in the "How Government Works" series. Do members agree to take those items in private?

Members *indicated agreement*.

Section 22 Reports

10:03

The Convener: Agenda item 2 is a briefing from the Auditor General for Scotland on two section 22 reports, "Scottish Executive Consolidated Resource Accounts" for 2004-05 and "The 2004-05 Audit of the NHS Pension Scheme Scotland Accounts". I invite the Auditor General to brief the committee.

Mr Robert Black (Auditor General for Scotland): I am able to report on the conclusion of the 2004-05 audit of the Scottish Executive consolidated resource accounts earlier this year thanks to the good work undertaken within the Scottish Executive and by the Audit Scotland team. If you do not mind, convener, I simply record my appreciation of that. Much effort has been put in this year to reach this position.

I have submitted two reports under section 22 of the Public Finance and Accountability (Scotland) Act 2000. One relates to the Scottish Executive consolidated resource accounts for 2004-05 and the second is a report on the accounts of the national health service pension scheme for 2004-05. I will take each in turn.

First, the Scottish Executive consolidated resource accounts relate to the activities of the seven core Executive departments, the Crown Office and Procurator Fiscal Service, all 13 executive agencies and all NHS bodies in Scotland. I have qualified the resource accounts of the Scottish Executive for the past financial year on the regularity of expenditure. That is because the resources used by the Scottish Executive Development Department and the Health Department exceeded the limits authorised by the Budget (Scotland) Act 2004 and by amendments to that act. I have also decided to mention in the same report two other matters: a ministerial written authority that was issued during the year to an accountable officer; and the buyout of the Skye bridge private finance initiative contract.

I turn first to the qualified opinion on the regularity of expenditure of the Scottish Executive Development Department. In 2004-05, the Development Department provided funding for the early repayment of Scottish Homes' outstanding loans to the national loans fund. When the autumn budget revision to the Budget (Scotland) Act 2004 was being compiled, the department provided for the interest and early redemption premium, but not for the early repayment of the principal. The principal was £101 million.

At the time, the Scottish Executive considered that provision in the budget for the early repayment of principal was not required. It was of

that view because the grant in respect of the principal repayment was to be funded from a balance in the Scottish consolidated fund. The Scottish Executive now accepts that the early repayment of principal also represented a use of resources. As a result, the Development Department's use of resources for 2004-05 exceeded the total provision in the Budget (Scotland) Act 2004 and subsequent amendments by £68 million, and that excess expenditure must be deemed to be irregular.

The second issue is the qualified opinion on the regularity of expenditure of the Health Department. The remaining 18 NHS trusts were dissolved at the end of 2003-04, and on 1 April 2004 their assets and functions were transferred to their local NHS boards. Prior to that, NHS trusts paid their capital charges to the Scottish Executive Health Department, and the funding of the boards included an element to allow trusts to repay capital charges to the department. After the dissolution of the trusts, there was no longer any requirement to pay those charges to the department.

The Health Department recognised that it had to consider the effect of the dissolution of the trusts and of the removal of the circular flow of capital charges income in its 2004-05 budget, and the auditors had also advised the department to make provision in the Budget (Scotland) Bill for 2004-05 for the loss of capital charges income arising from the dissolution of the trusts—that is, income coming back from the trusts to the boards. It appears that the Health Department considered the effect of the dissolution but came to the incorrect conclusion regarding the resource impact of the loss of income relating to the cost of capital and depreciation charges. Consequently, funds were over-allocated to the NHS. As a result, the Health Department's use of resources for 2004-05 exceeded the total provision in the Budget (Scotland) Act 2004 and subsequent amendments by £32 million, and that expenditure must be deemed to be irregular.

In my report, I have also taken the opportunity to mention the Ballycastle to Campbeltown ferry service. In March 2005, the Scottish Executive, together with the Northern Ireland Executive, announced that it would offer a contract to provide a passenger and vehicle ferry service between Ballycastle and Campbeltown. The invitation to tender was issued in September 2005, and it proposed a five-year contract with a maximum annual subsidy of £1 million and the option to add other routes around the subsidised service.

A previous tender exercise in 2002 offered the same subsidy but failed to find any bidders. At that time, back in 2002, the head of the Scottish Executive Development Department, who is the accountable officer, asked for written authority from the minister to proceed with the tendering. Accountable officers, as I am sure the committee will recall, have a duty to ensure that best value is sought from the use of resources, and they must obtain written instructions from the relevant minister if they consider that any action that they require to take is inconsistent with the proper performance of their duties. In this case, the request for written authority was the result of analysis by consultants, indicating that the subsidy on offer exceeded the expected economic benefits and so did not represent value for money.

In March this year, the head of department sought similar written authority to proceed with the tendering exercise for the same reasons. The Scottish ministers issued that authority on 31 March 2005. I emphasise to the committee that no expenditure has been incurred to date. The Scottish Executive is obliged to advise me when written authority has been sought and granted. I feel that it is appropriate to alert the committee to that, because the issue is potentially significant. I bring the matter to the attention of the Parliament because written authority has been issued. I will, of course, monitor progress in awarding the service.

The final item that I mention in my report is the buyout of the Skye bridge PFI contract. In December 2004, Scottish ministers and Skye Bridge Ltd reached an agreement to end the collection of tolls on the Skye bridge in return for a lump sum termination payment to Skye Bridge Ltd. That met a policy commitment given in 2003. The Scottish Executive was required by Treasury guidance to negotiate a termination payment that left Skye Bridge Ltd in a similar financial position to the position in which it would have found itself had the contract run its full course. In other words, there had to be no detriment to the company.

The Scottish Executive obtained financial advice on the cost of the options for terminating the concession agreement. The option chosen was to negotiate a voluntary compensation package with Skye Bridge Ltd. The eventual agreed compensation of £26.7 million was at the upper end of the £21 million to £27 million range that the Scottish Executive's advisers had deemed to be reasonable.

The cost of that option was less than the estimated cost to users of allowing tolls to continue, which would have been £38 million. The important point is that after allowing for the taxes that Skye Bridge Ltd would have paid to the United Kingdom Exchequer had it continued to operate, the net cost to public funds and users was neutral whether the tolls had continued or the buyout went ahead. It was the first buyout of a PFI contract in the United Kingdom. I will, of course, continue to monitor significant PFI contracts.

That concludes my comments on the first report. Do you wish me to continue with the second one or pause at this point?

The Convener: Carry on.

Mr Black: My second report relates to the NHS pension scheme Scotland accounts 2004-05. The auditor's report on the regularity of expenditure is qualified because the use of resources by the scheme exceeds the limits authorised by the Budget (Scotland) Act 2004. The issue comes about because of a problem that arose in the actuarial valuation of the scheme.

Both NHS staff and their employers contribute to the NHS superannuation scheme, which is a defined benefit scheme linked to final salary. Its future liabilities are not funded through investments. In other words, it is a pay-as-you-go scheme, which relies on regular contributions and Government grant to meet pension liabilities as they fall due.

The scheme is administered by the Scottish Public Pensions Agency. The auditor qualified the accounts of the scheme for 2003-04—a prior financial year—because the scheme actuary, which is the Government Actuary's Department, had not completed a statutory actuarial revaluation as at 31 March 1999, when it was due to occur, because of incomplete data. The actuary produced a resource accounting valuation in July 2005, which assessed the scheme liability at 31 March 2005 at £12.7 billion. That is an increase of £4.6 billion on the liability that appears in the 2003-04 accounts.

The increase arises from a misstatement in the estimation of past service liability provided by the GAD in its valuation of the liability at 31 March 1999, when the revaluation was due. That valuation, which was carried out in August 2000, was based on the earlier full statutory funding valuation in 1994. That was updated from 1994 to 1999 to reflect known changes that occurred in that period. Since some data continued to be unavailable, the liability in the 2003-04 accounts was based on the 1999 estimate—the 1999 estimate was flawed and it was rolled forward. The 2003-04 accounts wrongly state the scheme liability at £8.1 billion when it should have been £11.6 billion.

10:15

The 2004-05 accounts, on which I am currently reporting, reflect the amended valuation. The level of liability recorded in the prior year 2003-04 has been restated in the 2004-05 accounts and a prior year adjustment is also disclosed in those accounts to reflect the increase in the resources required to meet notional interest charges applied to the liability.

The Budget (Scotland) Act 2004 set a resource budget for 2004-05 for the scheme of £561 million. However, the impact of applying the restated valuation figure to the accounts for 2003-04 and 2004-05 is to increase notional interest charges. That results in an outturn for 2004-05 of £1,404 million, which is £843 million in excess of the 2004 act provision. Therefore, the auditor has qualified the opinion on the regularity of expenditure because, without parliamentary approval, the overspend must be deemed to be irregular.

I emphasise that the increased liability reflected in the 2004-05 accounts, which I have just mentioned, will have no immediate effect on the level of funding available to deliver health services. Health boards contribute to the scheme through the contributions that they make as employers. Contribution levels were increased in 2003-04 to reflect a new calculation methodology and to take account of the increased lifespan of scheme members. Future contribution levels will be assessed regularly by the Government Actuary's Department.

The Convener: Thank you.

Do members have any questions? I would prefer it if we could take questions in the order of the briefings. Are there questions on the expenditure by the Development Department or the Health Department?

I will ask a question on both, for the benefit of the record. Is there any requirement for retrospective parliamentary approval for the expenditure that had not been given prior parliamentary approval?

Mr Black: No. That is not required, neither is there any direct implication for service delivery. These are purely and simply accounting adjustments.

The Convener: Are there questions on the Ballycastle to Campbeltown ferry service or on the buyout of the Skye bridge PFI?

Margaret Smith (Edinburgh West) (LD): I have a general point that picks up on the Auditor General's final comment about this being the first buyout of a PFI contract in the UK. It took quite a long time to get to this negotiated position, which the Auditor General said was at "the upper end" of the range of what was seen as being reasonable. Can lessons be learned from the negotiations?

Mr Black: One principal lesson that may be worth mentioning is covered in paragraph 12 of my report, on the original contract. It states:

"The 1991 contract between the Secretary of State and Skye Bridge Ltd did not enable the Scottish Executive to terminate the Concession Agreement as of right. A right of termination subject to defined compensation is now standard for PFI contracts."

Therefore, a significant lesson has been learned as a result of the early experience, and it would be reasonable to suggest that if there was a desire to buy out PFI contracts in future, it would be less complicated and the public interest would be better safeguarded because a right of termination will have been properly incorporated in the individual accounts. That is a significant development since that early PFI deal—it was one of the first PFI deals in Britain—was concluded.

Margaret Smith: Do we know how many and what other contracts were signed before the change was made, in which that right was not included as standard?

Mr Black: I do not think that we have that information.

The Convener: From our previous meetings and reports, you will be aware of our interest in West Lothian College and its on-going negotiations with the Scottish Further and Higher Education Funding Council about the possibility of buying out its PFI contract. Might any aspects of this case have a bearing on those negotiations?

Mr Black: Audit Scotland is monitoring the situation. I wonder whether Arwel Roberts can help.

Arwel Roberts (Audit Scotland): The consultants have not yet reported back, so the funding council has not reached a decision on how to deal with the situation.

The Convener: We now move to questions on the section 22 report on the NHS pension scheme accounts.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Have there been discussions with the Government Actuary's Department to ensure that it complies with its statutory obligation to produce its actuarial report on time?

Mr Black: We have not had any such discussions. I wonder whether the Audit Scotland team can comment further on the matter.

Arwel Roberts: The department was unable to comply with what was expected of it at the time because of the shortage of available information. It has told us that it usually complies with its statutory obligation, and I see no reason to disagree with that.

Margaret Jamieson: Will the significant increases in the salary levels of consultants and general practitioners impact on the scheme's future liability? How will any such liability be met?

Arwel Roberts: Salary levels always have an impact on pension liabilities.

Margaret Jamieson: But these are significant increases.

Arwel Roberts: The information on pensions was revised according to individual length of service. The revision was not necessarily linked to salary levels, although they will have a knock-on effect. [*Interruption.*]

The Convener: There appears to be an electronic mouse in the room.

Auditor General, you said that there would be no immediate effect on health service funding. However, that suggests that there might be an impact later on. Will you comment further on that?

Mr Black: Any such impact—and there will be one—will come through the periodic reassessment of contributions that have to be made. It is impossible for me to indicate how those will move in future.

The Convener: An excess £843 million was required to cover the underestimated valuation. However, you said that contribution levels had been increased. Will the increase cover that excess, or does a gap have to be filled elsewhere?

Caroline Gardner (Audit Scotland): The increase in contribution levels was the result of a separate exercise and reflected the fact that, like all of us, members of the scheme are living longer. It appears that, from the re-evaluation of the scheme's liabilities, which is built into the process and takes place regularly, contribution levels are likely to be increased. Indeed, any such re-evaluation could affect employees and employers who are registered in the scheme, but a future catch-up exercise would cover the scheme's liabilities.

The Convener: You are saying that, as it is a pay-as-you-go scheme, the costs will have to be met at some point. However, they can be met by increased contributions from staff and employers.

Caroline Gardner: That is the usual way of dealing with such situations. In any case, the reassessment of the contribution levels that are needed to match the current estimate of liabilities takes place periodically.

Mr Black: In a project that we have initiated under the banner heading of "How Government Works", we are examining all the public sector pension arrangements in Scotland. In the course of 2006, we will submit to the committee a report on that project, which might help to fill in the context.

The Convener: That will be very interesting.

Mrs Mary Mulligan (Linlithgow) (Lab): I was about to ask a question on comparisons with other public sector workers. We have visitors with us from Wales. Does the situation affect only health workers in Scotland or does it also affect health workers elsewhere in the UK?

Arwel Roberts: This particular liability was increased because of a misstatement in the information available to the actuary in Scotland. For that reason, the adjustment relates only to the Scottish situation.

Mrs Mulligan: The final sentence of the section 22 report says:

"Future contribution levels will be assessed on a regular basis".

What is meant by "regular basis"?

Mr Black: Normally, re-evaluations take place every five years, so we expect the next one to happen in five years' time.

Mrs Mulligan: Given ever-changing circumstances in the health service and other public sector services, is five years between re-evaluations sufficient?

Mr Black: I am not qualified to comment on that question, because actuarial matters are highly specialised. However, in general, movements in longevity and so on happen over fairly long periods, which means that their short-term impact is quite minor. I am sure that, for that reason, much thought has gone into the five-year review period. Generally speaking, such a period is accepted as being appropriate.

The Convener: As members have no further questions, I thank the Auditor General for speaking to those section 22 reports. The committee will discuss its approach to them under agenda item 6.

"Overview of the performance of the NHS in Scotland 2004/05"

10:26

The Convener: Item 3 is a briefing from the Auditor General for Scotland and Barbara Hurst on the "Overview of the performance of the NHS in Scotland 2004/05".

Mr Black: As the committee will recall, last year I produced a financial overview of the NHS and a separate review of health service performance. This year, I am laying before the Parliament my first integrated overview report on the NHS, which relates to 2004-05.

The report, which concentrates on the main areas in which the Scottish Executive is committed to improving performance, comprises six parts, each of which covers a different aspect of the NHS. Those aspects are: health improvement; clinical outcomes; waiting for care; workforce; financial performance; and keeping pace with change.

The Kerr report and the Scottish Executive's recent response to that report clearly highlight the changes and challenges that face the NHS over the coming years. In our report, we acknowledge that changing environment and indicate areas in which it is putting pressure on the future design and delivery of services.

I will briefly describe some of our main findings. Health care improvements are resulting in better clinical outcomes and contributing to increased life expectancy for people in Scotland. Part 2 of the report shows that death rates for cancer, coronary heart disease and stroke have improved significantly. For example, between 1995 and 2004, the death rate for coronary heart disease fell by about 44 per cent. Because of that success, the Scottish Executive has recently raised the bar for that target and now seeks to reduce the number of deaths from coronary heart disease by 60 per cent by 2010.

It is emerging that, although the people of Scotland are living longer, they are not necessarily in good health. Exhibit 1 on page 5 shows that, although life expectancy at birth for men and women has risen, people's healthy life expectancy has remained relatively constant.

The poor health of some people in Scotland, particularly those in deprived areas, continues to be a problem. Exhibit 4 on page 12 shows that people who live in the most deprived areas of the country have a higher incidence of, higher death rates for and lower survival rates for cancer than people who live in the most affluent areas. The committee will be pleased to note that the

Executive has now set specific targets for improving health in Scotland's most deprived areas.

The Executive has made significant progress in reducing waiting times for in-patients, day cases and out-patients. The NHS in Scotland is on course to meet the six-month target for people with waiting time guarantees for in-patient and day case treatment. However, more needs to be done to meet the cancer waiting time target. I will produce a more detailed report on the management of waiting times next February or March.

10:30

Most patients who arrive at accident and emergency complete their treatment within the four-hour target. Most GP practices meet the 48-hour target of giving access to care. The number of patients who are delayed in hospital awaiting discharge has fallen significantly since 2000, with the discharge delay falling from a median of 80 days to 44 days between January 2001 and July 2005. New figures released since the publication of our report show that that median has risen slightly. There is some way to go to tackle the problem—a wait of 44 days or longer is a considerable period. The most recent information shows that just under 1,600 people are waiting to be discharged from hospital.

Waiting times continue to be a major challenge for NHS 24. The management of callback is its biggest problem, accounting for one third of all calls between December 2004 and August 2005.

Targets can help to focus attention on the Executive's priorities, but some of those need to be reviewed and developed. For example, the target for mental health care is a reduction in deaths by suicide. That is a relevant indicator, but it is at best partial, and inadequate for monitoring the improvement of mental health.

Part 4 of my report comments on the NHS workforce. The NHS in Scotland has set workforce recruitment targets, but progress has been mixed. The number of consultants has increased, but as exhibit 8 on page 23 shows, there are still significant problems with high vacancy rates in parts of Scotland. If the current trend continues, it is reasonable to suggest that it is unlikely that the recruitment target for consultants will be met. The number of nurses and midwives is increasing, but it is difficult to tell whether the recruitment target for those posts will be achieved. An indication of the pressures on this workforce is the increasing use of bank and agency nurses, on which we reported some years ago. The use of those nurses has gone up by 33 per cent since 2002, and the spend on them now stands at £87 million.

The implementation of the three major pay agreements has been very challenging for the health service. Further work is needed to ensure that those agreements deliver a more flexible workforce. Good information is needed to plan and manage the workforce effectively, but it is concerning to note that basic workforce information, such as sickness absence, is not routinely available in all health boards.

Most NHS bodies met their financial targets in 2004-05. However, four boards—Argyll and Clyde, Grampian, Lanarkshire and Western Isles—overspent their budgets in 2004-05. The combined cumulative deficit of those four boards has increased by nearly a half, from just under £62 million in 2003-04 to over £91 million in 2004-05. That is a very small proportion of total NHS expenditure, but the pressures are significant for the boards involved. There is evidence of wider pressure still in the system. Exhibit 11 on page 30 shows that at the beginning of the financial year boards projected funding gaps of around £183 million for 2005-06. There are plans to generate savings to address most of that gap, but a projected shortfall of around £28 million is likely. However, that projection is based on the estimates that we have been given.

The continuing financial pressures in the system are discussed at paragraphs 148 to 154. I have previously reported on the costs of implementing the new pay agreements and, in exhibit 13 on page 34, I have provided the committee with the Health Department's latest estimate of the additional cost for 2004-05 and 2005-06. Next year, I will bring a more detailed report on the consultant's contract to the committee.

The NHS in Scotland is expected to contribute to the Scottish Executive's efficient government initiative by making savings of £515 million by 2007-08. Audit Scotland has previously commented on the Executive's efficiency technical notes and has given evidence to the Finance Committee. I have asked the auditors of NHS bodies to report back to me on progress in that area.

The final part of the report looks at the issues that are involved in delivering change in the health service. The structure of the NHS in Scotland has changed significantly over the past few years, with the establishment of unified boards. The development of community health partnerships is seen as central to the future delivery of health services, but there have been delays in their implementation. We have provided an outline of the current position at paragraph 182. I have asked Audit Scotland to carry out a high-level review of governance arrangements in the community health partnerships, and I will report on that at a future date.

The committee has previously expressed concerns about shortcomings in performance information. There have been some improvements in the collection of activity data; for example, more information is available about nurse-led clinics. However, the NHS still has some way to go to provide a comprehensive picture of its activity, its costs and the quality of its treatment. For example, exhibit 14 on page 40 shows a continuing decrease in elective in-patient admissions and a levelling-off of day cases and emergency admissions since 2002-03. We do not have an explanation for that; we cannot say whether that trend is the result of quality improvements, a more complex mix of cases or whether there are growing problems of efficiency. We do not know whether those trends are explained by activity elsewhere in the system. For example, some patients are treated in out-patient situations. Therefore, the question of whether productivity as a whole is improving must remain unanswered. At the same time, we know that costs are increasing as a result of the new pay deals.

In conclusion, the NHS in Scotland is achieving significant improvements in health care, there are better clinical outcomes for major clinical diseases such as cancer and coronary heart disease, and it is significantly reducing waiting times. However, it faces major challenges in changing health services to meet the needs and expectations of the people of Scotland. It needs to improve its financial, workforce and performance management significantly.

The Convener: Thank you very much; that was a full briefing on the report.

Margaret Jamieson: I would like a little more information about exhibit 11 on page 30, which lists the funding gaps of each of the health boards in 2004-05 and the potential for gaps in 2005-06. What is that exhibit based on? Are those figures the boards' wish lists? I am concerned that the health board for my area does not appear. I take it that it is wholly satisfied and that it is able to achieve its own wish list.

Mr Black: Exhibit 11 shows individual health boards' assessments of the gap between their projected income and the funding that they need to continue services at this year's level. It does not include extra, one-off money, or the results of savings plans. It is an indication of pressure in the system, but it is not a confident prediction of what will happen, because that gap is being managed this year. The purpose of exhibit 11 is to indicate that, while the majority of boards came into financial balance in the last financial year, there was a lot of pressure in the system. It is appropriate to highlight that risk to the committee.

Margaret Jamieson: The differences between 2004-05 and 2005-06 are quite significant in some health boards, such as Greater Glasgow and Lanarkshire—a reduction of £21 million is quite significant. I am interested in what is behind those figures. What assurance do you have that the boards were robust in reaching those conclusions and in developing those figures? As you say, only Argyll and Clyde, Grampian, Lanarkshire and Western Isles were overspent. It is when we look also at the outturns that I start to ask who is really telling the truth.

Mr Black: It is fair to say that there are significant pressures in the system. The auditors invited the boards to give us their best indication of the potential funding gaps. The figures are not scientific, but they provide a reasonable indication that a number of boards are looking for quite significant sums of money to bridge the gap. If they do not manage to achieve savings or additional income from different sources, there will be a problem at the financial year end.

Margaret Jamieson: Am I correct in assuming that, because NHS Ayrshire and Arran has not provided information about its funding gap, it is happy with its lot?

Mr Black: I will turn to Angela Cullen for help with that.

Angela Cullen (Audit Scotland): The fact that Ayrshire and Arran is not listed suggests that it does not have a projected funding gap—on the basis that the other boards submitted the information. It is worth bearing in mind the fact that exhibit 11 lists projections at the beginning of the financial year, so the figures are the projected funding gaps at the beginning of 2004-05 and 2005-06. Ayrshire and Arran told us that it did not have a funding gap.

Margaret Jamieson: That information will be helpful to me at a later date.

The Convener: Before I move on to other questions, I note that in exhibit 11 funding gaps for the vast majority of health boards are going down, with two exceptions—Western Isles, which one cannot compare because it does not have data for the previous financial year, and Forth Valley, whose position appears to worsen. Are we aware of why Forth Valley is bucking the trend?

Mr Black: I will give a general answer then invite colleagues from Audit Scotland to help with your detailed question. Where there are significant financial pressures and funding gaps, the Health Department is requiring the health boards to have in place plans to get back into balance. There is a lot of activity in the system, so it is natural to see the figures for 2005-06 coming in below those for 2004-05.

With regard to Forth Valley, and possibly Western Isles, I turn to colleagues in Audit Scotland for assistance.

Angela Cullen: I can only assume that the majority of funding gaps are coming down because the boards are reducing their operating cost base, so they are taking recurring costs out of the system. I cannot give you an answer on Forth Valley at this time, because I do not know the details behind its funding gaps, or whether it is just starting to identify cost pressures that are coming into the system.

Eleanor Scott (Highlands and Islands) (Green): I have a couple of workforce questions. An obvious one relates to the comment on page 21:

"Basic workforce information, such as sickness absence figures, is not available in all NHS bodies."

I find that surprising. They must have to pay out sick pay and bring in staff. Such concrete information should be get-at-able, or am I being naive?

Mr Black: I agree with you. Given that the NHS in Scotland employs 150,000 people and services are provided through staff, it is entirely reasonable to expect the NHS to provide sickness absence information. Another factor is that sickness absence is comparatively high in the NHS compared with other parts of the public sector and the economy more widely. Boards will only be able to achieve the target figure for sickness absence of around 4 per cent, and the efficiency savings that they anticipate, if they have good information.

10:45

Eleanor Scott: In the table on consultant vacancies, Western Isles stands out. I also notice that you used Western Isles as a case study on governance arrangements on page 38. Are the two issues linked? At one level, I can understand that there might be difficulty in recruiting to more peripheral areas, but Orkney has no problem and Shetland has considerably less of a problem than Western Isles, which has a serious, embedded problem. You are also concerned about corporate governance in the Western Isles. Are the issues related, are they specific to Western Isles, and should we examine them?

Mr Black: We included the Western Isles case study on page 38 because, although it is a small board, it is clearly a vital organisation to the island community. For more than a year, auditors have reported concerns about the need for improvement in the governance of the board. We included in the case study examples of weaknesses, such as the absence of a full clinical governance framework, which we see in other boards. We could not make the leap and say that that is an explanatory factor for the comparatively high level of consultant vacancies in Western Isles, not least because Western Isles has had a problem in filling consultant vacancies for a number of years. Nevertheless, it is fair to conclude that a well-managed board would be more capable of tackling some of the challenges. There is a need for improvement in the Western Isles situation.

Mrs Mulligan: I will carry on that theme. Obviously, workforce costs are a significant part of a board's expenditure. We see that the numbers of consultants, nurses and midwives have increased but, as Eleanor Scott said, there are still vacancies. Are vacancies the result of shortages in certain specialties or are boards using vacancies to offset costs?

Mr Black: We do not have the level of detail to give you a full answer. I will offer a couple of comments, then invite Audit Scotland to come in and support with a fuller answer.

First, vacancies will never disappear, as we all recognise. There is natural turnover in the system. I am not qualified—neither is anyone here—to say what that level should reasonably be in the nursing workforce, let alone the NHS as a whole. Secondly, recruitment is taking place but, particularly in relation to the nursing statistics, we cannot talk significantly about the loss of nurses from the NHS. The NHS needs that total picture to manage its workforce well. I am sure that Audit Scotland can provide a fuller answer.

Barbara Hurst (Audit Scotland): We have no evidence that boards are deliberately not filling vacancies, particularly consultant vacancies, to manage some of their financial pressures. However, it is fair to make the link between nurse vacancies and the spend on bank and agency nursing. Something obvious is going on there. Boards should be tackling some of the efficiencies in terms of nurse recruitment.

Mrs Mulligan: Were there any examples of nursing recruitment being tackled, or of boards using innovative schemes to reduce the use of agency nurses?

Barbara Hurst: We are about to kick off a study that revisits nursing, so we will pick up the bank and agency aspect in that. There has been a reduction in the reliance on agency nursing, which is good, so most of the increase has been in the use of bank nurses, which is better in relative terms. However, we will consider this in more detail, particularly as we previously reported in 2002—as the Auditor General said—and that report does not seem to have had much impact.

Margaret Smith: I am delighted to hear that. I was going to ask whether you had any plans to review the matter following the work that was done in 2002. Some of the figures are worrying and some of us have concerns not only about the finances that are needed for bank and agency

nurses, but about the quality and continuity of care. However, I will skip over that.

Your report says that the data on productivity and performance are not there at the moment. The Kerr report says that there should be even more of a shift from the acute sector into the community sector, but you are saying that we do not have much idea about what is currently happening in the community sector. Will the Executive's on-going work do enough to tackle the problems or will things potentially get worse?

Mr Black: A lot of work is going on in the health service to improve information systems and it hopes to make a significant improvement next year in how it captures information. There is no doubt that that work is urgently needed.

I return to exhibit 14, which shows trends in acute activity. Planned admissions—or "elective in-patients", to use the jargon—are steadily declining and the number of day cases and emergency in-patients are levelling off. When such trends emerge and extra resources are being made available through pay deals and so on to improve the flexibility and quality of care, it is entirely reasonable to ask the health service what is happening in the acute system.

One gap lies in the underdeveloped nature of information about out-patient activity. Endoscopy cases, for example, will possibly become out-patient cases rather than day cases, but we do not have the data to allow us to assess that. At board level, as well as nationally, the NHS still has a long way to go to capture the performance information that will be critical to running the service.

Margaret Smith: Is the NHS on the right track with the work that it is doing? The report states:

"A Strategic Review of Health and Care Statistics has been undertaken by the SEHD and ISD".

Publication of that review is imminent. Do you have any idea whether it will satisfy your concerns?

Mr Black: I ask my colleagues to comment on that. We would not want to second-guess what is happening, but my colleagues can give a general impression of how things seem to be moving along.

Barbara Hurst: We understand that the review is considering filling in the data gaps on community activity and we want to find out the timescale within which that can be achieved. We need the information sooner rather than later and would want to consider such matters in a bit more detail.

Margaret Jamieson: NHS Quality Improvement Scotland collects information to satisfy itself that individual hospitals and health boards are meeting the stringent demands that are placed on endoscopy, for example. Is there a bit missing in the translation of that information to ISD Scotland?

Barbara Hurst: To tell the truth, I do not know how the flows of data work between NHS QIS and ISD Scotland. NHS QIS's data will be more qualitative than ISD Scotland's data, which are more quantitatively based. However, there appears to be a slight missing link in the chain between the quality outcomes and the activity that is going on. We hope that the strategic review of data will also address that.

Eleanor Scott: You said that the NHS in Scotland lacks information to monitor progress on improving mental health and well-being. I agree with what has been said about suicide rates. Obviously, a target to reduce suicides is relevant, but such a target cannot be the sole measure of improvements in mental health. What would meaningful targets be?

Barbara Hurst: That puts us on the spot. Mental health obviously involves far more difficulties than cancer or coronary heart disease, for example, as there are obvious outcomes for cancer and coronary heart disease. However, I would have thought that there would be indicators for long-term mental health that relate to the ability to return to what most of us would see as a normal way of life—I am referring to things such as return to the workforce and community involvement. The service users would have to be involved in developing indicators on what makes a difference to their lives.

Eleanor Scott: Involving them would be relevant.

The Convener: As members have no more questions, I thank the Auditor General for Scotland, Barbara Hurst and Angela Cullen for helping us with the report.

"A review of bowel cancer services"

10:56

The Convener: Agenda item 4 is consideration of a response from the Scottish Executive to the committee's sixth report in 2005, which is entitled "Bowel Cancer Services". Members have a copy of the Executive's response. An annex to it goes through the key findings and recommendations and what the Executive is doing or thinks.

I invite members and then the Audit Scotland team to comment on the response.

Margaret Jamieson: The Health Department agrees with what was said about GP referral guidelines and has undertaken work on a draft protocol, which will obviously assist a significant number of patients. However, I am concerned about there being no end date. We have heard about people presenting late to the GP and people presenting early to the GP. People have had problems in the system relating to the specialist service that was required. I would like a date on which the report will be made available to us. Perhaps we could ask about that, although it is good that the work has been undertaken.

The Convener: Members will no doubt be pleased to see the number of times that our report has been agreed with.

While members are thinking about whether they have any further questions, I invite Audit Scotland's observations on the Executive's response to our report.

Barbara Hurst: We are pleased that progress is being made and are aware from contacts in the health service that our report and the committee's report have had quite an impact. I agree with Margaret Jamieson that some commitments are a bit open-ended, but we are otherwise pleased with the response.

The Convener: As members have no further points to make, do we agree that I should write to ask whether there are target dates for some of the commitments? I could ask whether there is any more information about target dates and circulate the letter to the relevant sections.

Members *indicated agreement*.

The Convener: We are, however, generally pleased with the response.

The meeting will be suspended for 10 minutes for a comfort break before we move into private session for agenda item 5. I thank members of the public and guests for attending the public session.

11:00

Meeting suspended until 11:13 and thereafter continued in private until 11:36.

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