AUDIT COMMITTEE

Wednesday 19 December 2007

Session 3

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AUDIT COMMITTEE
9th Meeting 2007, Session 3

CONVENER

*Hugh Henry (Paisley South) (Lab)

DEPUTY CONVENER

*Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Claire Baker (Mid Scotland and Fife) (Lab)
*Willie Coffey (Kilmarnock and Loudoun) (SNP)
*George Foulkes (Lothians) (Lab)
*Jim Hume (South of Scotland) (LD)
*Stuart McMillan (West of Scotland) (SNP)
*Andrew Welsh (Angus) (SNP)

COMMITTEE SUBSTITUTES

Derek Brownlee (South of Scotland) (Con)
James Kelly (Glasgow Rutherglen) (Lab)
Iain Smith (North East Fife) (LD)
Sandra White (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Gemma Diamond (Audit Scotland)
Nick Hex (Audit Scotland)
Barbara Hurst (Audit Scotland)

CLERK TO THE COMMITTEE

Tracey Reilly

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Rebecca Lamb

LOCATION

Committee Room 5

Scottish Parliament

Audit Committee

Wednesday 19 December 2007

[THE DEPUTY CONVENER *opened the meeting at 10:30*]

Decision on Taking Business in Private

The Deputy Convener (Murdo Fraser): Good morning, ladies and gentlemen. I welcome to the ninth meeting of the Scottish Parliament's Audit Committee in this session members of the committee, the press and Audit Scotland staff. We expect Hugh Henry to join us shortly; he is having some travel problems this morning. I remind everyone please to switch off their mobile phones.

The first thing that we need to do is agree to take items 6 and 7 in private. Item 6 is consideration of our approach to the report by the Auditor General for Scotland on health; item 7 is discussion of a forthcoming evidence session on dealing with offending by young people. Are members agreed?

Members *indicated agreement*.

"Overview of Scotland's health and NHS performance in 2006/07"

The Deputy Convener: The second item on the agenda is consideration of a report from the Auditor General, "Overview of Scotland's health and NHS performance in 2006/07". I invite the Auditor General to introduce that, please.

Mr Robert Black (Auditor General for Scotland): I bring to the Audit Committee my overview report on the national health service, which was published on 14 December. Each year, we bring to Parliament an overview of the financial performance of the health service, and every second year over the past few years we have prepared a report that looks at NHS performance in the round, as well as at its finances. This year, it is a comprehensive report on the overall performance of the health service.

The commentary in the report, especially on financial performance, is drawn mainly from the reports by the auditors on each of the 14 health boards and the nine special health boards in Scotland. However, for the performance work, we also draw on our public performance reports and a variety of sources that are available to us.

The first three parts of the report look at performance and delivery, and the final part looks at financial performance. Members will appreciate that there is a lot of information in the report. Given the fact that this is the first time that the Audit Committee in this parliamentary session has had the opportunity to consider the performance of the health service in the round, I thought that it might be helpful if I took a few minutes to highlight some of the main findings.

The first part of the report considers the question, "How healthy are we?" The graphs and charts in the report attempt to summarise key features of the health of people in Scotland. Much of this information will be familiar to committee members from press coverage over the years, but the report attempts to pull it all together and share with you some of the high-level messages. The numbers of deaths from major diseases including coronary heart disease, stroke and cancer have decreased significantly and life expectancy has improved. Nevertheless, life expectancy is still lower than the European average and there are still big inequalities in health outcomes. There is, for example, still a seven-and-a-half-year gap between the life expectancy of men in East Dunbartonshire, at 78 years, and the life expectancy of men in Glasgow, at 70.5 years. Also, areas with a high level of deprivation continue to be linked to higher death rates, to

higher levels of major diseases and to more alcohol-related problems.

Scotland is still ranked behind other countries in many areas of health and well-being. The United States is the worst in the Organisation for Economic Co-operation and Development group of countries for obesity levels, but Scotland is second to the US with more than 25 per cent of the adult population being classified as obese. For teenage pregnancies, Scotland has the fourth-highest rate in the OECD countries, with NHS Tayside having the highest rate in Scotland.

The second part of the report looks at how the NHS is performing. In previous reports, I have commented on the difficulty of getting an accurate and balanced picture of NHS performance in the round, and that is still the case. The best information is still found in the acute hospital sector. Overall spending in the health service as a whole rose to £9.4 billion last year, but in the acute sector the increased investment does not appear to be matched by increases in traditional consultant-led activity, according to the information that was available to us. For example, consultants' out-patient activity shows a downward trend.

Exhibit 12 on page 12 shows that, at the same time, the number of emergency attendances at hospitals has increased—by 50,000 in the past year. The number of day cases has also risen, but planned admissions have been on a downward trend over the past decade and recently have remained fairly static.

I draw members' attention to exhibit 11, on the same page of the report, which shows a significant increase in accident and emergency attendances over the past two years, taking them back to a peak that was last seen in about 2000. The data for 2007 are provisional, but the general picture is undoubtedly that there has been a big rise. In the primary care sector, contacts between patients and their general practitioners have remained static over the past three years.

The Scottish Executive, as it was then called, introduced 32 new performance targets—known as HEAT targets—for the NHS in 2006-07. There are four categories of target: health improvement, efficiency, access and treatment. In the report, I comment on performance against some of the key targets. Generally, performance against the targets is improving, but there are some exceptions. One is sickness absence levels, which continue to be high, with NHS 24 having a significantly higher level than other boards. Details can be found in exhibit 14.

One important primary care target is that people should have access to GPs or practice nurses within 48 hours. That target has generally been met, but under the new GP contract such information is no longer published. I am sure that that is a performance target of real interest to the public, who must want to know how long it takes to get access to primary care. I encourage the Scottish Government to ensure that it is reported on in future.

Performance against cancer waiting times has improved, with 87.3 per cent of all cancer patients being seen within 62 days, but that remains below the target that the Scottish Government has set. In the report, we touch on the fact that the Government has directed cancer support teams to boards with the poorest performance.

Performance on in-patient and out-patient waiting times is good, and the Government has already met the 18-week waiting time target for in-patients. However, the abolition of availability status codes could make it challenging for health boards to meet such targets in future.

Delayed discharges have decreased over time, but 40 per cent of the patients who are ready to be discharged from hospital still wait for more than six weeks to get out. Readmission rates for elderly people—those who have to come back to hospital after a fairly short time—have declined marginally, but there is still much work to be done to meet the target of reducing the figure by 20 per cent by 2008-09. The trend in readmissions is described in exhibit 19 on page 17 of the report.

The HEAT targets were introduced to improve the performance and accountability of the health service in Scotland. However, information on performance is not published for all targets and is not brought together in an accessible format. As members can imagine, bringing together the information in an understandable form in one place involved a lot of work for Audit Scotland. The Scottish Government has several initiatives in place to gather information on costs, inputs, outputs and outcomes in the NHS, but those initiatives are not yet fully co-ordinated to give an overall picture of the performance of the Scottish health service. It is essential that the initiatives also support the Scottish Government's wider aim of developing outcome measures across the main public services.

The third part of the report looks at how the NHS is planning for major changes. The health service is undergoing a period of what is often called service redesign. Central to that is the intention to shift the balance of care from hospitals to community settings, but we do not yet have evidence that resources are shifting in line with the planned changes. As we show in exhibit 20 on page 21, the split of spending between the three main sectors—hospitals, family health and the community sector—has not changed in the past three years. The amount spent in each sector has risen markedly, but the relative percentages have

not changed. The information that is available to us indicates that resources are not moving in line with the strategy.

Community health partnerships were developed to help to make the shift happen, but they appear to be making slow progress. It is not unfair to say that so far they have concentrated mainly on establishing structures and processes. CHPs now need to focus on delivering benefits for patients.

Agenda for change is still being implemented and, by last May, 94 per cent of the workforce across Scotland had moved on to the new pay scales. We have commented in other reports on weaknesses in the plans to deliver the benefits of pay modernisation, and it is still not clear whether the full benefits of pay modernisation have been identified and are being monitored.

The final part of the report describes how the NHS performed financially in 2006-07. The financial performance of the NHS improved in 2006-07, with an overall underspend of £98 million. NHS boards underspent their annual revenue budgets by £113 million, and only NHS Western Isles overspent its revenue budget. In 2006-07 the boards had an underlying recurring deficit of £92 million, which represented only 1 per cent of recurring income. That is forecast to reduce to around 0.3 per cent of recurring income in 2007-08. However, NHS Western Isles and NHS Orkney have underlying recurring deficits that are substantially higher percentages of recurring income than is the case for other boards, and that represents a significant risk to those boards.

Despite the improving position overall, NHS boards had to use non-recurring funding and non-recurring savings to record an overall surplus. In previous overview reports, I commented on the extent to which health boards were relying on non-recurring funding in order to break even, but that does not now appear to represent a major financial risk. Boards generated £74 million by disposing of assets. In the past, profits from the sale of assets could be used to fund revenue spending but, starting from this year, those funds must be used for capital purposes. That will increase the pressure on revenue budgets, as the boards will not be able to use those profits to support on-going services.

The level of underlying recurring deficits is low relative to the level of recurring income and is forecast to reduce in 2007-08. Nevertheless, the challenge of meeting the forecasts should not be underestimated. Boards continue to face a number of cost pressures including service redesign, pay modernisation contracts, meeting performance targets—including waiting times—and drugs costs.

In conclusion, the NHS is making significant progress in its performance against Government targets and in improving its financial health. However, I encourage the Scottish Government to develop a more comprehensive system for measuring and reporting all aspects of performance together. The way in which services are delivered is changing, and the NHS needs to develop better ways of capturing and reporting the benefits of those changes. In particular, it needs to provide better information on quality and productivity.

As ever, convener, I am supported by the Audit Scotland team, and we will do our best to answer any questions that the committee may have.

The Convener (Hugh Henry): Thank you very much. I apologise for my delay in getting here.

I invite questions and comments from members.

Murdo Fraser (Mid Scotland and Fife) (Con): This is an extremely important and useful report from the Auditor General. It is comprehensive and there are a number of important messages in it.

Part 1 of the report, which paints the overall picture of how healthy we are, contains some striking and worrying statistics. We have probably seen them before, but when they are brought together and presented collectively they paint a fairly depressing picture of the health of the nation, especially in comparison with the statistics from other countries round about. For example, exhibit 6 on page 8 shows the obesity rates. Scotland's obesity rate is almost exactly double that of Ireland, which is quite a small neighbouring country with, I presume, a fairly similar population. If I remember correctly, Ireland spends substantially less on health than we do. Have the Auditor General and his staff considered any of the underlying reasons behind the statistics, or was the exercise simply about presenting the information in tabular form without considering the wider issues?

10:45

Mr Black: The short answer to that question is that what we are doing in this report is simply pulling information together into one place for the consideration of the committee and Parliament.

Why obesity levels in Scotland are so high and why they have been rising so rapidly are important and worrying questions. Obesity is a problem that affects many western countries. There are many reasons for that, which need to be investigated further and which are being investigated further by the Scottish health directorates.

Some of the data show obesity linked to deprivation. For example, they show that women in more deprived areas are significantly more likely

to have problems with obesity. On the other hand, the trend is the opposite for men: those in the least deprived areas are more likely to be overweight or obese. It is a complex picture and more work needs to be done to investigate the links.

I am sure that I do not need to tell members of the committee that the way to tackle the problem is not just to look at health alone; there are big questions of education, lifestyle, matters related to poverty and so on that need to be taken into account. However, that is not something that we have looked at.

Murdo Fraser: Thank you.

My second question is on an issue that you mentioned earlier—sickness absence rates. Exhibit 14 on page 14 of the report shows starkly the serious issue that exists at NHS 24 in comparison with other health boards. What makes that all the more worrying is that NHS 24 is, in effect, a call centre, so one would have thought that the working environment would be less conducive to people suffering from the kind of work injury that is caused by, for example, nurses lifting patients. I wonder whether you can add anything to what you said about the reasons why NHS 24 sickness absence rates should be so much higher than those in the rest of the health service are.

Mr Black: The board is certainly aware, as you might imagine, that it has a problem. There may be one or two issues related to how the data are captured by the Scottish Government; I will ask the team to help us on that. However, there are particular problems associated with sustained periods of out-of-hours working for staff in a call-centre environment. It is generally reckoned that such environments tend to have higher sickness absence rates than do other types of activity. I wonder whether the team can add anything to that.

Barbara Hurst (Audit Scotland): No. The situation is as the Auditor General said. It may seem counterintuitive, but call centres tend to have a higher percentage of sickness absence. NHS 24 links its higher rate to the stress of the job. However, it is clearly something that it needs to manage.

Willie Coffey (Kilmarnock and Loudoun) (SNP): My question relates to exhibits 2 and 3 on page 6. We can see from exhibit 2 that there is a general downward trend in mortality rates in Scotland for heart disease and cancers. However, exhibit 3 shows that the incidence of such diseases is much higher in our most deprived communities compared with the rest of Scotland. Is there any indication of a downward trend in our most deprived communities? Or is it an upward trend? It is hard to see that from the data that are presented in exhibit 2. Can you say anything further about that?

Mr Black: Can we help with this from our background knowledge?

Nick Hex (Audit Scotland): I am not sure that we can analyse the data to that level of detail. What we have shown in exhibit 2 is that mortality rates are coming down. However, there is still an issue about the difference in rates between deprived and less deprived areas.

Exhibit 4 shows that there are issues in relation to year-on-year changes in alcohol-related diagnoses in the most deprived areas, but that is probably a separate issue. I do not think that we have anything specific to show, unless Gemma Diamond can add anything.

Gemma Diamond (Audit Scotland): No. We have specific detail only for exhibit 5, on chronic liver disease, which shows that increases in rates seem to be much larger for the most deprived population than for those in the other deprivation categories, which may hint at the underlying issue to which Mr Coffey referred.

Willie Coffey: It is obviously a worry that we do not quite know what is happening with that category of people. A further worry is that, on the first HEAT indicator in the table in appendix 1, no data are available in any format to show whether health is improving among deprived communities. It must be a worry that we do not know what is happening with that group—we do not know whether we are meeting any of the targets or making a difference at all. How can we get a bit further towards having answers on that category?

Mr Black: Mr Coffey points to the important issue that we do not yet have evidence on whether the NHS is making progress on some of the important HEAT indicators. Clearly, that first indicator is a key one for the new outcome frameworks that are being promulgated by the Scottish Government. The Scottish Government must be concerned to ensure that it captures information that indicates whether it is making progress on that indicator, which is closely linked to one of the 45 indicators that the Government has established as the long-term outcome indicators in Scotland.