AUDIT COMMITTEE

Wednesday 10 September 2008

Session 3

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AUDIT COMMITTEE

12th Meeting 2008, Session 3

CONVENER

*Hugh Henry (Paisley South) (Lab)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

*Willie Coffey (Kilmarnock and Loudoun) (SNP)
*George Foulkes (Lothians) (Lab)
Charlie Gordon (Glasgow Cathcart) (Lab)
*Stuart McMillan (West of Scotland) (SNP)
*Nicol Stephen (Aberdeen South) (LD)
*Andrew Welsh (Angus) (SNP)

COMMITTEE SUBSTITUTES

Derek Brownlee (South of Scotland) (Con)
James Kelly (Glasgow Rutherglen) (Lab)
John Farquhar Munro (Ross, Skye and Inverness West) (LD)
Sandra White (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Roddy Ferguson (Audit Scotland)
Caroline Gardner (Audit Scotland)
Claire Sweeney (Audit Scotland)

CLERK TO THE COMMITTEE

Tracey Reilly

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Rebecca Lamb

LOCATION

Committee Room 1

Scottish Parliament

Audit Committee

Wednesday 10 September 2008

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

Interests

The Convener (Hugh Henry): Welcome to the Audit Committee's 12th meeting in 2008. I remind everyone to switch off their mobile phones if they have not already done so. In particular, I welcome members of the press and any members of the public.

For agenda item 1, I offer a special welcome to Nicol Stephen, who has joined the committee. This is a unique occasion for Nicol, as it is the first time that he has served as a member of a Scottish Parliament committee. It will be a novel experience.

Nicol Stephen (Aberdeen South) (LD): Thank you; that is much appreciated. I look forward to working with all members of the committee and its staff.

The Convener: I invite you to declare any relevant interests.

Nicol Stephen: I have no relevant interests, as far as I am aware.

Decision on Taking Business in Private

10:02

The Convener: Under agenda item 2, I ask members whether they agree that we should take items 6, 7, 8 and 9 in private. Is that agreed?

Members *indicated agreement*.

Audit Scotland (Corporate Governance)

10:02

The Convener: Agenda item 3 is consideration of correspondence from the convener of the Scottish Commission for Public Audit. The commission is undertaking an examination of wider audit functions in Scotland, including where Audit Scotland and the different organisations fit into the process. We have been asked whether we want to comment on the corporate governance arrangements for Audit Scotland and the public audit structure.

George Foulkes (Lothians) (Lab): Convener, you and I have the advantage of being members of that illustrious body, so we had advance sight of the letter. As you know, we had some discussion in the Scottish Commission for Public Audit, but I do not think that the meeting was held in public.

The Convener: No, it was not.

George Foulkes: Certainly, no one ever turns up, even if the meetings are in public.

At that meeting, it emerged—as you and I and others have felt for some time—that the structure relating to public audit in Scotland tends to confuse people. No one has any doubt about the Auditor General for Scotland, for whom I have particular respect. He and his team produce excellent and superb reports for this committee. However, we are never exactly sure to whom the Auditor General is accountable. There is a strange arrangement for his appointment.

Furthermore, we are not sure how the Auditor General relates to the Accounts Commission and why Professor Baillie is chairman of both the Accounts Commission and—I am getting confused already—the board of Audit Scotland. There is scope for the situation to be reviewed to make the arrangements for accountability clearer to us and to the public. With no disrespect to either the Auditor General or the Scottish Executive, I feel strongly that the ultimate responsibility of the auditor and the audit process, as it were, should be to Parliament, because Parliament represents the people and is ultimately responsible for ensuring the proper conduct of affairs in Scotland over a range of matters, including audit.

I hope that we can reflect that somehow when we make representations, which we should do; either the convener should make representations on behalf of the committee, or others should do so. I do not know how that would work, given that both the convener and I are members of the SCPA. Looking at the matter from the point of view of a parliamentary committee, we ought to make representations and participate fully in the study that is being undertaken by the SCPA.

Andrew Welsh (Angus) (SNP): Audit Scotland, from its foundation, has a superb record of doing what it is designed to do. The committee bases its reports on that work and the committee has been at the heart of fundamental reform of aspects of Scottish organisation. To whom is Audit Scotland accountable? To my mind, the SCPA is the auditor's auditor, so Audit Scotland is accountable to the Parliament through the SCPA and through the committee.

The essence of the issue is that we must maintain the independence of the Auditor General and his work, because Audit Scotland is the independent public watchdog. Whatever is done to clarify the situation, we must maintain that independence.

The Convener: I agree with Andrew Welsh that Audit Scotland's independence must be maintained at all costs.

One of the points that George Foulkes is driving at is that we can strengthen and enhance the role of audit generally by having greater clarity. Outside a small handful of people, many would not understand the relationship between the various organisations; if anything can be done to simplify that, so much the better. It is in the public's interest to have a good audit function, for both the Scottish Parliament and the Scottish Government and for other public agencies and bodies, because the public then know and can be assured that someone is acting diligently on their behalf at all times. Anything that can be done to clarify, improve and strengthen the function should be welcomed.

I am sure that we will receive further correspondence from Angela Constance, who is the convener of the SCPA. At the moment, other than taking up George Foulkes's suggestion that we feed into that process where we can, does anyone have any specific suggestions?

Members *indicated disagreement*.

The Convener: We will note the matter and come back to it as and when required.

Section 23 Reports

"Review of the new General Medical Services contract"

10:08

The Convener: Agenda item 4 is a section 23 report. The Auditor General will give us a briefing on the "Review of the new General Medical Services contract". Our approach will be determined later in the agenda.

Mr Robert Black (Auditor General for Scotland): Good morning, convener, ladies and gentlemen. It is a pleasure to be with you after an interesting summer, in all sorts of ways.

If I may, I will briefly introduce the report on the new general medical services contract. The report, which was published early in July, looks at how the new general medical services contract has been managed in Scotland in the early years.

As we all know, general practitioners are the first point of contact with the national health service for most patients and, on average, patients see their GP three times a year. In 2007, there were just over 4,700 GPs and just over 1,000 GP practices across Scotland.

The new contract was introduced in April 2004. It is a United Kingdom-wide contract, although small differences were negotiated by the health department in Scotland. The contract's four objectives were to reduce the workload on GPs and make it more manageable; to reward GPs properly for the work that they carry out; to address problems in recruiting GPs, particularly in more rural areas; and to try to achieve the delivery of more primary care services closer to where people live.

The new contract is between each local NHS board and each GP practice. That is significantly different from the previous arrangement, in which GP contracts were with individual GPs and not with the practice. By 2007, 904 practices in Scotland—about 88 per cent—had signed up to the new contracts. The remaining 12 per cent of practices are either managed directly by the health boards or have chosen to remain on primary medical services contracts.

As part of the new contract, GPs can choose to opt out of providing certain services, as I am sure members are fully aware, such as out-of-hours care and maternity medical services. In August last year we produced a report that looked at primary care out-of-hours services, so we have not examined those services again as part of this report on the new contract.

There is a lot of detail in the report that I will not go into, but the team from Audit Scotland is here to help me answer any questions. However, I will highlight briefly our findings under three main headings: the cost of the new contract, its impact and, in particular, the benefits for patients.

The cost of providing general medical services in Scotland has risen by 40 per cent over the past four years to 2007—from just over £500 million in 2003-04, which was the year before the introduction of the new contract, to just over £700 million in 2006-07. The new contract cost more than expected. In the first three years, general medical services cost £160.4 million more than was allocated to NHS boards for those services. Boards have funded the difference from their unified budgets. There was a significant difference between the estimate and the actual cost over that three-year period. Most of the additional cost comes down to two factors, the first of which was the additional cost of implementing an incentive payment for quality, known as the quality and outcomes framework. The second factor was the need to ensure that no GP practice was financially disadvantaged by the new contract; not surprisingly, that was known as the correction factor.

The elements that make up the new contract are described on pages 8 and 9 of the main report; two exhibits show the detail, so I will speak no further about that at the moment.

The net income of GPs who moved to the new contract increased significantly—on average by 38 per cent between 2003-04 and 2005-06.

I have concluded that the new contract was not as well planned as it should have been. For example, the quality and outcomes framework was not piloted before it was introduced and, therefore, there was underestimation of how well GP practices would achieve against the framework. That means that the payment under the QOF was significantly higher than was estimated originally. We highlight in the report’s conclusion that the Scottish Government should collect robust data before implementing major schemes so that it can base decisions on accurate information.

Another feature of the contract was that it was intended initially to target more resources at areas with higher levels of deprivation, or of rurality and sparsity. However, it has turned out that the protection of previous GP income levels—I mentioned the correction factor—has meant that resources have not been available to allow that targeting to take place. That has militated against the objective of targeting deprivation, sparsity and remoteness.

10:15

Between 2004 and 2007, the average cost of the system per patient increased from just over £112 to just over £123. The averages tend to be significantly higher in remote and rural areas. The variations are described in exhibit 6 on page 15 of our report. For example, the cost per patient in the area of NHS Highland, which is clearly a mainland health board, was £163 in 2006-07, compared with the average of £123. That brings particular pressures on such areas.

I turn to the impact of the new contract. The contract is intended to deliver benefits to patients, GPs and the wider NHS through the efficiency of its operation. It provides the opportunity for services to be tailored better to meet local needs by introducing payments for improved or targeted services. The quality and outcomes framework is designed to do that. Examples of improved or targeted services are health care services for homeless people and asylum seekers, which have been a particular concern in Glasgow. Such services are known as enhanced services. We found that NHS boards are spending more than the minimum indicative amount on them, so it is clear that they see redesigning and tailoring them as important. It is also clear that those services must continue to develop to meet local needs.

To my surprise, the team found that there are no national data on the number of full-time GPs in each health board area. That exemplifies the lack of basic general practice management. We suggest that it will be difficult for the NHS to plan primary care effectively or carry out workforce planning if good basic management data on the number of partners, salaried GPs and associated health professionals working in GP practices do not exist.

In exhibit 10 on page 20 of our report, we tried to summarise the progress that has been made in achieving the benefits that are expected from the new contract. In summary, at the time of our audit, we found that some progress had been made under five of the exhibit’s headings, limited progress had been made under two headings, and no real progress had been made on allocating extra resources to deprived and remote areas. There is evidence that the roles of practice staff are changing, and that practice nurses are taking a greater role in dealing with routine patient needs; there is also clear evidence that GPs are much more satisfied with their income and working hours.

The third heading that I mentioned is the benefits of the new contract for patients. We must all recognise that it will take time to secure benefits for patients from the new contract. Most NHS boards believe that patient care has improved as a result of it, but better monitoring is required, particularly on access to primary care. It is not surprising that people see access to a GP practice as important. However, at the time of our study, we found that only four Scottish NHS boards think that access to GPs has improved as a result of the new contract.

The target is that all patients should have contact with a health care professional in a practice team within 48 hours. That is not necessarily contact with a doctor; rather, it is contact with a member of the health care team. Of course, that should not prevent patients from requesting an appointment with a specific health care professional if they wish to do so—for example, they might be seen by a practice nurse and then request to see a doctor—but it is not guaranteed that they will get that within 48 hours. A significant shortcoming is that achievement of the central target of access within 48 hours is not being measured, so we cannot say to what extent such access is being delivered.

It is clear that the quality and outcomes framework is central to improving the health service. The framework has financial incentives to help to make that happen, and it can be renegotiated annually. In the report, we say that, because the achievement of the framework’s targets is so high, there is a real opportunity to move on and use it to do other things in future years. The contract clearly offers considerable scope to improve primary care services, and I encourage the Scottish Government, through using the framework to improve patient care, to move on in particular from an emphasis on processes—much of what is measured is to do with processes; I refer to disease registers, for example—to a greater focus on delivery and outcomes.

Our overall conclusion is that the new contract has led to some improvements for patients with certain long-term conditions—for example, there is better monitoring of patients with diabetes. However, we found limited evidence at the time of our audit that the contract has, at this stage, resulted in wider improvements for all patients. We recognise, though, that delivering the benefits will take time.

The Convener: Thank you; there was some intriguing information in that.

I note your comment that there is evidence of GPs being more satisfied. I am sure that many of us have seen that in different parts of the country. While that is an important factor—it was an important factor in the contract, too—it is not the only one.

What concerns me about the information that you have provided is that the targets on rurality and sparsity are not being adequately addressed. More concerning is the fact that deprivation is not being addressed. If we are to tackle Scotland’s shocking health statistics, everyone knows that we must tackle issues of deprivation. We knew that the contract was going to be more expensive. However, not only was it more expensive, it was actually more expensive than was originally anticipated and yet we have no evidence that deprivation is being targeted. Something is fundamentally wrong if we are spending the extra, substantial resources that we have, yet making no headway in tackling one of the key issues relating to Scotland’s terrible health record. What could or should be done to address that?

Mr Black: I will give you a full answer to that, if I may. In terms of the context, the first thing to say is that the quality and outcomes framework was intended to start encouraging the provision of a different type of health care in order to address some of the issues about which you rightly express concern.

When the contract was originally planned, the general estimate was that GP practices would achieve about 80 per cent of the quality and outcomes framework potential. The reality was that they achieved well over 90 per cent, rising from 92 to 97 per cent. That meant that the amount of money that was required to fund that element was greater perhaps than was originally anticipated and the value of each individual activity within that was enhanced during the contract negotiations. That sort of squeezed the resources that were available.

The second factor is that, as the contract was being negotiated, there was an understandable concern that no GPs should lose out financially. However, the correction factor has had the consequence of further limiting the margin of resources available for putting extra emphasis on areas of deprivation and areas of sparsity and rurality. That is the context.

There are encouraging signs, however, that, despite those constraints, there have been promising developments through the use of the quality and outcomes framework. For example, there is a category of activity called direct enhanced services, which are some of the things that the Scottish Government and the health boards want to see happen. Money is put into that. For example, areas such as childhood immunisations, influenza immunisations, cardiovascular risk registers, services for adults with learning disabilities and services for carers all receive more attention than they used to.

At board level, the boards have discretion to introduce locally enhanced services. Glasgow is quite an interesting example of that; enhanced services have been designed there to support the chronic diseases management programme, which is a significant development.

There are undoubtedly resource constraints, but that does not mean that nothing is happening. It is important that the committee appreciates that. With regard to the overall issue of the failure to move resources as planned, the best people to answer your questions and address your concerns about that would be the Scottish Government.

Murdo Fraser (Mid Scotland and Fife) (Con): I apologise for my late arrival, which was entirely due to traffic difficulties. Somebody thought that it was a good idea to install trams in Edinburgh. I am not entirely sure who took that decision.

I thank the Auditor General for the report and his comments. I have a couple of questions about costs—in particular, the rise in the costs for providing general medical services. I note the Auditor General's comments about some of the changes that the contract introduced, which include GPs being allowed to opt out of out-of-hours care. When Audit Scotland looked at costs, did it consider the impact that the contract changes had had elsewhere in the health service? For example, the GP opt-out for out-of-hours care put an additional burden on the remainder of the health service, because health boards had to provide alternatives to the out-of-hours care that GPs had previously provided.

Mr Black: I remind you that we produced a report last year on the out-of-hours service. Colleagues from Audit Scotland will be able to give you more detail on that than I can. In general terms, as part of the new GP contract, more than 95 per cent of practices opted out of out-of-hours care. That changed the context in which a primary care out-of-hours service works.

In 2006-07—the last year for which we had data before we made our report—the cost of the out-of-hours service was about £68 million. The cost was significantly higher in remote areas: at the time, I think that we advised the committee that the cost of out-of-hours care per head was just over £43 in Argyll and between £7 and £8 in Glasgow, so there were significant differences. You are right to say that we need to consider the GP opt-out in the wider context, because it causes additional pressures on services and costs.

Claire Sweeney, who led the project, will give you more information on some of the other implications.

Claire Sweeney (Audit Scotland): The easy answer is that it was impossible to give a clear answer about the impact on the rest of the NHS. We started out trying to do that, but there was poor monitoring information. There are some key issues in the contract that one would think would naturally have an impact on other services, such as the increased referrals for particular drugs and tests, and certain other arrangements. We expected clear monitoring of the impact of those as the contract played out, but we simply did not see such data, so it was difficult for us to pinpoint the contract's impact on the wider NHS.

Murdo Fraser: Would it be fair to say that the figures that you quote in the report are, in fact, only part of a wider picture and that the new contract's overall cost to the health service may be higher—possibly substantially higher—than the figures that you quote?

Claire Sweeney: It is extremely difficult to try to track through the contract's full impact, which would naturally lead to additional costs in certain areas. Yes, we published a previous report on the impact on out-of-hours services and the strain that the opt-out led to for NHS boards, which had to ensure that they put in place sustainable arrangements that met basic patient needs for out-of-hours care. There are gaps in the information that was available on activity and cost.

Murdo Fraser: Has the new contract given the taxpayer value for money, given everything that your report says? I suspect from what you have said, Mr Black, that your answer might be that it is too early to say or that there is insufficient evidence, but I would be interested to hear whether you think we have had value for money from the new contract.

Mr Black: To the extent that it had the objectives that I outlined earlier—to improve GPs' working conditions; give extra powers to health boards to provide financial incentives to develop the sorts of discretionary services that were necessary; and improve the general quality of GP care and get it closer to the communities—the early signs are that some progress is being made.

As I mentioned, it is difficult to give an overall assessment of whether value for money is being achieved at this stage. In exhibit 10 on page 20 of the report, we look at the expected benefits. In some categories, such as "Expansion of general medical services", "Improvements in recruitment and retention of staff", "Control of GP workload" and "Greater flexibility in commissioning of general medical services", some progress is being made. However, in other areas, we are seeing less progress. One really needs to assess progress against those criteria.

10:30

Andrew Welsh: I have a question about assessment criteria. Understanding and evaluation of the new contract require the ability to check and test whether resources are being deployed effectively and efficiently. We are told that, overall, there is a lack of basic management information about staffing and activity in general practice. Why is that, and how easily could that problem be solved?

Mr Black: The question why is perhaps best directed to the health directorates. Before the new contract was introduced, the relationship was between the health board and the individual GPs, who were remunerated on the basis of their individual contribution to the health service.

As we understand it, the new contract, which is negotiated with the GP practice, contains no requirement to provide information on the number of partners, salaried GPs, practice nurses or other professionals in the GP practice. Therefore, there is no comprehensive set of important basic information to assist in managing the NHS and planning its workforce effectively. There is a survey that GP practices can opt into, from the results of which we have provided the overall figure of the number of GPs in Scotland. However, that information is not sufficiently detailed, reliable or comprehensive to allow good workforce planning.

Andrew Welsh: So there is a data collection gap. How difficult would it be to fill that gap?

Mr Black: I suggest that we use slightly different language and say that there is a gap in the management information. I would not want to give the impression that we are looking for a bureaucratic exercise to collect more information. I would have thought that, in procuring health services, the health board could reasonably be expected to have good knowledge of the inputs that are being supplied in particular parts of Scotland—the number of partners and so on, which I have mentioned.

Andrew Welsh: I agree. The last thing we want to do is tie everybody down with bureaucracy. However, if there is a gap in planning, that is a problem for the overall management.

George Foulkes: Andrew Welsh has put his finger on an important point. Paragraph 64 of the report states that

> "The NHS does not know the number of GPs, full or part-time, by NHS board."

That is astonishing. It continues by saying that

> "The lack of data on GP practice staff does not allow robust workforce planning at a national or local NHS board level."

Paragraph 66 states:

> "Only three NHS boards (NHS Ayrshire and Arran, NHS Greater Glasgow and Clyde and NHS Shetland) routinely collect and monitor information on recruitment and retention in primary care."

When you went to the other boards, did they say why they do not collect that information?

Claire Sweeney: GPs are independent contractors; therefore, they do not have to supply any information that is not requested through the formal contract, which is where the problem has arisen. Under previous arrangements, they were paid according to particular procedures that they carried out. The new contract has simplified the payment arrangements, but it means that there is no requirement to tie that to who does what. The contract is now with the practice; therefore, it does not really matter, in terms of payment, who carries out the work. That leads to difficulties in establishing the number of GPs and practice staff and in determining who is doing what activity.

George Foulkes: That must make things difficult when it comes to training doctors in our universities. We need to know how many GPs are currently working, how many are retiring, when they are due to retire and so on. I wonder whether Mr Black can comment on that. I have raised the issue of workforce planning in other professions: for example, teacher numbers are not collected nationally, so the Scottish Government does not know how many teachers there are in the country as a whole and cannot, therefore, undertake any workforce planning. Should we consider workforce planning collectively at national level for all professions, including the medical profession?

Mr Black: Let me develop the point slightly in relation to the general medical services contract. We have established that there has been significant growth in the number of salaried GPs, which has now increased to more than 400. That is a significant change in how the service is delivered in some areas which will, in turn, have implications for planning how GPs come into the system and how their careers develop. Those matters must be of concern to the NHS.

A more general point is that we are giving serious consideration to including within our next round of performance audits—which we are currently consulting on—a study of workforce planning across the whole of government in Scotland. That would, we hope, address some of the wider concerns that Lord Foulkes has mentioned.

The Convener: Further to Andrew Welsh's question on remuneration of GPs, who determines how much a GP in a practice earns? Is it determined by the head of the practice?

Mr Black: The salaries of salaried GPs are set nationally. At the time of our study, their average salary was between £45,000 and £46,000.

The amount that individual GP practices receive depends on their core allocation, the amount of additional payment that they receive under the quality and outcomes framework and the correction factor. It is for the GP practice to determine how much of that income should be retained in net income and how much should be invested in support services, equipment and premises and so on.

The Convener: So, leaving aside the salaried GPs, if a practice's level of income increases under the contract, it is for the practice to determine how those funds are used. Therefore, might some GPs earn well in excess of the figures that you have mentioned if the practice decides to invest that money in GPs' own salaries rather than in local services?

Mr Black: In theory, that is possible, but we do not see that happening in Scotland. Our figures suggest that the percentage that has been retained is about 6 per cent.

Claire Sweeney: That is right. The report includes information that tracks practice income over time and the amount that has been reinvested. Although the amount of income has increased, the amount of reinvestment has increased at a slower pace. The rate of reinvestment within practices is not keeping pace with the increase in income.

The Convener: If the amount that is being reinvested within practices is not keeping pace with their increase in income, does not that give the lie to the idea that more is not being taken in salaries?

Claire Sweeney: Yes—it is true that a greater percentage of income is not being reinvested in practices.

The Convener: So, in some cases—we do not know how many—GPs are removing that income for salaries rather than reinvesting it in improving services to the community. Do you know what salary levels are within individual practices? Anecdotal evidence that has been given to me suggests that some GPs have taken huge salary increases. Do we track what salaries individual GPs take or is that just left to local practices?

Mr Black: On page 16 of the report, exhibits 8 and 9 give some information on GP income that is retained by GPs. In 2005-06, which is the latest year for which we had data, the average net income of such GPs in Scotland was about £90,000. Exhibit 9 shows that the percentage of reinvestment has reduced somewhat over time. In Scotland, the percentage of reinvestment has gone down from 55 per cent to 49 per cent during the period that we are examining.

It is also worth emphasising that we do not have robust information on the net income of GPs throughout the whole of Scotland. There is evidence, but it varies significantly: for example, GPs in more sparsely populated areas have less opportunity to increase their incomes at the margin through doing extra work because the practice list is not so long and there are fewer patients to operate on.

The Convener: Yes—but the figure that you gave for net income is presumably per GP, and it is almost twice the salaried GP level.

Mr Black: Yes. There is a big difference.

The Convener: At the same time, the level of reinvestment is, however, going down?

Mr Black: Yes.

The Convener: Is that a cause for concern?

Mr Black: We are not able to answer that from our study. We are not able to give an indication of what an appropriate percentage should be, as it will vary according to local circumstances. As Claire Sweeney mentioned, the amount that is invested has increased, but it is a lower proportion of the total gross income that GP practices receive on average.

Nicol Stephen: On that point, paragraph 52 states in relation to salaried GP income that the average figure of £45,000 has risen to almost £47,000. It also states:

> "This does not reflect an average full-time salary, however, as many salaried GPs work part-time hours only."

Mr Black: Yes, that is correct.

Nicol Stephen: Would we need to know what the average hours were in order to understand the significance of the £46,905?

Mr Black: That is correct.

Nicol Stephen: Do we have that information?

Mr Black: Unfortunately we do not. That is a significant part of the data gap.

Nicol Stephen: I will ask about a different area, in relation to paragraph 83 and exhibit 16 on page 26 of the report. We have spoken about the benefits to and the data on GPs, but I am interested in the benefits for patients. It is astonishing that access to GP practices is not measured—I wonder how that can be the case. My knowledge on access comes anecdotally from my constituents. They phone up on a Monday morning to try to get an appointment with any GP in their practice, but cannot be offered an appointment that week.

The Scottish Government and NHS trusts will, I presume, proudly say that under the new contract there is a 48-hour target for access to a GP practice. We are told that the GP practices proudly say that 99.4 per cent of them have in place arrangements to support achievement of that target. It is clear, however, that in some cases they are failing to meet that target by a considerable margin.

What can be done to change that situation, and to put in place measures that give a genuine indication of how long patients in Scotland are waiting for access to a GP? As I said, I know that waiting times remain significant in some cases. We cannot even say whether they are improving or deteriorating, because we do not have the data.

Mr Black: It goes without saying that the situation is a moving picture. Perhaps Claire Sweeney can update us on the current position with regard to monitoring the central target, and on how the NHS assures itself that the information that it gets about the arrangements that are in place is robust.

10:45

Claire Sweeney: The core problem that we identified in the report is that the target implies that there is monitoring of arrangements to see GPs or staff in general practices within 48 hours. In fact, the target is to do with whether or not arrangements are in place to allow that. The situation can be properly monitored only if the relevant data are being collected: my understanding is that that has not been the case.

There are examples of good practice, which we highlight on page 27 of the report. Some practices

“have reduced the average waiting time to see a GP”.

However, although case-study work has been carried out on trying to improve rates of access to GPs, that is not reflected in the target arrangements.

Nicol Stephen: If I phone up and ask for an appointment with my GP or if I ask for an appointment at the practice, as is now the situation, and am told that there is nothing available that week, is that noted or recorded anywhere?

Mr Black: The contract requires the patient to see a member of the team within 48 hours, and it requires the practice to provide an assurance that it has the systems in place to allow that to happen. It does not, however, require recording of information on whether or not that happens.

Nicol Stephen: So the answer to my question is, “Probably not.”

Mr Black: That may well be the case.

Nicol Stephen: It is not for Mr Black and his team to respond to that, but that is a serious gap in the new contract, which we require to—

Mr Black: Claire Sweeney could comment further. She has detailed knowledge and might be able to expand on the matter.

Claire Sweeney: I cannot give you a comprehensive picture for the whole of Scotland, but I can tell you a little bit about what we found when we were out and about doing our fieldwork. The situation is different across Scotland, but in some cases arrangements are in place whereby certain amounts of data are collected in some practice areas, but they are not collated or reported at national level. It is difficult to give a fuller picture.

Willie Coffey (Kilmarnock and Loudoun) (SNP): I suspect that the answer to Nicol Stephen’s question lies at the root of the contract that was negotiated in the early days. If we consider the reduction in workload and the ability to opt out of providing 24-hour care, some of the outcomes that have been reported are inevitable.

I want to ask more about the quality and outcomes framework. Do you have any information about why it is not directly tied to positive outcomes for various communities? As someone mentioned earlier, health inequalities remain prevalent in Scotland, particularly with regard to areas of multiple deprivation. I am wondering why the framework was not more closely tied to those outcomes. Even as we speak, is any move afoot to tie in the framework in that way? Mr Black said that we have an incentive scheme for quality outcomes. Is that tied more closely to positive outcomes, in order to reduce health inequalities?

Mr Black: Exhibit 2, on page 9 of the report, attempts to summarise the different components of the quality and outcomes framework. There are four domains, to use the Audit Scotland jargon: clinical, organisational, patient care experience and additional services. Under each of those domains are a significant number of activities that general practices are incentivised to provide. Under the clinical domain, for example, there is encouragement to set up clinics to address the problems of coronary heart disease, asthma and hypertension. That is clearly linked to deprivation, and that goes back to my answer to the convener’s question from some time ago. There is a lot of potential in the system to achieve positive outcomes—I have mentioned some of the work that has been done in Glasgow in that regard.

The framework should provide a useful tool for community health partnerships when they plan packages of care for their areas, as they try to identify the particular aspects of primary care provision that are really important in their communities. They will be able to use the flexibility of the system to provide financial incentives to get the services that are important in the eyes of the partnership.

Claire Sweeney: In part, the new contract was brought in to reward general practitioners adequately for the work that they were doing, and the results can be seen quite easily in the achievement levels under the quality and outcomes framework. The indicators for GP practices showed that many of them were delivering the results anyway, so the quality and outcomes framework has served to bring the few poorer-performing practices up to the level of the rest. We sought additional added value through the new contract. Recommendations in the report deal with the stretch in the contract, where we go from now, and how the contract can be continually reviewed to ensure that it is delivering value for money.

Willie Coffey: Four years on from the start of the contract, should we be taking the opportunity to strengthen areas that might bring greater benefit to the public?

Claire Sweeney: A considerable amount of work has been done on indicators that might come into the quality and outcomes framework, but some have not been included because of a lack of robust evidence. The quality and outcomes framework takes in part of the negotiations between GPs and takes account of various areas in the rest of the UK. We feel that there is scope to have a much greater focus on outcomes for the patients rather than on processes and registers in practices. It is now time to move on from that.

George Foulkes: I want to follow up on what Nicol Stephen was saying about benefits to patients. Paragraph 86 is on opening hours. Did you get any information on out-of-hours opening in evenings or on Saturday mornings? How extensive is it?

Claire Sweeney: At the time of the report, it was tricky to keep an eye on developments in extended opening hours, so the report does not contain much information on that. GPs were given the option of opening for extended hours in the evenings; I believe that around half of GPs have decided to take up that option. However, because that has just come into play, the report has no information on how effective it has been or on what difference it has made to patients.

George Foulkes: Paragraph 85 mentions a national patient access survey to provide data on patients' experiences. When will that survey be carried out?

Claire Sweeney: I am sorry, but I do not have a date for that.

George Foulkes: We will pursue that issue.

The report does not talk about when, instead of people deciding to go to their doctors, doctors decide to call in the patients on their list for screenings, flu jabs and all that kind of thing. Was such information part of your work?

Claire Sweeney: The simple answer is no. We did not look into GPs being called out to people's homes—

George Foulkes: No—I did not mean that. I am sorry, but I did not ask that very well. I was asking about GPs calling people in, for screening purposes for example. I am thinking about elderly people, so I suppose I should declare an interest. GPs get paid extra, do they not, for the number of people over a certain age on their lists, and they are supposed to call them in and screen them for different conditions, and give them—or give us, I should say—flu jabs. Did you look into that at all?

Claire Sweeney: We looked into the overall payment arrangements for that. We have data on that, which are not in the report. A relevant point concerns the changing role of practice staff. We have seen indications that some routine processes that GPs used to undertake are now being undertaken by other people; for example, practice nurses are now taking on a much greater role in some routine work. It is argued that that frees up GPs to give them more time for more complex cases. Small studies have been done, but we do not have a picture that covers the whole of Scotland and which gives accurate figures for that.

The Convener: As there are no further questions on this agenda item, I draw our discussion on it to a close. I thank the Auditor General and his staff for the information that they have provided.

"Review of palliative care services in Scotland"

The Convener: Item 5 is a section 23 report entitled "Review of palliative care services in Scotland". We will receive a briefing from Caroline Gardner.

Caroline Gardner (Audit Scotland): This is the second report on the health service that we have placed before the committee today. The aim of the review was to look across all palliative care services in Scotland, and the report was published in August.

Overall, more than 55,000 people die each year in Scotland, and it is estimated that three quarters of those people could benefit from palliative care to make their last months and days more comfortable, which would make a big difference to patients and their families. The report's main message is that, at the moment, such care is not available to everyone who could benefit from it.

Palliative care aims to control pain, to deal with other symptoms, including the psychological, social and spiritual needs of patients, and to achieve the best quality of life for them and their families during the final period of their lives. It is provided in a variety of ways: by specialists working in hospices and hospitals and with patients in the community; and by generalists, including the GPs and district nurses we have just discussed, and other hospital staff and home carers. Overall, the aim is that specialist palliative care should be available for people who have complex care needs, such as pain management and psychological support. Historically, palliative care has focused on the end of life, but in recent years it has been broadened to focus on people all the way through from their diagnosis with a life-limiting condition to their last days.

Access to palliative care varies across Scotland, depending on the health condition that someone is suffering from and on where they live. Before I comment further on that, it is worth saying that we found many examples of excellent care. We recommend that that quality of care should be available to everyone, whether they are in a hospice, a hospital, a care home or their own home. Care also needs to be better co-ordinated by NHS boards, voluntary sector providers and councils. The Scottish Government is due to publish a palliative care action plan next month, and we think that there is an opportunity for that plan to address the concerns that our report has highlighted.

My introduction will deal with four main themes. First, we found significant variation across the country in the availability of specialist palliative care services and in how easily patients who have complex care needs can access them. People with a range of conditions, including organ failure and neurological conditions such as Parkinson's disease and dementia, would benefit from specialist care but, at the moment, such services remain heavily focused on people who have cancer. Cancer causes less than 30 per cent of deaths, but cancer patients account for about 90 per cent of the specialist care that is provided. The access of people who do not have cancer but who have other life-limiting conditions to specialist services that could make a great difference to them is therefore a significant issue.

The reasons for that are partly historical. Specialist palliative care was initially developed by voluntary sector hospices, primarily to support people who had cancer. In practical terms, the fact that it is easier to identify the different stages of cancer as people move towards death makes it easier to identify those people who would benefit from specialist services, but it is now widely recognised that everyone with a life-limiting condition who has complex care needs should have access to specialist palliative care when they need it, and that is not happening.

The second theme relates to the general palliative care that is provided by GPs and other generalist staff. It is clear that most palliative care is already provided by generalist staff in hospitals, care homes or patients' own homes. We found many examples of excellent care, but we also found that some patients' palliative care needs are not recognised, or are not well supported, by staff who are not specialists. In some ways, that is not surprising. Generalist staff need increased skills, confidence and support so that they can tap into what specialists can offer. We must ensure that they have the necessary support to provide such care, that they are able to recognise the patients who will benefit from it and that they know when to refer them on for specialist care.

Another finding was that good-practice guidance is not always provided or applied consistently. For example, we found that only 5,000 people are on GPs' palliative care registers, which we estimate represents only about 12 per cent of the total number of people per year who would benefit from palliative care.

We think that the provision of palliative care needs to be much better joined up, particularly at nights and weekends. If good communication between daytime services and out-of-hours services is lacking, there is a much greater risk that people will be admitted to hospital when they do not need to be, which can affect the quality of care that they receive. We think that it would be relatively straightforward for the various agencies involved to work more straightforwardly together, and for community health partnerships to play a role in planning and overseeing the palliative care services that are needed and provided in their areas.

11:00

The family and friends of people with palliative care needs also require support. The carers to whom we talked as part of the work told us that such support is not always available. For example, two thirds of the carers who were looking after somebody who was nearing the end of their life said that they had not been offered an assessment of their own needs. It is obvious that that reduces the likelihood that they will receive the respite and support that would make all the difference to their ability to care for their family and friends.

Information about the cost of care is—again—a bit patchy. We know that £59 million was spent on specialist palliative care in 2006-07, of which almost half came from the voluntary sector. We cannot say how much the palliative care that is provided by generalist staff costs, as it is not identified separately, but we know that it forms a significant part of their workload. District nurses told us that, on average, one tenth of their patients had palliative care needs and they estimated that they spent about one third of their time on providing palliative care. We have no distinct information, but palliative care is an important part of the workload of those staff.

As I said, the Government plans to publish a palliative care strategy next month. This is a critical time for health boards and their partners to plan how to meet the needs for palliative care, which are likely to increase given that the population is ageing and that people are living for longer with life-limiting conditions. For example, the number of people with chronic obstructive pulmonary disease—we used to call that emphysema—is expected to rise by one third in the next 20 years, which will increase the need for palliative care in specialist and general services.

I hope that that has given members a picture of what the report is about. My colleagues and I will do our best to answer questions.

Stuart McMillan (West of Scotland) (SNP): Exhibit 9 on page 19 lists the percentages of hospice funding that health boards have provided. Did health boards explain why, even in the same health board area, different hospices received different contributions?

Caroline Gardner: The broad principle is that health boards should fund half the agreed costs of the voluntary sector services in their area. The health board and the voluntary organisation should sit down together to agree the needs, for which the health board will meet half the costs. In some cases, the hospice or charity will decide to provide more than what they agreed with health boards, which accounts for some of the difference. However, some health boards and voluntary sector providers might simply disagree, which leads to a difference that is not as amicably agreed in practice.

Stuart McMillan: That explains the situation. Some of the figures in the exhibit—especially the different figures within health board areas—stand out. I was unsure about the reason for the differences.

I was concerned about what paragraph 26 on page 10 says. The first bullet point says,

> "There has been no coordinating national strategy,"

and the second bullet point says, "There is no consistency". Has Audit Scotland had any input into the Government strategy that is expected to be announced next month?

Caroline Gardner: In all our work, we aim to keep in close contact with the Scottish Government and the health boards that work in the relevant area. We have talked about the questions that our report raises and gained a sense of what the Government is doing about them. The strategy and the plan will be the Government's and not ours, but we hope that the issues that we have identified will assist the Government in achieving the right content for the plan and examining how health boards and their partners apply it in practice.

Andrew Welsh: My question is about what appears to be a co-ordination problem. The report says:

> "Generalists need increased skills, confidence and support from specialists to improve the palliative care they give to patients and their families."

How could such skills be acquired? Are in-house or outsourced training facilities assumed?

The report also says:

> "Palliative care needs to be better joined up,"

which you said was relatively straightforward to solve. Were you talking about training or better communication and working together? How is the problem to be addressed?

Caroline Gardner: I will deal with training and then pass on to Roddy Ferguson to talk about working together. A fair amount of training is available. For example, Marie Curie Cancer Care and Macmillan Cancer Support run training courses for GPs, district nurses and other general staff on how to recognise people with palliative care needs, on what can be done in generalist settings and on who should be referred on to specialist care. However, there is a question about ensuring that the training is widely taken up by GPs and other members of staff. That could be measured through the quality framework, which is available and to which about 75 per cent of practices are signed up. The other 25 per cent are not signed up, which may be an issue that the action plan should address, with the aim of widening the sign-up.

Another question arises about providing support to people working in general care settings, after training. Those people can carry out the role much better if it is easy for them to contact a specialist nurse or doctor to talk through the issues when they are not sure what the best way of working is for a patient. It can make a great difference to have in place arrangements so that GPs or district nurses know whom to contact and can do so pretty readily, so that it becomes part of the way in which they manage their working day. However, at present, it is not clear how that happens throughout Scotland.

On working together, there is an issue with the way in which patients' records are held—the use of emergency care summaries would make a difference. Roddy Ferguson will talk about that.

Roddy Ferguson (Audit Scotland): On out-of-hours arrangements, one of the key areas that we identified was that generalists and specialists need to work well together to provide round-the-clock support to patients who are nearing the end of life. When GPs record emergency care summary information about a patient in their general practice, they record it on to a computer. We identified that systems should be in place to link that summary automatically to out-of-hours care teams, so that when somebody phones in out of hours, perhaps with a change of symptoms or with worries and concerns that they want to talk to a specialist about, the information is readily available. We have noted which boards are or are not providing access to specialist support out of hours. Given the complex needs that some patients have, potentially during the night, they need to be able to access a specialist service not only in normal working hours but out of hours.

The Convener: It is worth putting on record a comment about the phenomenal contribution that many charities make to palliative care. My family benefited greatly from the contribution of Macmillan nurses, and other organisations perform a similar function. However, it will be interesting to see the strategy that is to be published soon, because it is clear that improvements can be made in the co-ordination of services for those who need palliative care at home, not just within the health service but between health and social work services.

There is also a significant gap for those who need palliative care for their remaining days while in hospital, where the standard of care, particularly for elderly people, often leaves a lot to be desired. I am concerned that the similar stories that we hear from different parts of the country about phenomenal levels of care, compassion and input from staff are mirrored by stories about very poor service at times. With the growing demographic problem, which Caroline Gardner touched on, we need to change fundamentally what happens in hospital.

Willie Coffey: Exhibit 2 on page 9 shows which health boards have a palliative care strategy in place. Two of the boards that have strategies stand out because they have not conducted a needs assessment. I cannot understand how a board could have a strategy if it has not carried out a needs assessment. Perhaps you could explain that in a bit more detail.

The gold standards framework that is described on page 32 seems a marvellous approach to improving matters such as service planning. Are health boards and practices encouraged to adopt those standards, to strengthen the system? The framework seems as though it would be useful and productive for families and patients.

Caroline Gardner: You are right about the apparent mismatch between the strategy and the needs assessment; it looks odd to us as well. The strategy is the overall approach that the health board, GP practices and others in the area have agreed to take to providing palliative care. It is likely to differ depending on whether there is a voluntary sector hospice in the area, whether the area is urban or rural and therefore whether they are looking at providing specialist beds and specialist teams in hospitals or specialist staff in the community.

It is possible to have that broad strategy without having an up-to-date needs assessment of how many such facilities a health board provides, but one without the other does not seem particularly useful. The publication of the Government plan is a good opportunity to have another look at how well the arrangements are in place in each NHS board area. Another point worth noting is that a couple of the strategies are relatively old. One goes back to 1998, and we know that the situation has changed a lot since then. In some instances, the strategies could probably do with some refreshing.

We agree that the gold standards framework is a powerful way of helping general care staff who deal with people coming toward the end of their lives to recognise those with complex care needs and to refer the right people to specialist services. I will ask Roddy Ferguson to tell you what we know about how the framework is being applied.

Roddy Ferguson: When the gold standards framework was launched in Scotland, there was support and facilitators were appointed throughout the country to promote it in local general practices. As you will see from the report, there was varied success. Some boards took it on and had more than 80 per cent of practices signing up, while others had levels of only 20 or 30 per cent.

That was a short-term piece of work, and the funding stopped in October 2006. Some practices are still finding out about it afresh and becoming involved in it, but the rate of practices signing up has slowed because there are no facilitators actively promoting it.

Willie Coffey: Does the framework allow us to tackle the problem that was mentioned earlier—that cancer causes less than 30 per cent of deaths but cancer patients account for 90 per cent of specialist care provided?

Roddy Ferguson: The framework focuses on all conditions—it does not discriminate. It promotes recognition of palliative care needs across conditions and does not specify one disease or another.

Willie Coffey: How come it is not achieving some kind of balance?

Caroline Gardner: Over time, it should help GPs and district nurses to recognise the non-cancer patients who have complex needs, but we have not yet seen its impact since its introduction. That is likely to take some time, and there is room for further improvement.

Nicol Stephen: I want to ask about page 12 and about the map of care provision across Scotland in exhibit 3. Convener, I agreed with your points about older patients, but I am also interested, at the other end of the spectrum, in services for children. The report says:

> "Specialist palliative care for children is provided on a national basis by the Children's Hospice Association Scotland".

The Children's Hospice Association Scotland has two hospices, but we can see from the map that they are both in or close to the central belt.

Is specialist palliative care for children a national service and is there a national strategy, or is it left to individual boards? Do boards' palliative care strategies always include children, or is the cover patchy? I would like more of a three-dimensional view of the facilities, quality of care and strategies in place for children. It is a significant concern to many constituents.

Caroline Gardner: You are right. There are several layers to the answer. The broad picture is that the two hospices and the hospice at home service, which are all provided by CHAS, are funded nationally. All 14 health boards contribute to the costs, and they are planned for as a national service. Having said that, we think that we should be planning for services to people in remote and rural areas, where there is a gap in care.

11:15

We have talked about the way in which specialist palliative care services tend to focus on people with cancer; there is also a risk that they are not as available to younger people, particularly adolescents rather than children. Older people are also underrepresented, which needs to be worked through when planning for the future.

We all recognise that we need to be more flexible when providing specialist services in remote and rural areas. There are good examples of flexible hospice at home services in some parts of Scotland, but we are not sure how that is done throughout the country for children and other groups that tend to have less access.

Nicol Stephen: Do the young patients who are in national hospices tend to live close to those hospices or elsewhere in the central belt? I remember the same sort of argument being made about the national services available to deaf or blind children—there are national facilities, but they tend to be based in the central belt and dominated by children from close by or within easy travelling distance. Therefore, services for deaf or blind children are variable—that is probably the best description—depending on which local authority area they live in. Is the situation similar for children with terminal illnesses? Does it depend on where they happen to live and the quality of provision that their NHS board has put in place, even though theoretically, there is a national strategy and national provision at those two excellent hospices?

Caroline Gardner: Very much so. People in remote and rural areas generally have less access to hospices, which is exacerbated for children because the two hospices are in the central belt. That is one of the reasons why the hospice at home scheme is so important; it provides a method of providing palliative care that does not rely on bricks and mortar.

Roddy Ferguson: The location of any building will prove a barrier—the further away people live from it, the more difficult it is to access. The children's hospices try to work around the access issue by having good provision for families to come and stay over. Even though they might travel a long distance to get to the hospice, there is a floor at the facility in Kinross where the families can stay. The parents can stay upstairs and the child and their brother or sister—in many cases, the condition is hereditary—can stay downstairs. The family might travel a long distance to reach the hospice, so stability once they are there and their wider needs are catered for.

George Foulkes: This is another fine report from Audit Scotland. It is appropriate and timely that we should have a report on this subject at this time. We were asked during the recess to suggest subjects for the report and I just wonder who suggested this one. Whoever did was very forward thinking and sensitive.

Caroline Gardner: It is tempting to say that it was one of the studies that came through the experience of the team when we looked at the health service. We had not looked at palliative care throughout Scotland and, on further investigation, we found that nobody had taken a wide-ranging look. The timing was fortuitous because we were looking towards the development of the Scottish Government's plan for palliative care. We hope that the two can fit together well.

George Foulkes: Commendation is due.

Nicol Stephen: Agreed.

The Convener: Thank you very much for that stimulating and fascinating discussion to which I suspect we will return not only in the committee but in Parliament, which might wish to return to the debate.

That concludes the public part of our business. I ask members of the public and press to leave the room now.

11:19

Meeting continued in private until 12:02.

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