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Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 24 March 2010

Session 3

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PUBLIC AUDIT COMMITTEE
6th Meeting 2010, 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)
*Cathie Craigie (Cumbernauld and Kilsyth) (Lab)
George Foulkes (Lothians) (Lab)
*Bill Kidd (Glasgow) (SNP)
*Anne McLaughlin (Glasgow) (SNP)
*Nicol Stephen (Aberdeen South) (LD)

COMMITTEE SUBSTITUTES

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

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Angela Canning (Audit Scotland)
Caroline Gardner (Audit Scotland)
Ffion Heledd (Audit Scotland)
Nick Hex (Audit Scotland)
Tricia Meldrum (Audit Scotland)
Claire Sweeney (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

Robert Calderwood (NHS Greater Glasgow and Clyde)
Richard Carey (NHS Grampian)
Tim Davison (NHS Lanarkshire)
Dr Linda de Caestecker (NHS Greater Glasgow and Clyde)
Dr Pauline Strachan (NHS Grampian)

CLERK TO THE COMMITTEE

Tracey White

LOCATION

Committee Room 6

Scottish Parliament

Public Audit Committee

Wednesday 24 March 2010

[The Convener *opened the meeting at 10:01*]

Decision on Taking Business in Private

The Convener (Hugh Henry): Good morning. I convene the sixth meeting in 2010 of the Public Audit Committee. I remind members and anyone else who is here to ensure that all electronic devices are switched off.

Do we agree to take items 4 and 5 in private?

Members *indicated agreement.*

Section 23 Reports

"Overview of the NHS in Scotland's performance 2008/09"

10:01

The Convener: I welcome our witnesses. Richard Carey is chief executive of NHS Grampian; Dr Pauline Strachan is director of acute services at NHS Grampian; Robert Calderwood is chief executive of NHS Greater Glasgow and Clyde; Dr Linda de Caestecker is director of public health at NHS Greater Glasgow and Clyde; and Tim Davison is chief executive of NHS Lanarkshire. Does anyone want to make opening remarks?

Tim Davison (NHS Lanarkshire): I do not think so.

The Convener: Okay. I invite questions.

Murdo Fraser (Mid Scotland and Fife) (Con): I thank the witnesses for coming. The committee is considering the financial pressures that face the national health service in Scotland. In his report, the Auditor General for Scotland identified as an issue the target of 2 per cent efficiency savings. Will the chief executives talk about the pressures on their budgets that are created by the requirement to meet the target? How sustainable is the approach in the long term? We have heard that many boards try to meet the target by, for example, deferring expenditure until a later year. That can be done in the short term, but it might not be realistic to do it on a medium to long-term basis. Will you give a flavour of how you deal with efficiency savings and say whether a 2 per cent target is viable in the long term? Please do not think that each of you must answer every question; we will end up with a long session if that happens.

Tim Davison: It is essential that we achieve 2 per cent efficiency savings, because we need those savings, together with the uplift that we get from Government, to cover cost growth. The achievement of 2 per cent savings is not a discretionary luxury but an absolute necessity if we are to meet the cost pressures that we face.

Sustainability is a big issue. When I was appointed as chief executive five years ago, NHS Lanarkshire had a cumulative deficit of £20 million. It has taken us five years to get back to a healthy state. We posted a £14 million surplus last year and are on target to post a £12 million surplus in 2009-10. Looking forward to 2010-11, our cost growth, together with the uplift that we get from Government, means that we have to find the full 2 per cent efficiency savings to meet our costs.

Murdo Fraser: Anyone else?

Robert Calderwood (NHS Greater Glasgow and Clyde): To set it in an historical context, 2 per cent has allowed us to introduce a whole series of service developments. In the years under consideration, particularly 2008-09, a large element of the cash-releasing savings was redirected into providing new services either in line with the Government's health improvement, efficiency, access and treatment targets or—in NHS Greater Glasgow and Clyde, for example—through the opening of new health care premises and the capital charge uplift that new buildings bring with them. Until now, we have been able to generate savings through increased productivity, and we have reinvested in services in the areas in which the opportunity to do so arose.

As Tim Davison said, we are now looking at how, by using best practice, benchmarking and a range of other tools across Scotland, we can ensure that the NHS provides a consistent quality and level of service. We believe that the NHS across Scotland still has the opportunity to learn from and roll out best practice.

Richard Carey (NHS Grampian): I have little to add to that, except to agree that the financial performance of the NHS in Scotland hitherto has been a success story. The levels of funding that we have enjoyed during the past few years have enabled us to grow the health service in a positive way and improve performance in a number of key areas.

The situation in the future is going to be much more challenging, but we believe that we can deliver savings in the budget through effective management, good productivity and service redesign.

Murdo Fraser: I have a follow-up question on what you said about how you are making efficiency savings. The evidence that we heard from Audit Scotland suggests that roughly 70 per cent of health boards' budgets goes on salaries. Can a continuous 2 per cent per annum efficiency target be achieved without impacting on the salary bill? Will it mean having to make savings in that area?

Tim Davison: It is absolutely inevitable that we have to reduce our wages costs. There is no avoiding that. We have significant above-inflation cost pressures on drugs, new technologies, property costs and capital investment aspirations, so we cannot avoid looking at the workforce. We are doing a great deal around that.

NHS Lanarkshire was told that our uplift for 2010-11 would be significantly reduced on previous years, and for the past six months, we have gone through an intense process of discussion and negotiation with our area clinical forum and our area partnership forum to put together a 120-point cash-releasing efficiency savings programme that includes a proportionate approach to reducing workforce costs and other costs. We are trying to increase our efficiency in areas such as product use by trying to restrict the number of orthopaedic prostheses that we use and to reduce the range of surgical sundries, appliances and cardiac stents that we use. We are also trying to constrain our expenditure on prescribing by agreeing with our general practitioners a whole series of switches to less expensive drugs. However, there is a significant balancing sum that requires us to save money on wages. We are trying to run down overtime as much as possible; reduce the amount of bank staff that we use; reduce to virtually nil agency costs, which are at a premium; reduce the number of medical locums, whose costs are also at a significant premium; not fill vacancies unless they are in absolutely essential, front-line posts; and impose a 10 per cent reduction in corporate, back-of-house department costs. We are confident that we have a fighting chance of delivering our efficiency programme next year on the back of such steps.

The Convener: I want to pick up on a number of things before I bring in Anne McLaughlin.

These savings are described as efficiency savings. Are they savings, or are they efficiency savings?

Robert Calderwood: They are a range of savings. I will characterise the clinical savings on theatre utilisation. Historically, there was poor practice in theatres, involving late starts, early finishes and bad scheduling of patients. That resulted in very high fixed costs for the theatre team and the infrastructure, which was, in some cases, utilised for as little as 50 per cent of the available operative time. We have now, throughout Scotland, moved that figure well into the mid 80s and it is heading towards 90 per cent.

That has resulted in true efficiency savings: we have been able to put more patients through the system and achieve the HEAT targets within the current fixed costs. On top of that, other examples of true efficiency savings include those in the area of shared services, in which bringing together the backroom services of finance, human resources or information technology, for example, has resulted in improved efficiency and centralisation of economies of scale.

As Tim Davison pointed out, all those schemes affect the earnings of individual employees, the way they work or the location of their work. At present, the changes have not affected existing employees—where manpower has changed, we have been able to do that through the redeployment of turnover.

Those savings are, in the main, true efficiency savings. We are now, as we move forward, examining other backroom services—as Tim Davison mentioned—such as supplies and prescribing, and we are considering opportunities to set a benchmark and deliver against that as part of a quality to cost equation.

My own board is looking to get out of all our office premises that are not on a hospital site and which we do not own, with a view to making a saving that we consider has no real impact on people. It is not a loss to the NHS if we move into hospital premises and are not renting a city-centre office block for £1.5 million.

The Convener: Can each of you say, hand on heart, that you will be able to squeeze out of your organisation efficiency savings of 2 per cent year on year? If you can for the foreseeable future, does that beg the question how efficient the operation is just now? If you are able to make those efficiencies year on year, why are you not efficient at the moment?

Robert Calderwood: There are opportunities for future efficiency savings, but I qualify that by saying that those would not involve squeezing 2 per cent per annum recurrently out of the status quo. A large element of the opportunity to achieve savings in future years will involve service redesign, and we will need to consider that as we go forward.

In a business that spends £8 billion of taxpayers' money, there are still areas of overlap, duplication and historical working practices that need to be examined and resolved. Audit Scotland's reports put the spotlight on a lot of the areas in which we can all improve and follow best practice.

Ultimately, however, elements of service redesign and change will be needed to ensure that we provide the necessary volume, quality and safety of service in future years while living within the fiscal constraints. Nobody can squeeze the status quo by 2 per cent, another 2 per cent and then 2 per cent again.

The Convener: Mr Carey, is that the same in Grampian? Is service redesign merely about efficiency, or will it lead to cuts?

Richard Carey: In Grampian, we also have to examine all areas of the organisation to ensure that we can meet the efficiency savings targets that the Government has set for us. In common with other health boards, we have been managing the size and skill mix of our workforce carefully. In the current financial year, we implemented a voluntary severance scheme to reduce the number of back-office staff by 60, which will bring about a revenue saving of £1.5 million in the coming financial year.

10:15

There are also issues of best clinical practice. We are looking at each specialty, considering how the clinicians deliver the service and comparing that with the best in class, if you like. That could include day-case rates, the average length of stay or the pre-operative time that people spend in hospital. By applying the best-in-class standards that are achieved elsewhere in the NHS, we can predicate efficiency savings. That also benefits patients, because they do not want to be in hospital for longer than they need to be. Such efficiency measures are happening throughout the NHS in Scotland, and NHS Grampian is no exception.

Your question about service redesign is relevant. We need a wider debate about the future level and configuration of services and the extent to which they can best be delivered differently. Your premise was a 2 per cent year-on-year salami-slicing approach, to use the jargon, but that will be increasingly difficult to sustain in the longer term.

The Convener: At what point in the next few years will that difficulty reach a critical point? How many years will we have of 2 per cent efficiency savings?

Richard Carey: That is a difficult one to call because we do not know what the financial allocation will be from 2011-12 onwards, although we know that it will be very tight, and tighter than it is now.

The Convener: Yes, but those are two separate issues. If the future settlement is substantially less in real terms than it is now—

Richard Carey: Which it will be.

The Convener: —you will clearly have major challenges. What I am asking is, if all things were equal, how long could you sustain 2 per cent efficiency savings?

Tim Davison: Things will start to get very tight in 2010-11 and the bite will really happen in 2011-12. However, it would be wrong for us to give you the impression that it is an easy jaunt to take 2 per cent of cash out of an NHS that has growing demand placed on it year on year. The current year is probably being characterised as the last of the good years and we will get some residual benefit from that.

Although I have spent six months negotiating with my teams in Lanarkshire to deliver, as I said, a 120-point savings plan that will deliver £15 million-worth of cash savings, that is not without risk and uncertainty in some areas. When one has taken 10 per cent out of corporate departments, reduced consultants and public health medicine posts and reduced overtime to negligible levels,

there is a limit to the number of times one can go back with the same begging bowl to release savings. That is when we begin to look to the configuration of services as being at least part of the solution to driving out efficiencies. However, we know that driving out efficiencies through the reconfiguration of services brings significant public concern. That is a difficult issue for us all.

Robert Calderwood: I will try to put service redesign in context with a practical example. In NHS Greater Glasgow, before we became NHS Greater Glasgow and Clyde, we entered a maternity services strategy at the end of the 1990s that saw us commit to move from four consultant-led obstetric delivery units in relatively questionable estate to two brand-new, state-of-the-art maternity units, the second of which, at the Southern general hospital, opened in January this year.

On the back of that service redesign, we have built more than £60 million-worth of new NHS estate, and we have been able to accommodate the additional demand created by a 5 per cent increase in the birth rate in greater Glasgow during that period while reorganising antenatal care back out into health centres in the community. The net effect is that, in real terms, the health board is spending about £3 million a year less on obstetric services while providing, we believe, a much higher-quality and more responsive service with regard to the balance between the obstetric, consultant-led, in-patient episode and the antenatal and postnatal care in the community.

As Tim Davison said, people view such redesigns differently. The clinical community can view a redesign such as the one that I have described very positively—they might see it as being about investing in their services and giving them the tools to do the job—but individual communities can view some such changes in a different light. I have given an example of a case in which redesign has, we believe, led to the provision of a better, higher-quality service that is fit for purpose, but which can be delivered within a shrinking revenue envelope.

The Convener: Before I bring in Cathie Craigie on the same point, I want to follow that up. Mr Davison, Mr Calderwood and, to a lesser extent, Mr Carey have mentioned service redesign as being key to their ability to deliver future savings so that the budgetary challenge can be met. You have hinted at the difficulties in delivering service redesign because of the inevitable reaction that you get. How do you deliver the anticipated cash savings from service redesign if politicians and public opinion are against you?

Tim Davison: Clearly, we cannot. If we base a financial plan on service redesign that we cannot achieve, the cash pressure comes on to trying to pull savings out of the status quo. As we have been saying, pulling savings out of the status quo ultimately takes you into the law of diminishing returns.

In a bleak economic context, the challenge for all of us—politicians, the NHS and the public—is to have as sensible a discussion as we can about how to live with a reduced level of expenditure.

The Convener: So to meet the targets that you know exist and the challenges that you will face, your service redesign is predicated not just on your ability to identify changes, but on the willingness of politicians to co-operate with you in delivering those changes.

Tim Davison: We need the co-operation of the public as well.

The Convener: Yes, that is an obvious requirement.

Tim Davison: I was the chief executive of North Glasgow University Hospitals NHS Trust when Scotland's first independent MSP was elected, on a save Stobhill hospital ticket. The level of service redesign that was associated with Stobhill attracted intense opposition, as you will know. When the Glasgow acute strategy is finally implemented, the redesign configuration will come to fruition between eight and 12 years after the original decision was taken.

The service redesign that I oversaw in Glasgow in the 1990s involved the transformation of a hospital-based model of care in mental health and learning disabilities to a community-based model of care. That is probably the biggest shift in the balance of care that we have seen in Scotland in the past 15 or so years, and it had intense public and political opposition. The public were really unhappy and concerned about people with mental health problems and learning disabilities living in their street. They did not want medium-secure facilities built at the end of their road and they did not want the big institutions—which, in parts of Glasgow, employed whole families—closed, so there was a significant level of public opposition and political concern. That strategy was based on a policy of the 1960s, which it took the best part of 40 years to implement. In a Glasgow context, implementing it took us more than a decade. Service redesign is part of the solution, but none of us should pretend that it is quick or easy.

Cathie Craigie (Cumbernauld and Kilsyth) (Lab): You have dealt with a point that I was going to make. If 2009-10 will be okay—you will be able to manage—2011-12 is the year that you will really have to look at, and it is clear that service redesign will not fill the gap. We will probably come on to deal with that in greater detail as we move through our questioning.

I do not think that the question that Murdo Fraser asked at the start has been answered by any of the chief executives. He asked what percentage of the savings were one-off and what percentage of them would be there for the long term—in other words, what percentage were real efficiency savings.

Robert Calderwood: All the savings in NHS Greater Glasgow and Clyde that have been made in the financial years 2008-09 and 2009-10 are recurrent savings that have been released from how we do current business and reinvested in new services or meeting increasing demand.

It is important to set the context, particularly for 2008-09 and 2009-10, that the cash-releasing savings allowed boards to develop new and more extensive services more quickly. There was not a loss of cash to NHS Greater Glasgow and Clyde—we continued to spend all the money that we had, plus the growth money. We invested that money, in some cases in bricks and mortar. The two new ambulatory care hospitals created a new cost to NHS Greater Glasgow and Clyde of £21 million a year, because the old Victorian buildings that they replaced cost a fraction of the cost of the new buildings. Therefore, we took the efficiency savings that we made and reinvested them to meet the cost of the new buildings.

The money has stayed invested in NHS Greater Glasgow and Clyde. It is the same for 2010-11, although we are taking the opportunity to meet some of the inflationary costs of the status quo from the efficiencies rather than from the whole range of additionality. Up to now, all the savings in NHS Greater Glasgow and Clyde have been recurrent and reinvested recurrently.

Tim Davison: The position for Lanarkshire is similar, although I would add two qualifications to supplement what Robert Calderwood said. When you set a savings programme—in our case, £15 million of cash-releasing savings for next year—unless every single proposal starts to release cash on 1 April you have to aim for a higher number. If you have a £15 million target but all the projects involved in releasing that £15 million start half way through the year, you will be short by 50 per cent.

Our savings programme is actually an £18 million savings programme. It starts predominantly at the beginning of the year, although some schemes are phased to come in later in the year—one scheme in particular may require public consultation.

As I said earlier, we are in the fortunate position in Lanarkshire of having been able to build up a non-recurring revenue surplus, and we can bridge some of the gap in 2010-11 non-recurrently, by investing some of our capital surplus. We will invest £5 million of our non-recurrent revenue surplus next year, together with recurrent savings of £15 million.

Richard Carey: We are in a similar position. In 2009-10, £24 million of the £26 million of efficiency savings that we have managed to deliver has been recurring. We have an important job to do to identify further recurring savings in 2010-11, and we have an efficiency savings programme in place that identifies an £18 million requirement.

Cathie Craigie: I have a specific question for Tim Davison. I know about the service redesign in Greater Glasgow and Clyde, which seemed to go on for about 20 years. As I am sure you will confirm, NHS Lanarkshire made proposals in the consultation document "A Picture of Health: A Framework for Health Service Improvement in Lanarkshire" not to save money but to deliver a better service. NHS Lanarkshire is now in a position in which it has to deliver a service without the savings that it thought it might make, which, if I remember rightly, were about £50 million from Monklands hospital and £8 million a year on-going. How are you managing to deliver savings on top of the additional burden that has been placed on you?

10:30

Tim Davison: As you say, the reconfiguration of acute services in Lanarkshire was not about saving money. The figures that you quote are to do with how much less additional cash was needed for the preferred solution at the time, not the additional cash needed to deal with the next best priority. All the scenarios for reducing accident and emergency configuration in Lanarkshire actually cost more money and the principal driver for reducing the number of A and E hospitals from three to two was the need to address Lanarkshire's chronic medical staffing shortage. The decision to make Monklands the preferred site to be reduced from a fully functioning emergency hospital to a planned care hospital was based on the fact that it was a relatively old hospital that required a lot of capital investment, and upgrading it would be very difficult. After all, it is more difficult to upgrade an acute hospital while it is being run as such, rather than build a new facility on a brownfield site.

The financial consequences of the revised policy of a presumption against centralisation and the retention of three A and Es have not given us a particular headache up to now. However, the challenges that we were trying to address with "A Picture of Health" remain. The medical staffing situation is still fragile and we are still required to make significant capital investment in order to sustain in the long term three emergency hospitals in Lanarkshire. As public servants, we are committed to implementing Government policy

and, since 2007, we have put absolutely every effort into ensuring that we sustain the model of care that the Government has asked us to sustain. Obviously, the challenge becomes more significant in tighter financial times, but we are committed to delivering it.

The Convener: Before I bring in Nicol Stephen, I wonder whether Mr Davison will clarify his comments. You said that the situation is fragile and that the challenges that you previously identified still exist and have not been addressed. Do you have the resources to remedy the situation or will you need additional resources?

Tim Davison: We are still scoping the capital that would be required to upgrade Monklands hospital significantly. In the past two years, we have invested about £7 million or £8 million in fabric repairs, and our capital investment programme for the next three years allows us to invest a further £15 million. We are addressing some of the problems, but we still have to deal with the fundamental rebuilding of Monklands hospital.

The Convener: But that is the issue. You said that the redesign was part of a deliberate process to tackle challenging and grave staffing and investment difficulties that existed and still remain in Lanarkshire.

Tim Davison: Yes.

The Convener: Are you being given the resources that will enable the current design to be sustained in the long term?

Tim Davison: As I have said, we are managing to sustain the configuration. Indeed, in the past two years, we have developed a £12 million surplus. Historically, however, Lanarkshire has had a relatively low level of medical staffing because, over its history, it has received below average funding compared with the Scottish funding norm. Obviously, that means that some health boards receive above average funding. Nevertheless, we have a relatively low funding base and our medical staffing is relatively poor and spread relatively thinly. That position has not changed. We are planning to invest further in medical staffing, but the difficulty in Lanarkshire has been as much about being unable to recruit people to funded vacancies as it has been about finding the money to create additional posts.

We are now in a period of intense national and regional work on reshaping our medical workforce to address the concerns that I have described, and I have absolutely no doubt that, if we can sustain services over the next couple of years in the way that we have done over the past couple of years, we should be able to tap into the oversupply of medical staff that Scotland is likely to have by then.

The Convener: Let me ask the question in another way. Do the problems that you identified in your redesign proposals still exist?

Tim Davison: Yes.

The Convener: Will you be able to eliminate those problems under the current model?

Tim Davison: It very much depends on our funding position during the next five or 10 years. As I said, reconfiguration of acute services does not happen overnight. Had we been able to press ahead with the previous plan, it would have taken a number of years to implement. Even if our reconfiguration proposals had been implemented, we would still be sitting here in 2010 trying to sustain three emergency hospitals in Lanarkshire.

As we go forward, we face a number of challenges. First, can we design our medical workforce in a way that attracts doctors to work in Lanarkshire? Secondly, can we afford to employ them in the jobs that we need to employ them in if we are to sustain services? Thirdly, can we afford significantly to refurbish Monklands hospital during the next 20 years? That is probably how long it would take fully to refurbish a hospital while continuing to use it, given the series of decants that would be required. All that is in the realms of speculation; what happens will entirely depend on future uplifts for NHS Lanarkshire.

Nicol Stephen (Aberdeen South) (LD): I do not want to put words in the witnesses' mouths, but I want to be clear about what you said about service redesign. Are you saying that making 2 per cent efficiency savings through a salami-slicing approach will start to get tough in 2010-11 and that a reliance on that approach simply will not achieve 2 per cent efficiency savings beyond 2011? I see that two chief executives are nodding in agreement.

Robert Calderwood: We must set the issue in context. I repeat that we cannot go to individual services or groups of staff and expect them, year on year, to deal with 98 per cent of the money that was in the budget line in the previous year if we do not assist them to deal either with the demand equation in the primary/secondary care balance or with other cost pressures. Therefore, we are talking about service redesign, looked at over the next three to five years. An uncertain and poor outlook for the public sector, which might last for 10 years, means that we will not be able safely to deliver services in the way that we currently do if all we do is take away 2 per cent each year. We must go back each year and consider what is safe and sustainable.

Let us take the performance of the acute sector of the NHS in Scotland in the calendar year 2008-09. If all Scottish hospitals performed at the level of the upper quartile of the best hospitals in

Scotland—let us not even seek UK or European comparators—we have identified, by considering length of stay, turnover and a series of factors, that in the acute sector alone we could deliver the same volume of care but £75 million a year cheaper. There are therefore still opportunities to take something out of the status quo, but once we get to a safe level of service we must consider opportunities for more radical redesign. I talked about how better and more cost-effective obstetric services can be delivered in Glasgow. Of course, a whole range of issues must be gone into. We must look over the next three to five years.

Nicol Stephen: I understand those points. The witnesses have suggested that the salami-slicing approach to making 2 per cent efficiency savings is increasingly tough and that you must consider service redesign. You then told us that service redesign is slow and that you are looking at a period of three to five years, as Robert Calderwood said, if not decades. Service redesign is not only slow but politically controversial. It is difficult to convince the public that it is a good thing. Does not all that suggest that at the end of 2011 the NHS will face a financial crisis?

Tim Davison: We face a very difficult problem that the NHS cannot fix on its own. We face the most difficult economic position in public spending in a long, long time, and to assume that any great public service such as the NHS can deal with that in isolated splendour is fallacious. It will take strong leadership from all public leaders—whether they be politicians or people like us—to find some kind of compromise between the inexorable rise in public expectations of what we should deliver and our public accountability to deliver what we can within taxpayers' resources. The NHS cannot do it on its own.

Nicol Stephen: That leads to my final question. You look for 2 per cent efficiency savings every year and try to implement service redesign that you believe is in the best interests of the health service, yet it seems at least possible—perhaps probable—that you will still not meet the targets if the reported scale of the pressure on the public sector finances is accurate. What will you do then? How will you manage? I presume that the same things must have happened in the past, although perhaps not under your leadership. When you hit the buffers and run out of cash, how do you manage and implement the savings that you must achieve in order to meet Government targets?

Richard Carey: Germane to that are the political decisions that are made on, for example, pay policy. The scenarios going forward can be radically different, depending on what we do on public sector pay. A period of public sector pay restraint—I suggest that it would need to be quite severe restraint—might give us the opportunity to sustain the approaches that we have been describing over a longer period to enable redesign to happen. Part of the equation is the decisions that are made at the policy level, which will either help or hinder the future sustainability of the service.

Nicol Stephen: That is completely outside your control.

Richard Carey: Exactly.

Nicol Stephen: Those are national agreements. I am asking what you do when you are in your crisis situation—when the financial cosh is on you. How do you respond if you cannot implement your service redesign quickly enough and the 2 per cent efficiency savings have run out?

Tim Davison: We respond by trying to continue to salami slice. However, our best advice is that that is looking increasingly unsustainable, as the Auditor General points out in his report. Going forward over a number of years, we would concur with that.

Nicol Stephen: You cannot say that that is efficiency savings—it is just straight cuts. Is that correct?

Tim Davison: Yes.

Nicol Stephen: You somehow have to select—

Tim Davison: The least worst.

Nicol Stephen: Exactly.

Tim Davison: All managers in any sector try to do that while minimising disruption to front-line services. The parlous state of some of the NHS estate is a result of taking that kind of thinking to its conclusion. When it is a choice between replacing a computed tomography scanner or a lift in a hospital, the CT scanner will tend to come before the lift. We have all worked in the health service for decades, from the early 1980s until now, and we have lived through successive Governments under which there have been very lean times, especially in the 1980s and the early 1990s. In the past 10 years or so, we have lived through times of huge growth, and we are now facing a downturn again.

Richard Carey's point is linked to my point that it is unfair to assume that the NHS can just continue to cut costs. There are two sides to the equation in any economic environment. The first is about cutting costs; the other is about stemming growth. The levers around growth are clear: they are pay, new drugs and technologies, property and capital investment, targets and initiatives, and growth and demand. If we face the most difficult economic times going forward, we must play with permutations of all the levers that are at our disposal.

We have to be as efficient as we can be. There is scope to make further efficiencies, although, as I have said, doing so becomes more difficult. Growth levers can be tweaked, and we require them to be tweaked if we want to come out of the other end of the process with a health service that we can comfortably sustain.

10:45

The Convener: I want us to move on to population changes, but before we do I want to put something on the record. Mr Davison, you mentioned things that you are doing to tackle rising expenditure. You want to cut back substantially on overtime, and you said that you are cutting back on the use of agency and bank staff. I presume that that is an issue throughout Scotland. It would be unfair of me to be particular, but I have just written to Mr Calderwood about Dykebar hospital, which is in my area. The complaint there is that there is significant overtime, significant agency work and significant use of bank staff. I will not use this meeting to go into that, but I want to say that if my letter has not arrived, it is on its way. There are issues from this discussion that I will consider with a different interest, not just a local interest. I will return to those issues.

Robert Calderwood: Indeed. I look forward to receiving and responding to that letter. I do not know the details of the situation to which you refer.

It is fair to say that when NHS Greater Glasgow and Clyde came together, it inherited from the former Argyll and Clyde Health Board a set of heavily institutionalised mental health services. Community services were poor, and there was to be a £9 million cut in them to bring Argyll and Clyde Health Board back into revenue balance. NHS Greater Glasgow and Clyde ripped up that mental health strategy, reconsulted the community and ripped up the £9 million saving. Indeed, we have provided £3 million a year to move mental health services into the community, mirroring the model in greater Glasgow. Those services should therefore be available to all residents of the greater Glasgow and Clyde area equitably. It is possible that we are going through a transition phase in the downsizing of our institutions. Such a phase would normally let us use temporary staff to effect that transition while we fill the substantive vacancies with the skills that we need in the community.

That does not specifically answer your question. However, fundamental changes are taking place across the Clyde area, and Dykebar hospital is at the centre of a number of them. [*Interruption*.]

Richard Carey: I am sorry, I thought that I had turned my phone off.

Nicol Stephen: There is a fine for that.

The Convener: I will have a 99, please.

Anne McLaughlin (Glasgow) (SNP): I will resist the temptation to tell Robert Calderwood about my specific issues. Perhaps I will do so outwith the committee.

There is a lot of good news in the report. As it is an overview of the performance of all the witnesses' health boards, I congratulate them on achieving the efficiency savings; reducing deaths from cancer, heart disease, stroke, AIDS and suicide; and reducing waiting times. I hope that hidden waiting lists will be gone for ever. It is clear from what they have said that doing such things is challenging, and they have achieved astonishing results. All of those things are extremely important to everybody in Scotland, which is why there are real-terms increases in this year's budgets to deal with them, whereas other budgets are being cut.

However, it is clear that there will be pressures in future, which the panellists have spoken about. Scotland's changing demographics and ageing population will be among the biggest pressures on the public sector as a whole, and on the health service in particular. I invite the panellists—perhaps the discussion can be opened up to include the two doctors—to talk a little bit about how they are planning to deal with the ageing population. What plans are in place? What investment is being made in preventive medicine, anticipatory care and service redesign? How are you planning to deal with that situation and what investment are you making? How will the future pressure on finances that we have mentioned put pressure on the work that you are doing?

Tim Davison: I will start by setting the context. I am the chief executive leading on the work to address the demographic challenge. I am sure that Linda de Caestecker and Pauline Strachan will add some comments.

An enormous amount of preparatory work has been done in the past couple of years in a partnership process involving the Scottish Government, led by the Minister for Public Health and Sport Shona Robison; senior elected representatives from councils; the Convention of Scottish Local Authorities; health board chairs and myself as chief executive. We have been steering a process of trying to size the challenge and engage with statutory and third sector stakeholders on how we might address it. We have had events throughout Scotland and we have held high-level summits for local authority leaders and health board chairs, in Dunfermline about a year ago and again in Dunblane about two weeks ago.

We have a number of work streams considering the various components, such as the absolute growth in the older population, the growth in

healthy life expectancy rather than simple life expectancy, workforce issues, carers issues, housing and supported-housing issues and the model of care. We are beginning to consider the issues that Anne McLaughlin mentioned, such as anticipatory care, self-care, supported self-care, more complex care at home and trying to shift away from an institutional model to a more supported self-care at home model. All those work streams have been reporting. We had a successful event in Dunblane, at which some of the issues were addressed.

The growth in the older population and the very old population—in particular the over-85s—in absolute terms in Scotland is enormous. The challenge is that continuing to admit the current proportion of the older population to institutional care—by which I mean care homes as well as hospital care—will drive huge growth in future demand that will, frankly, bankrupt us. That is what is driving the significant consideration of a revised model of care.

To set the context, the issue has been identified for a good couple of years and there has been an intense process of engagement with statutory and third sector stakeholders. The Government is about to launch a public engagement process with the wider public on some of the issues. We are well-sighted on the issue and a lot of work is going on. I am sure that Linda de Caestecker and Pauline Strachan will want to add to that.

Dr Linda de Caestecker (NHS Greater Glasgow and Clyde): Although, as Anne McLaughlin says, we have an ageing population and increasing life expectancy, we do not have such a large increase in healthy life expectancy, so people are living longer with chronic diseases. She talked about anticipatory care, which I believe is an effective way to promote healthy life expectancy. We try to prevent some of the problems of chronic diseases, particularly cardiovascular disease, through primary prevention, primarily through primary care. We call people in for health checks to consider the preventable risk factors and to try to manage them.

However, a really important part is our secondary prevention. NHS Greater Glasgow and Clyde has invested a large amount of money in that so that, with people who already have chronic diseases, such as chronic obstructive airways disease, coronary heart disease or diabetes, we manage their disease at as early a stage as possible to prevent hospital admission and progression of the disease. That has been effective and patients like and appreciate it. There is a high uptake of the service, which is currently an important part of GPs' work.

Primary prevention is currently targeted at deprived populations. The research tells us that continuing that strategy of targeting the most disadvantaged populations, as well as people with a family history of coronary heart disease, will allow us to pick up more than 80 per cent of the people who are at risk. Based on evaluating the keep well pilots and knowing what is effective, we will want to roll them out to all areas of deprivation and to look at all those with a family history.

Dr Pauline Strachan (NHS Grampian): I would like to answer the question first as a practising GP and secondly as someone who has responsibility for acute services.

As a GP, I absolutely agree with Linda de Caestecker that we are doing an enormous amount to try to get ahead of illness as much as possible. We know that prevention works in the vast majority of cases, and that we need to target even more of our efforts on deprived communities, where the increase in life expectancy is not as marked as it is in better-off areas.

In the acute sector, it is critical that patients receive the best care that they possibly can get as quickly as they possibly can—and then get out of hospital as quickly as they possibly can. The longer that patients are in hospital, particularly elderly ones, the more unwell they become. In particular, their muscles waste as they are lying in bed.

Rehabilitation is incredibly important. Programmes involving cardiac rehabilitation and pulmonary rehabilitation have been shown to reduce readmissions to hospital among patients with chronic obstructive pulmonary disease and to improve their quality of life at home.

Those are the areas on which we are concentrating much of our efforts: preventing people becoming unwell in the first instance, ensuring that those who do become unwell are treated as quickly as possible and get out of hospital as quickly as possible, and ensuring that they receive proper rehabilitation packages, either at step-down facilities or, best of all, at home.

Anne McLaughlin: At the weekend, the Cabinet Secretary for Health and Wellbeing announced free health checks for over 40s. As far as I am concerned, that is the only benefit of being over 40—not that I am. How early does preventive action start? You spoke about the healthy ageing population as opposed to the unhealthy ageing population—perhaps you did not put it like that—but will the preventive measures have a significant impact in the longer term?

Dr de Caestecker: The key component lies in getting a good uptake of the health checks, as we have found with the keep well programme. We have had to put a lot of effort into ensuring that the

people who are most at risk take up the health checks and then adopt the behaviour change that accompanies them. Just having the health checks per se will not be sufficient. However, 40 is certainly an early enough age for routine, systematic health checks. We also need to consider young people's health behaviours, particularly with regard to tobacco, alcohol and obesity.

Dr Strachan: It is never too early to start. Ideally, we start prenatally, with good maternal health, continuing through good health for children. It is a matter of supporting as many people as possible to follow healthier lifestyles.

Richard Carey: The programme will be organised through NHS 24, and it will be really helpful to have that national infrastructure. Grampian will be one of the initial pilot areas, and we will be looking with interest to see what impact there is on the growth in demand for services. If it creates demand that we have not previously encountered, we will need to consider the matter very carefully.

The Convener: The suggestion has been made in parts of this discussion that you are concentrating on areas of deprivation. Will you be concentrating on areas of deprivation in the Grampian pilot project?

Richard Carey: Alongside patient safety, we have identified addressing health inequalities as our major strategic objective in Grampian. We are trying to deliver services more locally in deprived communities. There are a number of good examples of that in places such as Torry and Middlefield in Aberdeen. Contrary to public belief outside Aberdeen, the city has quite significant areas of urban deprivation. By targeting services in people's communities, we find that the uptake of services and people's willingness to use services are much better. That will be very much part of the pilot project. We have the infrastructure, and we know, from postcodes and details that are already available, who we need to target, as we do with the keep well programme. We will proceed on a targeted basis, otherwise the risk is that we would end up dealing with the worried well. We want to identify the people who really need the service.

11:00

The Convener: Will the pilot project be focused on the deprived areas or will it be rolled out over some of the more affluent areas in Grampian as well?

Richard Carey: It will probably be a universal service, but it will be up to us to ensure that we target the activity and resources in the areas of greatest need. That is important.

Dr Strachan: In common with other boards, we are participating in the keep well programme, which targets deprived areas. The new over-40s checks will work in tandem with that programme. It will help us to identify the people who are not coming forward and who we are not reaching. It is early days to say that it will be the panacea for deprivation, but it will certainly contribute to dealing with inequalities.

The Convener: Perhaps it is not your decision, but if deprivation and its consequences are the major issues, I do not understand why your pilot project will be rolled out everywhere, including to the worried well whom you describe. Why is it being done like that rather than by tackling the parts of the country where deprivation is a chronic issue?

Dr de Caestecker: There is a place for universal programmes. The over-40s checks are a much lighter touch and a much less intensive type of intervention than keep well, which is specifically for those who are least likely to take part in something that is universal and who need a much more targeted approach. In prevention terms, there is room for both approaches.

Bill Kidd (Glasgow) (SNP): Unfortunately for you, it is not for health boards to make up their own minds about where their funding goes. With the NHS Scotland resource allocation committee having been upgraded and a new formula having been introduced in 2009-10, the share of funding will change. The changes will be phased in over time. With the phasing in, do you have enough information, as boards, to decide about your future financial and service planning? Do you know enough about what is coming from NRAC to enable you to do that?

Richard Carey: We do not make any assumptions about NRAC growth year on year because it is very much at a marginal level at the moment. For example, our NRAC uplift in 2010-11 represents 0.42 per cent of our revenue resource limit, which means that it is £1.8 million. That is welcome, but in overall terms it is a relatively small growth towards NRAC parity. NHS Grampian is, as the report identifies, currently £25 million light of the money that we should have if the NRAC formula were to be applied. That said, we recognise that the stability of the overall system in Scotland requires us to avoid making seismic shifts in resource allocations, because our doing that would simply destabilise other health economies. We have to try to strike a balance between ensuring that the boards that need to grow in terms of NRAC can do so at a reasonable rate, and not destabilising the system in terms of the boards that will, in relative terms, receive less. That balance is quite a challenge.

It is not a new thing. Tim Davison made the point that we have all worked in the health service for decades. I remember this debate from when we had a different name for the formula; SHARE—the Scottish health authorities revenue equalisation formula. From memory, it took something like 20 years to get to SHARE parity. When we got to SHARE parity, we came up with a different formula. There is an issue around NRAC and we need to find a manageable way of making the required changes.

Bill Kidd: The suggestion seems to be that NRAC, under the new formula, when it is eventually completely rolled out, will ensure that some areas that are currently receiving below the percentage amounts of the overall cake that they should be getting—either because of high levels of deprivation, or as a result of having large rural areas, or a mixture of both—will get that, but that there will a potential reduction for NHS Greater Glasgow and Clyde. Is that correct?

Robert Calderwood: Yes. Based on the 2009-10 allocations, if the money had been allocated exclusively on the basis of the NRAC calculations, NHS Greater Glasgow and Clyde would have received—based on the figures that I have here—£51 million less in its annual weighted capitation uplift as a consequence of the fact that, although the board's population is marginally rising, it is rising at a lesser rate than the population in the rest of Scotland, and population is the biggest multiplier of the formula.

It is fair to say that not all professionals in the NHS believe that the NRAC formula, despite all the work and effort that have been put into it, has captured the full costs of deprivation and of a board's covering remote and rural areas. There is a view among the professionals that there is still work to be done, although you would probably expect me to suggest that the formula could do with further review. At a moment in time, a board such as NHS Greater Glasgow and Clyde might be receiving above the national funding formula that has been approved. Therefore, in looking forward over any period of time, if parity is not achieved by the distribution of surplus—disproportionately giving growth to boards—but is applied fundamentally on the basis of fair shares, we in Greater Glasgow and Clyde would need, in essence, to plan to not seek efficiencies of £51 million but to take out £51 million-worth of care services that we deliver. We are conscious of that and we are working through what that means.

I will give an example—again, I stress that I suppose I would, wouldn't I? If you took the average occupied bed days for the most deprived population in Scotland, which is in the NHS Greater Glasgow and Clyde area, and said that those patients would stay for the average length of stay in hospital for the rest of Scotland, we would reduce our costs in the acute sector by £60 million. We are therefore convinced that there is a direct correlation between the costs—particularly in acute care—of deprivation and our "gap from parity", but that is work that professionals continue to review annually.

The big challenge for us all will be after the 2011 census, because the key driver is the multiplier, which is population. Colleagues in Glasgow City Council and other local authorities would suggest that there is a view that in the past a number of people chose not to be recognised in national statistics and that there may therefore be a resident population in the NHS Greater Glasgow and Clyde area that is not captured in the statistics, but that is not proven.

Bill Kidd: I will follow that up, because I believe that the Scottish Government health directorates will constantly re-evaluate how NRAC will divvy up the money, if I can put it in such a way. Does Dr de Caestecker have anything to say about that, on the basis of her work on projections on health patterns?

Dr de Caestecker: My main comment is that, as Robert Calderwood mentioned, the question is whether the formula fully captures the effects of deprivation. People in the most disadvantaged areas have the poorest health, so they use services more. NHS Greater Glasgow and Clyde also has a much higher prevalence of, for example, drug misuse, so we spend substantially more on drug and alcohol services and other addiction services than other areas spend. That is because of need and because we have given those services a high priority.

For alcohol-related harm, our standardised mortality rate is substantially higher than that in the rest of Scotland. Although excess alcohol consumption happens across the board, we know that the harm that alcohol causes in terms of ill health is much more concentrated in the most disadvantaged areas. Therefore, we would make a case that funding must more sensitively recognise deprivation as well as population projections.

However, as members will be aware, many of the solutions to those problems do not lie solely within the health service. Solutions to issues such as alcohol misuse may be as much about availability and price as about our health services, even though our alcohol services and brief interventions target and assist large numbers of people.

Willie Coffey (Kilmarnock and Loudoun) (SNP): I want to lead off with a related question. My colleague Anne McLaughlin highlighted some of the great improvements that have been made over the past few years, but two of perhaps the

greatest challenges remain. As the Audit Scotland report highlights, alcohol-related discharges in Scotland have increased by 36 per cent over the past period and

"Drug-related deaths in Scotland have risen by 36 per cent".

I would appreciate getting a brief flavour of how the various health boards are tackling those two issues using the powers that are available to them. I am mindful of Dr de Caestecker's comment that the solutions often do not lie entirely within the health boards themselves.

Dr Strachan: We are most concerned about those figures and statistics. The increasing levels of morbidity and mortality from alcohol and drugs misuse are of great concern, as is the fact that the impact of drugs and alcohol misuse is coming through at an earlier age than has been the case hitherto. Mr Carey chairs our alcohol and drug action team in Aberdeen City Council and is very much involved in setting the strategy for developing our drug and alcohol services. Linda de Caestecker is absolutely correct to say that the problem is not simply an issue for the NHS, but is a societal issue that all public bodies need to deal with. However, our alcohol and drug addiction teams are at the forefront of delivering improvements as much as possible.

That is probably as much as I want to say about the context within which we deal with drug and alcohol misuse.

The Convener: I want just to pick up on that point about problems beginning to manifest themselves at an earlier age. According to the evidence of the statistics, what would the average age have been at which such problems previously became apparent and what is the average age now? How significant is the shift?

Dr Strachan: I will give an example. Alcohol has always featured in accident and emergency attendances. It has probably done so for as long as we have had accident and emergency departments, but those in the past who presented were traditionally in their 20s, 30s or 40s. Today, our children's hospital is seeing increasing numbers of young children in their early teens—and even 10, 11 and 12-year-olds—presenting in a very drunken state. That happens not just at weekends but on any day of the week and not just at night but at any time of day. Our children's services have had to change ever so slightly in order to deal with that. The number of children under the age of 16 presenting drunk at our A and E departments has increased by, I believe, some 60 per cent.

The Convener: Are the numbers of older children presenting with alcohol-related problems stable, or are those numbers also rising? Are we now facing a problem on two fronts, with that older age group presenting a bigger challenge as well as that problem with younger teenagers, or has the balance simply shifted towards a younger age profile?

11:15

Dr Strachan: No. As well as people in a drunken state, increasing numbers of relatively young people are presenting to our liver services, for example, and are requiring help with chronic liver disease because of alcohol in particular. In the past, about 20 to 25 years ago, it tended to be 50 to 60-year-olds who presented with chronic liver disease. Nowadays it is not unusual to see individuals in their 20s presenting with chronic liver disease. Of course, that has had an impact on things such as the requirements for liver transplants, which has had an impact on all our budgets.

The Convener: It is truly shocking and unbelievable that on any day of the week at any time of the day numbers of young children are now presenting in a drunken state. Is that an issue for NHS Greater Glasgow and Clyde?

Dr de Caestecker: It is. A national NHS Quality Improvement Scotland audit looked at that. The numbers are small, but it is still a very worrying statistic, and it is likely to be the tip of the iceberg.

The Convener: Yes—the numbers are small but they are growing.

Dr de Caestecker: Yes. It is a new problem. We are seeing it where we did not see it before. You will have seen the graphs of liver cirrhosis deaths in Greater Glasgow and Clyde, in which there has been a huge increase since the early to mid-1990s. The level of liver cirrhosis deaths is mainly plateauing in middle-aged men, but is still increasing in young men and women.

Tim Davison: That is a significant issue in NHS Lanarkshire as well. One of our councils is in the ignominious position of being in the top three or four councils in the whole UK for premature mortality associated directly with alcohol misuse.

Dr de Caestecker touched on the fact that this is an area in which the NHS, working with partners, is at the forefront. In common with our health board colleagues here, we have an alcohol and drug partnership in Lanarkshire, which involves the health board, both councils, the police, the Crown Office and Procurator Fiscal Service, and the Scottish Prison Service. The problem has been the subject of ring-fenced and targeted investment during the past few years. Our Lanarkshire alcohol and drug partnership's funding has almost doubled from just under £3 million to almost £6 million during that time. Interestingly, we

have seen a reversal from the days of the initial HIV/AIDS outbreak when the split in drug and alcohol spending leaned more towards drugs. The larger proportion of spend is now being directed towards alcohol. That targeting of investment at alcohol and the growth of ring-fenced investment has allowed us to make significant strides in recent years.

Willie Coffey: I think it was Dr de Caestecker who mentioned some of the statistics and patterns in deaths due to cirrhosis of the liver. That is getting very worrying and it has seen an upward trend in Scotland for a number of years. The situation in Europe seems to be going in the opposite direction. Clearly, there are other issues to consider that are outwith the powers of health boards, but I was interested to hear about the measures that they are able to take in partnership with other agencies. I am thankful for those comments.

James Kelly (Glasgow Rutherglen) (Lab): I want to try and encapsulate what has been said. Throughout the morning, we have heard a number of contributions about the benefits of NHS spending. During an eight-year period since 2001, there has been a 30 per cent real-terms increase in NHS budgets. How would you justify that, and what would you say are the tangible benefits of that substantial increase in spending over that eight-year period?

Tim Davison: First of all, it is not necessary for us to justify the increases: they have been the policy decisions of democratically elected Governments at UK and national levels. The investment has fallen into the areas that I was describing earlier of levers for future growth. We have therefore seen significant expansion in pay. This committee and others have examined those areas in minute detail while looking at the consultant contract and the general practitioner contract, among other things.

A significant amount of new drugs and technologies have been introduced that bring enormous benefits, but at great cost. Demand for services has risen significantly through the demographic changes that we were talking about earlier. We are now able to cope with a growing number of accident and emergency attendances, acute admissions, and referrals in every specialty in acute services.

We have put in place a raft of new and improved access performance targets, including targets for in-patient or day-case and out-patient waiting times, a four-hour A and E target and so on, and we have introduced a raft of new initiatives, including screening programmes and the keep well programmes that we have been discussing. Notwithstanding my comments, which I stand by, about the parlous state of the residual bits of our estate, we have seen over the recent period what has, in my health service career—which spans nearly 30 years—been the biggest capital investment programme of improvements in the capital estate. Those are the areas that successive Governments have chosen to invest in: there have, as a consequence, been some very significant changes.

Robert Calderwood: The NHS in March 2010 bears absolutely no resemblance to the health service that we might have been discussing five years ago. For example, five years ago, it would not have been unusual to hear about a patient writing to a health board about having to wait more than a year to see a consultant, about a patient waiting more than two years to have an elective procedure, particularly in orthopaedics, and about the debilitating effect that such conditions have on people's lifestyles.

As we reach the end of this financial year, the NHS in Scotland now guarantees that the patient will see a consultant within 12 weeks of referral from a GP; that he or she will receive a range of diagnostic investigations within four weeks of the consultant decreeing that such investigations are necessary; and that he or she will be admitted for treatment within nine weeks of the consultant deciding that inpatient or day-case treatment is appropriate. Absolutely none of that bears any resemblance to the position at the beginning of the decade. I could cite numerous other examples in mental health with the introduction of care in the community, the investment in crisis intervention teams and so on.

The money that has been put into the health service in recent years has achieved a lot. Speaking personally, I say that the service in NHS Greater Glasgow and Clyde is unrecognisable compared with what it was. In this decade, we have been able to bring forward plans that have allowed us to move away from the strapline of "21st century staff in 19th century premises" and work has commenced on the last major phase of our hospital modernisation programme which, when allied with the mental health work in Clyde, will give us one of Scotland's most modern health care estates. As I said, all of that has been achieved over the past decade.

Although that investment has had many positive results and has improved the public services that we deliver, we are—as we said at the start of the meeting—not complacent and not unaware of the facts that more efficiencies can be made and that there are opportunities to use the significant amounts of money that the Parliament votes to health to deliver more.

Dr de Caestecker: The survival rates for breast and colorectal cancer have improved enormously and mortality from heart disease has reduced to a

level that is equivalent to that in countries that have the best health statistics. Although some of that is down to changes in lifestyle, improved treatment of cardiovascular disease accounts for a huge proportion.

James Kelly: You have all listed an array of projects and lifestyle benefits that have been delivered through increases in spending. The Audit Scotland report highlights the measuring of productivity. Given earlier comments about the tightening of the financial situation, it is absolutely crucial to get the most out of those budgets. How are you intending to measure productivity and demonstrate that you are getting value for money?

Robert Calderwood: We are tackling productivity in a range of ways. We have a fairly long history of improving productivity in our ancillary services—our hotel services—in which benchmarking has been more developed and we have, in effect, another industry alongside us in which we can look at best practice. We have invested in those areas over many years, so our productivity in functions such as laundry, decontamination and our catering departments probably stands comparison with that of any other sector. We certainly always subject them to that kind of evaluation.

In the past decade or so, we have got into clinical productivity in a way that probably did not happen in the first 50 years of the NHS. Under the national pay deal that was introduced in 2004, consultants now have annually reviewed job plans that set out what duties they are to perform each day of the week, whether on in-patient theatre lists, out-patient consultations or ward rounds. We are then able to alter that job plan to meet our needs. The job plan is annually reviewed and constantly changing.

We are also examining productivity in our theatre sessions. As I mentioned earlier this morning, significant changes have been achieved by turning a forensic microscope on how we manage theatres. By introducing a lean technology and methodology into how we manage them, we have improved our theatre productivity within a static cost year on year, particularly over the past two years.

Most health boards in Scotland are now looking at out-patient productivity, which is a big issue in getting waiting times down. We need to ensure that consultants are supported in the out-patient environment with the right support staff so that they see patients appropriately, with the right mix between new patients and return patients. Historically, the practice of some consultants was to bring back patients for a check-up every six months or every year for five or six years after the procedure. We aim to transfer that responsibility to primary care and enhanced community services, so that the consultant can see new patients who need his expertise rather than return patients who need the reassurance of an evaluation. We are creating what we call out-patient templates, which state how many new patients and return patients the consultant should see, so that we maximise bookings for the four-hour slot. Again, there might have been a tendency to start late or to finish early or, if the consultant managed to get through 20 patients in two hours—hey presto!—the other two hours were not used. There is now much greater scrutiny, so that is improving.

Productivity in community services presents more of a challenge, because there are less recognisable benchmarks. However, about two or three years ago Forth Valley NHS carried out a review of district nursing using an extended work study approach, which identified that only about 40 per cent of a district nurse's contracted hours were spent in contact with patients, and the rest were being spent either travelling to and from the patient consultation or on paperwork for those duties. Consequently, Forth Valley NHS rearranged the programming of district nurses' days so that when they are out, they are out for the day and have less point-to-point travelling. By transferring some money from nursing, an admin and clerical function was also introduced and the productivity of those nurses increased.

We are also getting into productivity in the clinical environment, which is a big issue for us. Some aspects of productivity are linked to infrastructure. For example, Greater Glasgow and Clyde NHS has a number of hospitals that we plan to close, including the Victoria infirmary in Mr Kelly's constituency. Each ward in that hospital houses 17 beds, but a safe ratio between the number of patients and the inputs from trained and qualified nursing staff could, in a proper environment, be maintained while handling 24 in-patient episodes. Redesign and modernisation will improve that productivity. The new south Glasgow hospital that is currently under construction will have just short of 1,360 single rooms, all with en-suite accommodation. We will be able to move services from the Victoria infirmary, from the old Southern general and from the Western infirmary into that new hospital with fewer nurses because we will move away from very ineffective and unproductive nursing units into purpose-built and designed accommodation that maximises the nursing inputs.

There are many such examples of increasing productivity although, as I pointed out at the beginning, we still have some distance to go. We cannot say that everything is as productive as it should be.

11:30

James Kelly: You mentioned a number of initiatives in which consideration is given to how to get best value. Do you have a performance management system that enables you to consider how you operate in different budget areas and how you can improve productivity?

Richard Carey: We do. A detailed and robust performance management system applies throughout Scotland. Health boards can consider how they compare with other boards on key performance indicators and the HEAT targets, which the Government sets. The system helps us to compare and contrast performance and to target areas for improvement.

Some investment in the health service during the past 10 years has not necessarily improved productivity but has certainly improved the sustainability and quality of care. A good example is the investment that was required to buy out the arrangement whereby GPs were providing out-of-hours services as well as doing their day job. We came to a view that the proposition was not sustainable and, with significant investment, we put in place replacement out-of-hours facilities, which I think that people acknowledge have bedded down. That investment has led to a better way of doing things and has improved the quality of service that we can deliver, although there is not necessarily a productivity gain. Therefore, some of the investment that we have talked about should be considered not only through the lens of productivity gain; we must consider whether it enables us to deliver a service that is more effective and sustainable and safer for patients.

James Kelly: Mr Calderwood talked about the importance of IT in improving efficiency. The auditors considered IT systems and categorised them according to whether they were achieving

"basic, better or advanced levels of compliance with best value principles."

Most were found to be achieving a basic or better level of compliance, which suggests that there is room for improvement.

The Scottish Government's health department is considering the creation of an electronic patient record system. It is frustrating, to say that least, that it has taken until 2010 to do that. Why has progress been so slow?

Robert Calderwood: First, during the past year or 18 months there has been movement on the e-health agenda in the NHS in Scotland, and during the next two years movement on the issue will be significant. The three boards that are represented here today are part of a consortium that has just signed a £45 million contract to bring in a new patient management system, which will cover five boards in Scotland. NHS Lothian, which acquired the system through another procurement route, will also come across to the Scottish foundation model. More than 75 per cent of the Scottish population will be covered by a single patient management system in the next two years as we roll out the InterSystems TrakCare system, which will bring us cutting-edge facilities.

The big challenge in the e-health agenda is not the technology, which exists in many parts of the world, and it has not been resources, given the resources that we have had up to now. The fundamental challenge is to do with patient confidentiality, data security and public confidence about a move to electronic records to which a significant number of clinical staff will have access as they perform their duties. There was, quite correctly, an outcry when a GP in Scotland inappropriately accessed data that he did not need for the delivery of his task, through a patient's emergency care summary. The big challenge in relation to all electronic health records is to do with the concept of assumed informed consent for the data to be shared.

When a consultant has a unique identifier that gives him access to patient records through the patient management system, he can look at my record whether I entered a hospital in Aberdeen or in Ayrshire and Arran. Part of the challenge is that I may have left Glasgow to have treatment in Grampian because I did not want that information to be known locally. Those are the big challenges that we are getting into—they are about patient confidentiality and ensuring that the data are shared in a way that society and the individual are prepared to accept.

In the next couple of years, the debate will be about those challenges rather than about the technology or whether we have the resources to install and roll it out. We have the new PMS; the clinical portal in NHS Greater Glasgow and Clyde, which the committee has debated; and a similar version that is targeted at a different group of records in Tayside. Colleagues in NHS Lothian are leading a consortia either to procure version 3 of the portal or to invest in one of the two existing versions. Appropriate clinical professionals, wherever they are in Scotland, will be able to see a patient's record either by having direct access through a single PMS, or by looking at the record in a captured format through the portal. A lot of investment that has been made in the past five years is starting to come together.

In the e-health strategy, the phrase "connectivity and convergence" is used. In the next two to three years, convergence will be seen in a big way. We now need to deal with the patient confidentiality aspect of that data moving about the country.

The Convener: You said that 75 per cent of the population will be covered by the new system.

Robert Calderwood: The new patient management system.

The Convener: Which health boards are not participating in it?

Robert Calderwood: It might be quicker to run through those that are participating. The boards in the first phase are: Greater Glasgow and Clyde; Lothian; Lanarkshire; Ayrshire and Arran; Grampian; and Borders. Because of their size, they cover the significantly greatest percentage of the population. Other boards, as their current contracts come to an end, will be able to join the system through the framework contract at any time over the next 10 years.

The Convener: Does that mean that there cannot be an interface between those in the system and those outwith it?

Robert Calderwood: No. The clinical portal work through the Scottish care information store provides the connectivity of access to records. For example, all our digital X-ray imaging is stored through the single application that used to be called the Kodak picture archiving and communications system but which is now called Carestream. Every health board in Scotland uses the Carestream picture archiving system and we all archive our pictures in a central store, so if a consultant in Aberdeen has the access, he can draw up images tonight that have been taken in any other radiological department in Scotland.

The Convener: Right. We are a bit pressed for time. We want to raise two other issues.

Bill Kidd: Service redesign was addressed earlier with regard to efficiency savings; this question concerns service redesign with a view to shifting the balance in care from acute and secondary services to community and primary services, so it is not exactly the same. The Auditor General's report states that that shift has been mentioned in previous reports, going back to the Kerr report, "Building a Health Service Fit for the Future". The Kerr report referred to that form of redesign and the transfer of resources, but it seems that the level of transfer that was hoped for has not been achieved since 2005. What are the barriers to shifting resources from acute services to primary and community-based services?

Richard Carey: I will say a bit on that issue generally; my colleague Dr Strachan will then comment on it from a general practitioner's perspective.

In Grampian, we have been shifting the balance of care for at least 10 years. There is a view that not enough evidence has been shown of resource transfers to go with that shifting of the balance but, in fact, services in the acute sector that otherwise would have been inundated have managed to cope because much more of the work has, in essence, been picked up by primary health care teams in the community. The best example of that is the transformation in diabetic care. Ten or 15 years ago, hospitals were full of people in clinics who were attending for diabetic care that was delivered by a hospital specialist. Now, nearly all that care is delivered in the community by primary health care teams, with the consultant in the consultant's classical role of advising the people who deliver the service—GP-led primary care teams. A huge amount is being done on that.

Dr Strachan: Diabetes is a success story in terms of how we deal with it, but not in terms of its burden on individuals and society. Year on year, the incidence and prevalence of diabetes in the community are increasing by 10 per cent. Just a few years back, we started with about 11,000 patients on our diabetes register in Grampian, but we now have more than 20,000 patients who are living with—not suffering from—diabetes. The vast majority of that is type 2 diabetes—such patients might be more elderly and a little bit overweight. Type 1 diabetes tends to affect younger patients. It is incredibly important that type 1 diabetes is dealt with effectively and efficiently. If both types are treated well, that can prevent complications in later years and help to improve life expectancy.

Our diabetes consultants must still look after the most difficult diabetic patients—particularly type 1 diabetic patients. Consultants start them on looking after their diabetes well and ensure that they know what to do when things go a little bit wrong, which they will—like everybody else, diabetic patients can become unwell, and consultants ensure that diabetic patients and their families know how to cope with such problems. That means that, although the number of patients with diabetes who require care and attention has increased rapidly, our specialist services can identify and look after the most needy patients—those who really need their specialist care. The rest are looked after in a primary care environment and largely through much self-care.

The other critical task that we expect our consultants and specialists to do is to support, train and help to develop community teams. Whereas our diabetes specialists principally saw patients in a clinic setting 10 years ago, they are now out in the community and might run clinics alongside our GPs and practice nurses. Specialists are also involved in delivering education and training packages and in supporting primary care teams to make the best decisions for their patients. That means that we have not reduced but maintained our specialist diabetic service and ensured that it is used most appropriately to deliver the best possible care for patients.

That is one example of investment that has been made in primary care. Some investment has been made in secondary care services, too, and the overall package of care for patients is better.

Tim Davison: What has been said links well with our earlier discussion. As activity has shifted out of the secondary care sector, it has generally received additional funding in primary care in the growth years. The capacity gap that is left in secondary care is filled by increasing demand.

We have said that we all require to deliver cash-releasing efficiency savings so, to stand still, acute hospitals must make savings to meet the additional cost of pay awards, drugs and new technologies in diabetes care such as insulin pumps, which are increasingly being demanded. It is vital that the acute service delivers savings that it can reinvest in acute services, to cover the costs of demand, drugs, pay and technology and—increasingly—to fund the significant capital investment that Robert Calderwood described. Bill Kidd asked what the barriers are—the issues that I have listed are the barriers.

Bill Kidd: I understand the barriers that you have mentioned, but is there likely to be greater potential for moving further resources out into the community, rather than have them in big buildings where people have to go to be treated?

11:45

Robert Calderwood: There are opportunities in a range of services to move from institutional care to care in the community. I cited earlier our work on mental health services in the Clyde area. When we took over responsibility for those services, the balance of spend was 75 per cent on institutional care and 25 per cent on community care. In the greater Glasgow area, the balance had evolved over the years to 50 per cent on institutional care and 50 per cent on community care, and there was a slightly higher total spend per head of population. The changes that we are making in Clyde will result in a move in 2010-11 to a 60:40 split in spend between institutional care and care in the community, and a slightly higher total spend, as a result of the growth moneys that we have put into mental health. That is a shift in the balance of care, but people do not portray it as a move from secondary or acute care to primary care.

In the acute setting, we argue that the two new ambulatory care hospitals in Glasgow that we have spent £200 million of taxpayers' money buying and building are about shifting the balance of care. We have taken the concepts of day surgery, diagnostics and one-stop clinics out of hospitals and into purpose-built buildings that are closer to the heart of the population than the hospitals that we are constructing.

We consider those ambulatory care hospitals to be part of shifting the balance of care, because they are about moving care into the community more appropriately for individual citizens. However, that care is still delivered in the main by secondary care consultants. Our day surgery rates in Glasgow have gone from being fairly static for years at 62 per cent up to 71 or 72 per cent. Because consultants have purpose-built facilities that have enhanced the capacity for day surgery, they have moved more of their patients out of in-patient beds and into day surgery. The patients want that and they now have brand-new, state-of-the-art facilities. Again, we regard that as shifting the balance of care.

When I talked about maternity services, I mentioned that we have moved antenatal services and ultrasound screening out of maternity hospitals into community premises. Those services are still delivered by midwifery staff, so some people consider that to be secondary care, but we say that it is shifting the balance of care and bringing it closer to the population and out into the community.

Cathie Craigie: I am glad that you moved the issue on a bit, because I agree with you about that shift away from the hospital setting to the community. However, do you account for that care differently? For example, if a midwife consultant goes out to visit people in the community health centre in Kilsyth, how is that person's salary and time accounted for? Is it accounted for under the health centre or in the acute budget? To make the question even more difficult, who pays for it? Is it NHS Greater Glasgow and Clyde or NHS Lanarkshire?

Tim Davison: That would be one of my midwives in Kilsyth, so I will answer for Robert Calderwood. We would still account for that as an acute service delivered locally. This is where we get into huge semantics. I talked about the huge growth in drug costs. Some of those drugs, such as chemotherapy drugs, are delivered in the community, but we still count them very much as acute spend. We could spend a fortune on an army of accountants counting the beans in a different way but, frankly, that would not change the world one iota. We need a sensible discussion about how much we want to differentiate.

The proof of the pudding is absolutely in the eating. Much of the shift in the balance of care has been funded by growth. In the mental health and learning disabilities field, the new services have cost more than the institutional services that they replaced. We are not apologists for that, because the model means that the care that we provide is more appropriate and much better quality than what went before it. It is a truism that shifting the

balance of care is better as an activity than as a methodology for reducing overall cost.

Cathie Craigie: We probably need Audit Scotland to dig further into how that operates. My colleague Bill Kidd pointed out, rightly, that Audit Scotland tells us in the report that it has not really seen a change in the balance from hospital to community since 2004-05. Are there any reasons for that?

Finally, given that cash will be tight over the coming years, should we be considering a redesign of NHS Scotland? Do we still need to have 14 or so health boards?

Richard Carey: The number of health boards that we have is a matter for the politicians. I will highlight an issue about the way in which the service in Scotland is configured, which I think is one of its great strengths. We have, within a single organisation, responsibility for all aspects of the health care system. We need to try to preserve that. Some time ago, I attended a meeting in England at which there was a discussion about the opening of a new polyclinic. The chief executive of an acute trust there was more concerned about the loss of his market share than about whether the polyclinic would be of benefit to patients. We must consider the model carefully, and I suggest that the model in which we have a single organisation that has the opportunity to plan and implement changes, and to avoid the transactional costs associated with shifting the balance of care, is helpful.

The Convener: Does Nicol Stephen want to follow up on the balance of care?

Nicol Stephen: Yes—just one final area, really.

You said that you were responsible for all aspects of health care, but there are many aspects in which you have to work with others, particularly, but not solely, in the public sector. I want to ask about co-operation within the public sector. Councils are under severe budgetary pressures—you know some of the consequences of that for shared working. Recently we have considered resource transfer, not within health boards or health care but from health to councils, for example for care in the community and the ageing population. Audit Scotland has shown us that some of the information that is held on resource transfer at the Scottish level is poor and inconsistent. Will you comment on those issues in general? I am thinking not just of the elderly but of drugs and alcohol, and of teenage pregnancy; those are issues in which a co-operative approach is required in the public sector, and in which the financial pressures will perhaps make it more difficult to be progressive, innovative and co-operative.

Robert Calderwood: First, in the context of community planning, the health boards sit alongside their local authority partners and other appropriate statutory agencies to consider the wider community's needs and how the total sums available vested in those statutory bodies can be aligned to create the best impact for the patient or the citizen. In NHS Greater Glasgow and Clyde, we believe that by integrating health and social care for service delivery—I am not commenting on structural accountability for services—for the populations for which we have a shared accountability and responsibility, we can meet the needs of the patient with less duplication. There are fewer of the stories that one hears about patients interacting with statutory agencies five or six times on the same journey of care because of the hand-offs; for example, "I'm a health visitor, so I can only do this bit", or "I'm a social worker, so I can only do this bit."

We believe that there is a real opportunity to streamline our services. We have been working with all our local authorities—we interact with seven, but significantly with six—and we are at different stages of that journey of integrated community health and care partnerships. With Glasgow City Council, for example, between the statutory responsibility of the city and the responsibilities of the health board for the city's population, we jointly spend about £900 million a year on services for the elderly and for children throughout the city. We believe that working with Glasgow City Council in an integrated way so that we have joint strategies and joint management resources, and so that money is targeted to meet citizens' needs, presents opportunities. We are going down that road, and such an approach gives us confidence.

Trying to debate cost shunting openly is a clear issue in community care planning partnerships. If I closed an elderly care facility, there would be cost shunting across to the council, and there would be cost shunting if, in considering its budgets in the coming years, the council took policy decisions that meant that the number of delayed discharges went back up. We sit and debate such things in a forum, but it is clear that both statutory bodies ultimately have democratic accountability back to the Parliament through the Cabinet Secretary for Health and Wellbeing. That structure gives us confidence that the public bodies should openly debate and at least publicly explain to the people whom we serve the consequences of our individual decisions.

Tim Davison: Is there enough time for a quick supplementary comment, convener?

The Convener: You should be quick.

Tim Davison: First, I am in a group that works with COSLA, local government, health boards and

the Scottish Government to consider resource transfer. That term has possibly been interpreted incorrectly in the discussions that the committee has had with the Scottish Government, which I have read. It has been interpreted as though there is wholly a one-way vehicle between the NHS and councils. At first, resource transfers meant transfers from institutional care to community care, not from health boards to councils. That was the principle behind them. One of the biggest shifts from institutional care to community care was within the NHS; we transferred enormous sums of money from institutional care to community health care. I want to nail the principle that resource transfers are about transfers from institutional care to primary and community care, not from health boards to councils.

Secondly, resource transfer is very much oldspeak—the term goes back to 1992. The newspeak is about integrating resources. We need to work in a more integrated way and get better value out of integrated resources. Cost and resource shunting between organisations will not help in that at all.

My third point relates to the question whether such an approach can be applied more broadly. I reiterate my earlier point that hospitals need to reinvest savings that they can make in order to stand still. They would have to make significant savings in order to have additional savings to fund improved primary and community care. When significant resource transfers from institutional care to community care have happened—hundreds of millions of pounds have been transferred from institutional care to community care to deal with mental health, learning disabilities and older people in Scotland in the past 15 or 20 years—there have been wholesale institutional closures. Big hospitals have closed in their entirety to release their total resources. With partners, we have then supplemented those resources to improve community care. We need to replicate that kind of model in order to see significant resource shifts from institutional care to community care. That takes us back to the debate that we had about the difficulty of achieving service redesign, how long that takes, and the levels of opposition that have to be overcome to achieve it. From our perspective, there is no getting away from the fact that there are no easy answers.

The Convener: I thank the witnesses for their comprehensive input into the discussion. It is right to echo what Anne McLaughlin said about the contribution that NHS staff throughout Scotland have made and continue to make to the quality of life here. We should also acknowledge the huge improvements that have been made on the back of the significant investment that has been made over the past 10 to 15 years, which has been identified. Equally, we should all be aware of the challenges that will confront us as a result of the demographic changes and financial pressures that are clearly in front of us.

I am not putting any pressure on the witnesses, but they should feel free to sit and listen to what is said under the next agenda item.

Tim Davison: If you do not mind, we will take our leave.

"Managing NHS waiting lists"

12:00

The Convener: The next item is a report from the Auditor General for Scotland on managing NHS waiting lists.

Mr Robert Black (Auditor General for Scotland): I invite Angela Canning, who led on the project, to introduce it to you.

Angela Canning (Audit Scotland): A report on new arrangements for managing NHS waiting lists was published on 4 March 2010. The new waiting times guidance, known as new ways of defining and measuring waiting times—or new ways—came into effect in January 2008, and our report examines whether boards are complying with new guidance for managing patients and recording information. It also considers the impact on patients.

The committee will see that we have included in the key messages document cross-references to relevant sections of the main report in response to a suggestion from Willie Coffey. We welcome any feedback from the committee about the new approach.

I will start with our findings on waiting times. Our review did not focus on performance against waiting times targets, although we have provided that as context. As the committee will be aware, waiting times targets have reduced in recent years and waiting times have come down in every board since the new ways guidance was introduced, as we highlight in exhibit 4 on page 9 of the main report.

The new ways approach has stopped the practice of excluding people from waiting time guarantees, which used to be referred to as hidden waiting lists, and has stopped people waiting indefinitely for treatment. Patients who would previously have been excluded from the waiting time guarantee because they were unavailable for treatment for medical or social reasons—such as being on holiday or having another health condition that needed to be managed first—are now entitled to the same waiting time guarantee as other patients on the waiting list.

I will set out how the new guidance is applied. The new system is intended to ensure that patients are managed fairly. It is a relatively complex system, which needs support from many different people to make it work effectively. Exhibit 1 on page 4 of the main report illustrates how it works in practice.

Introducing the system to all NHS boards in Scotland was a big task for the NHS. It involved significant changes, including different working practices for staff, extensive training programmes and major changes to local IT systems. That has all taken time, but the system's aims are now largely being achieved.

Boards are able to apply some elements of the guidance differently to reflect patients' clinical needs, which has led to some differences in how patients are managed. For example, if a patient does not or cannot attend their appointment, boards can refer them back to their GP or keep them on the hospital waiting list. That discretionary element has led to some variation among boards in how patients are managed that is unlikely to be explained by clinical needs alone. We have given more information about that on page 17 of the report.

We found that boards record most of the information that they need to manage their waiting lists, but there are some gaps. For example, patients whose waiting time clock has been stopped due to unavailability should have their cases reviewed after 13 weeks but, according to our case-note review, that information is not always routinely recorded, which means that there is a risk of patients slipping through the net.

I will outline what the new arrangements mean for patients and the NHS. Patients now get less notice of appointments, particularly as waiting times continue to come down. Since April 2009, NHS boards need to give patients a minimum of only one week's notice of their appointments, so it is important that they ensure that they provide information that people can understand and that patients understand their own responsibilities.

As I mentioned, if patients fail to attend their appointments, they may be referred back to the end of the waiting list or back to their GPs. However, the amount and type of information that patients are given about the implications of failing to attend varies. Two thirds of patients in our survey did not recall receiving any information from their GPs about what might happen if they could not or did not attend an appointment.

Good communication is especially important for people who may need additional help to understand information or attend their appointments—for example, older people and people who are homeless, who have learning difficulties or whose first language is not English. We found that NHS boards do not always have a record of patient needs for additional support, such as access to translation services or information in large print, and we recommend that NHS boards improve systems for recording that information and putting in place appropriate support for people who need it. That would help patients have a better experience and help hospitals improve how they communicate with people about their appointments.

Colleagues and I are happy to answer any questions that the committee might have.

The Convener: Thank you, Angela.

The recommendations on page 21 say that NHS boards should

"review the reasons why patients are coded as being removed from the waiting list as treatment is no longer required and ensure that patients are being managed appropriately and in line with the guidance".

I have read the section in the report that that recommendation refers to. Is there a suggestion that patients have been removed from the waiting list because it was said that treatment was no longer required, when in fact they might have still required treatment? What is that recommendation about?

Tricia Meldrum (Audit Scotland): We did not find any evidence to suggest that people were being removed inappropriately, but the numbers looked quite high. When we followed them up with some of the boards and talked to ISD Scotland, which collates the statistics, one issue that came up was the coding of some information. For example, we were told that, if patients are subsequently treated at the Golden Jubilee hospital, Stracathro or another such service, the code of no longer requiring treatment may be applied. There are, therefore, some coding issues that the NHS is sorting through.

The Convener: So it is a technical issue. If, for example, someone was referred to the Golden Jubilee hospital, their local board would code them as "treatment no longer required" because they were not being dealt with locally, even though they were in fact being treated.

Tricia Meldrum: That could be the case. The numbers look quite large, so we included the recommendation that we want boards to be sure that people are not being removed from the list inappropriately. There is still a risk, so we wanted boards to check.

Willie Coffey: I thank Audit Scotland for the changes in the summary report that Angela Canning mentioned. As members will have noticed, it leads us into the main report and gives

specific references. It gets us there a lot more quickly, so the change is much appreciated.

I want to ask about the new ways procedure and the algorithm—the rules about when the clock starts ticking, is reset to zero and so on. What happens if a patient accepts a reasonable offer but the hospital cancels it? I was following the process and thought, "Oh, what happens in that case?"

Tricia Meldrum: The patient would not be adversely affected.

Willie Coffey: Does the clock go back to zero, and does the patient go back to the end of the queue?

Tricia Meldrum: No, their clock would keep running.

Willie Coffey: Would the waiting time increase because it was the hospital that made the cancellation?

Tricia Meldrum: No, I think that the patient's clock would keep running because it was the NHS, not them, that cancelled the appointment. The patient would still have the guarantee to be seen within 16 weeks.

Willie Coffey: I apologise for asking about that but, from my previous life as a computer scientist and looking at algorithms, I thought, "There's something missing here."

I am also interested in the point about the qualitative information to potential patients and the short notice period that people experience. Is that having an adverse impact? Is there any hint that people are cancelling more because of the short notice period?

Ffion Heledd (Audit Scotland): When someone needs to make arrangements such as child care or does not understand English and needs additional help to understand their letter, there may be instances in which that is made more difficult by the fact that they receive, for example, only a week's notice of their appointment. We did not look at the situation in enough detail to point out huge increases in numbers, but we have heard examples of that.

Willie Coffey: Time will tell.

Angela Canning: There is obviously a balance to be struck between the waiting time targets coming down and giving patients enough notice so that they can make it to the appointment that is booked for them.

Willie Coffey: Yes, we would not want the shortened notice period to lead to more cancellations by the patients because they cannot organise child care, for example. It will be interesting to see whether that develops any further.

Murdo Fraser: I want to ask about the figures for patients not attending appointments, which are in exhibit 6 on page 14 of the main report. It is interesting that there has been no reduction in the numbers of those not attending out-patient appointments. Can you give us a flavour of what more you think health boards could do to reduce the figure? In NHS Greater Glasgow and Clyde, the statistic is more than 12 per cent. That is one no-show in eight appointments, which obviously puts a substantial financial and administrative burden on the health service. If we could drive the numbers down, it would make for a much more efficient service.

Tricia Meldrum: We have made some recommendations about better communication with patients, and boards have talked about moving towards a system of communicating with patients about their appointment. The process is more iterative: they might contact the patient to ask them to phone to arrange a suitable appointment date. Some boards are doing that to an extent at the moment, but the numbers were not big enough to see any clear relationship between that and a reduction in did-not-attend rates. However, more boards are seeing the opportunities and are trying to move towards communicating a bit more by using things like the text reminders that people get from some dentists, for example, and other ways of being interactive with patients.

Areas such as Glasgow and Lanarkshire have high levels of deprivation, so a multitude of factors can affect did-not-attend rates.

Murdo Fraser: It might be worth different boards trialling different methods of contacting people, such as phoning them up to remind them on the day before their appointment, or sending them text messages, to see whether that could help. Great savings could be made if the problem could be addressed.

Anne McLaughlin: They might want to consider alarm calls. I know a 19-year-old who did not get her operation because she slept in; I was quite astonished by that. Perhaps the boards should consider waking people up in time.

The Convener: They could send a taxi to take them to hospital. Where do we stop?

Cathie Craigie: I have agreed with Murdo Fraser twice this morning. Like him, I am concerned that the number of patients who do not show up has not gone down. Your report points out the need to take account of when people have special needs and require support, whether it is to get to the appointment or perhaps to overcome a fear of going. We need to pay attention to that.

I have had correspondence with the minister about when the ambulance or hospital transfer

service just does not turn up to collect a patient. Did you do any work on that?

Tricia Meldrum: We did not look at that as part of this study.

Cathie Craigie: I know about it because I have a constituent who is tallying up the number of no-shows for appointments because of the failure of transport.

Could you explain something about exhibit 13? The column headed “Special needs flag” tells us that it has been used very few times.

Tricia Meldrum: That is our language. We gave the column that heading, but there is no code as such. We used it when there was evidence of something being recorded in the patient’s case notes or in the electronic system to flag up that the patient needed additional support. It is not that the field was left blank; we found no evidence of any of that information having been recorded. We would have expected more people than that to have had some additional needs.

That is one of the issues around how the system is linked together. That information is not routinely collected and available to hospitals. The systems are not there automatically to transfer the information from the GP, who might be closer to it.

The Convener: As there are no more questions, we will end this meeting on the positive note of Cathie Craigie agreeing twice with Murdo Fraser. Thank you for your contribution.

12:14

Meeting continued in private until 12:39.

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