The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 29 February 2012

Session 4

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PUBLIC AUDIT COMMITTEE
3rd Meeting 2012, Session 4

CONVENER

*Iain Gray (East Lothian) (Lab)

DEPUTY CONVENER

*Mary Scanlon (Highlands and Islands) (Con)

COMMITTEE MEMBERS

George Adam (Paisley) (SNP)
*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Mark Griffin (Central Scotland) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Tavish Scott (Shetland Islands) (LD)
*Humza Yousaf (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Mr Robert Black (Auditor General for Scotland)
Angela Canning (Audit Scotland)
Jillian Matthew (Audit Scotland)
Gil Paterson (Clydebank and Milngavie) (SNP) (Committee Substitute)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

Committee Room 6

Scottish Parliament

Public Audit Committee

Wednesday 29 February 2012

[The Convener *opened the meeting at 10:00*]

Decision on Taking Business in Private

The Convener (Iain Gray): I welcome members of the committee, the Auditor General for Scotland and his staff, and members of the press and the public. I ask everyone to make sure that their phones are switched off. We have apologies from George Adam, and I welcome Gil Paterson, his substitute.

Agenda item 1 is a decision on taking items in private. Do members agree to take items 6 and 7 in private?

Members *indicated agreement.*

Section 23 Report

"Cardiology services"

10:01

The Convener: Our first substantive item is a section 23 report on cardiology services. Robert Black, who is the Auditor General for Scotland, Angela Canning and Jillian Matthew will present their report and answer the committee's questions.

Mr Robert Black (Auditor General for Scotland): Thank you, convener. There are not many new things that happen to me in my professional life, but presenting a report on a leap year day is a first for Audit Scotland. We will be as professional as ever and not let the excitement go to our heads.

I remind the committee—particularly newer members—that over the years we have run a series of performance audits that look at efficiency and effectiveness in the health service. We have looked at day surgery and orthopaedic surgery, and at general practitioner prescribing, which we will look at again in the autumn. This report is one of that series and I invite Angela Canning, who led the project, to introduce it.

Angela Canning (Audit Scotland): Our report on cardiology services was published on 23 February. It looks at how well the national health service in Scotland manages cardiology services, how much is spent on them, whether patients across Scotland have the same access to services and whether there is scope to improve their efficiency.

To give some context, heart disease is one of the most significant health problems in Scotland. It is the second biggest cause of death after cancer, and rates of heart disease in Scotland are the highest in western Europe. Our report focuses on cardiology services that are provided by Scottish hospitals. It is a hospital specialty that treats people with heart disease and is an area of high activity and spend. At least £146 million was spent on hospital cardiology services in 2010-11, but we know that that is an underestimate, as not all relevant costs are recorded accurately and consistently. As part of the audit, we also looked at some activity and prevention work in the community, such as prescribing and health checks for people at high risk of heart disease.

Although Scotland has high rates of heart disease, we found that outcomes for patients have improved in recent years. Death rates have reduced by 40 per cent over the past decade, more patients are getting more effective treatment, people are living longer after treatment and waiting times have fallen.

However, there is still inequity across some groups of the population. For example, rates of heart disease and death are higher for people living in deprived areas but procedure rates for that group are lower. Exhibit 8 on page 20 of the report shows that rates of procedures to treat narrowed arteries, angioplasty and coronary artery bypass graft surgery for people living in the most deprived areas of Scotland are lower than would be expected and in the least deprived areas are higher than would be expected.

Many of the risk factors for heart disease can be controlled or reduced to prevent heart disease from either occurring or becoming worse. Those factors include smoking, diabetes, high cholesterol and high blood pressure, lack of exercise and being overweight.

There are plans to evaluate the impact of measures in Scotland that aim to prevent heart disease, such as health checks for high-risk patients, but comprehensive evidence is not yet available. That evidence would help to inform the Scottish Government's and NHS boards' priorities for spending on preventative services. Although there have been significant improvements for heart disease patients, there is still more to be done to ensure that all patients get the services that they need.

In particular, the report highlights the fact that people with heart failure are not always getting the care and treatment that they need. People with a particular type of heart disease, atrial fibrillation, are at high risk of stroke but they are not always being prescribed appropriate medication to reduce that risk. Most heart attack patients are referred to cardiac rehabilitation programmes to help with their recovery but it is not clear that other patients who would also benefit from those programmes are being referred to the same extent. Also, some people are not able to get the most effective treatment for a severe heart attack because it has to be provided at a specialist centre within 90 minutes of diagnosis.

We found that there is scope for the NHS to make efficiency savings of at least £4.4 million a year in cardiology services by: using less expensive tests; reducing the length of stay; increasing day-case rates; prescribing more cost-effective drugs; and better procurement. We also identified scope to make savings by improving the efficiency of out-patient clinics. However, those efficiency savings are a conservative estimate as we have not been able to calculate savings in a number of areas due to limitations in the data.

As part of the audit, we carried out a number of focus groups with people with heart disease who have had experience of hospital cardiology services over the past two years. Participants were generally positive about the treatment and care that they had received, but they identified some areas for improvement. Improving communication and getting better information about their condition and treatment were the most important issues for them. A summary of our findings from the focus groups are in case study 2 on page 15 of the report. We have also produced a separate report, which is available on our website.

The main report makes a number of recommendations for the Scottish Government and NHS boards that are summarised on page 4. The usual self-assessment checklist for the report is also available on our website. I am happy to answer any questions from the committee.

The Convener: Thank you. The top line from the report seems to be positive. The fact that more patients are receiving more treatments earlier is paying off in terms of significant and on-going reductions in death rates. It is worth putting that on record because the tendency is to go straight to the "but" and look at more problematic areas. The one that jumped out at me from this report was the difference between survival rates in more deprived areas and in less deprived areas. While there might be reasons to expect higher rates of heart disease in more deprived areas, it is interesting that there was not just a difference in outcome; people in more deprived areas were also less likely to receive certain treatments or procedures. Is that a fair summary?

Angela Canning: That is correct. We looked at two procedures in particular—angioplasty and coronary artery bypass graft surgery—which are covered in paragraph 55 onwards and in exhibit 8. Work done by the NHS highlighted the fact that people in more deprived areas of the community were getting fewer procedures than those in the least deprived areas. The report mentions a six-year study done in Glasgow, looking at over 5,000 patients. It found that a number of reasons are likely to contribute to those lower procedure rates, including: people living in more deprived areas being more likely to have a heart attack; being less likely to reach hospital alive; and being more likely to die during the heart attack. Jillian Matthew may wish to expand on that.

Jillian Matthew (Audit Scotland): Everyone is aware of lower treatment and procedure rates for those in more deprived areas, but how to tackle the problem is less clear. The research points to some reasons, but the evidence is still anecdotal or uncertain. There are other reasons why people might not get to hospital: people in more deprived areas present later, and people who smoke—smoking is also linked to deprivation—are more likely to die from sudden death. There are therefore a lot of things preventing people from getting to hospital in the first place; that also

includes people not being aware of the symptoms due to educational problems.

The next section of the report—on page 21—looks at prevention measures, and some of the measures that are being taken target people in more deprived areas. In the report, we have said that it is unclear whether that approach is working—the evidence is not there to show that. The approach targets people who are at high risk—which makes sense—but we do not know whether people are taking action as a result of the measures and things are improving. The Scottish Government plans to evaluate that area in the coming years, but the evidence is not there. We have said that more needs to be done in that area to show what works for people in Scotland.

The Convener: Paragraph 56, which points towards what might be some of the reasons for the difference in treatment rates, is quite speculative—you used the word anecdotal in your comments—although some research has been done in Glasgow. Is it fair to say that the possible explanations for the difference in accessing treatments are speculative, and that we do not really know why it is there?

Jillian Matthew: I think so, yes. We have recommended that we need more research in that area, and more evaluation of the measures that the Government is employing to show whether they are working.

The Convener: Exhibit 9, on page 25 of the report, which looks at non-invasive tests, identifies significant differences in the tests provided by local NHS boards for heart disease—some tests are offered only by a handful of or less than half the boards. Some of those non-invasive tests seem to be related to early diagnosis. Is there is a connection or are those two different issues?

Jillian Matthew: The tests referred to in exhibit 9 are all, as you said, diagnostic and non-invasive—apart from the angiography, which we compared them against—so there is some relation in that respect. The sources that that data came from were not organised in a way that we could necessarily link to deprivation, although we did a comparison with boards in areas of higher deprivation.

It is important to point out that even if a test is not available through a particular board, people can be referred to another board—so they can still get the tests. There is variation depending on what is provided locally and, obviously, it is easier to have testing done locally.

The Convener: Referral to another board is a possibility, but does that happen?

Jillian Matthew: Yes. People are referred for a procedure, but they are less likely to be referred for a diagnostic.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): To continue with the convener's theme, the report's message, as shown through the statistics that Audit Scotland presented, is generally very encouraging. The convener talked about exhibit 8. Does that show procedures rather than survival or death rates?

Jillian Matthew: That is correct.

10:15

Willie Coffey: This question may not fall within your remit, but I will ask it anyway. In exhibit 5, on page 13, there is a chart that shows the 10-year downward trend in death rates. Is a similar chart available that shows death rates by community, health board or area covered by the Scottish index of multiple deprivation statistics? Is there perhaps a picture emerging that death rates in those communities are not as impressive as those in exhibit 5?

Jillian Matthew: The statistics are available by health board and community health partnership area. Exhibit 5 relates to the overall population, but statistics are available for the 15 per cent most deprived areas of Scotland. They show the rate for the more deprived areas as a whole. As we say in the report, death rates are higher in more deprived areas. There are figures available from the past 10 years that show that death rates in those areas have gone up slightly.

Willie Coffey: That is obviously worrying. That particular issue is probably one for the Health and Sport Committee, but it is certainly of interest that the downward trend is not reflected in those communities that perhaps need the most intervention.

My attention is also drawn to angiography—the x-ray procedure that can identify potential heart issues. As there has been information for the past 10 years, has there been any increase by health boards in the uptake of angiography in those communities, to try to identify issues at an early stage?

Jillian Matthew: We do not know that about deprived areas, specifically. The rate of angiography has gone down slightly because other diagnostic tests that are less invasive are being done, as shown in exhibit 9. We did not have the figures by deprivation category.

Willie Coffey: As the convener has suggested, perhaps there is an opportunity for further work to be done to assist those communities so that earlier interventions can be carried out and the statistics will decrease rather than increase.

Mary Scanlon (Highlands and Islands) (Con): I have a question on deprivation, in addition to what my two colleagues have said. I was shocked that the number of did not attends in a deprived area is more than twice that in a less deprived area, as stated in paragraph 91. Seventeen per cent of patients failed to turn up for out-patient appointments and gave no explanation why. There is a problem not only before diagnosis or before a person reaches a hospital and not only about disparity in treatment, but in the fact that 17 per cent do not turn up. That is more than twice the national average—a shocking figure.

Coming from Dundee, I know that that city has its fair share of deprived areas. However, exhibit 15, which is on page 31, shows that Greater Glasgow and Clyde and Lanarkshire have the largest percentage of did not attends. Tayside, an area that I know well, has a low percentage. Did you discover any processes or things that were done better in Tayside to ensure that people turned up for appointments, or do you have an explanation for the high percentage of did not attends in deprived areas?

Jillian Matthew: Greater Glasgow and Clyde and Lanarkshire have a higher proportion of deprived areas, so that pushes the figures up. We did not do a lot of detailed work in Tayside. We did further work with a small sample of boards, but Tayside was not one of them. Case study 3, on page 32, has a variety of examples from boards across Scotland on how they are trying to improve did not attend figures. Some of those apply to more deprived areas, where the problem is obviously more difficult.

Mary Scanlon: The figure is quite shocking. Convener, I would like to move on to rural areas. Is that all right?

The Convener: Mark Griffin wants to follow up on the original point, so I will come back to you after that.

Mark Griffin (Central Scotland) (Lab): Has any work been done on the reasons given for missed appointments, for example failures in patient transport?

Angela Canning: We did not look at that issue specifically in the report, but we have done work on it previously. We published a report last year—"Transport for health and social care"—that picked up on some issues about delays, for instance in getting patient transport to patients. If patients missed their transport, they missed their appointment, or if it was late, they were late for their appointment.

Mary Scanlon: As an MSP for the Highlands and Islands, I always look at how NHS care is provided in remote and rural areas compared with elsewhere. Paragraph 17 of the "Key messages" version of the report refers to

"the most effective treatment within the required 90 minutes from diagnosis".

That time limit raised concerns, particularly in relation to the northern isles. Also, paragraph 48 of the main report refers to the fact that NHS Grampian now provides out-of-hours cover—as of the end of 2011—but

"NHS Highland does not provide any out-of-hours cover."

Have you looked behind the figures? What are the problems with not providing out-of-hours cover? Did you analyse whether people in the Highlands and Islands manage to get the most effective treatment within the required 90 minutes following a severe heart attack?

Jillian Matthew: Not every board provides the same service because, as a new service, it had to be introduced gradually to make sure that it was done the right way. The service started in NHS Lothian and it has been rolled out across Scotland over the past five years. The six regional centres have come online gradually. Highland regional centre is the last one of the six to provide the service so it is at an earlier stage. It is not providing full cover yet because the service is not fully up and running yet, unlike in the other areas.

Patients need to get the most effective treatment within 90 minutes so they need to be within a certain distance of a regional centre. We asked the boards providing that regional service if they could tell us what percentage of patients with the most severe heart attacks were getting the most effective treatment. They were unable to give us those figures so we were unable to assess that fully. We know that there is disparity and that there are areas where people are less likely to get the most effective treatment.

It is important to point out that those patients who are not getting the most effective treatment—the angioplasty within 90 minutes—are still getting treatment. They get clot-busting drugs before they go to hospital—the first line of treatment if patients cannot get to a regional centre—and in some cases that is enough. It does not always work, but then they can still get the angioplasty procedure to open the arteries again and get the blood flowing back to the heart. It does not need to be done within 90 minutes—patients can still get the angioplasty treatment after they have had the clot-busting drugs.

Mary Scanlon: So, you are saying that NHS Highland does not provide any out-of-hours cover but it is developing an out-of-hours service at present. Where would people from north-west Sutherland, for example, be taken? Would Aberdeen be their nearest regional centre?

Jillian Matthew: We try to show where people might go on the map on page 19—exhibit 7. I think that a lot of patients would go to Aberdeen but some who are further south might go to the Golden Jubilee national hospital. It depends on where they are and which is their closest centre.

Mary Scanlon: If I was a patient with a heart condition in the Highlands and I read that, I would be pleased that the service is being developed. However, it is worrying when you say that treatment is most effective within 90 minutes. In Orkney and Shetland, which is Tavish Scott's area, were there any problems in getting people not just to the airports in the northern isles but to Aberdeen, particularly given that NHS Grampian has only recently started an out-of-hours service? Would patients from Shetland have gone to Glasgow or Tayside? Those journeys would definitely take longer than 90 minutes.

Jillian Matthew: Those patients would more likely get the clot-busting drugs, and possibly further treatment after that. We were told that there may be cases when someone in the islands would get to hospital quicker: with air transport, some might get to hospital within 90 minutes.

Mary Scanlon: You said, in response to the convener's question, that the Scottish Government was looking at various issues. Is it also looking at patients receiving the treatment within 90 minutes, in spite of where they live?

Jillian Matthew: The Government has that issue under review. Part of that work involves looking at whether treatment within 90 minutes is the most effective treatment, and whether it can be extended to 120 minutes. The treatment is fairly new and further evidence is always emerging. In Europe, for example, some countries allow a longer time between the diagnosis and the treatment. The Government is also looking at the patient flow and whether the current set-up is appropriate. If the time was extended, potentially more patients would get the most effective treatment.

Mark Griffin: To return to exhibit 8, the table shows that more than one in five men and roughly one in five women from the two deciles with the highest areas of deprivation are, perhaps, not reaching the hospital and missing out on surgical procedures. Those figures are from 2008-09. However, the Government has started preventative work and all NHS boards have exceeded their targets for the number of cardiovascular health checks, and I hope that that would improve the situation. When do you expect the 2008 figures to be updated to reflect the increase in health checks?

Jillian Matthew: I am not sure when the Government plans to update the figures, but it may look at that as part of its evaluation of health checks over the next few years.

Mark Griffin: Paragraph 39 of the report states that

"79 per cent of patients were referred to"

rehabilitation. Why were only 79 per cent referred? Almost one in five were not referred—were those people not suitable for rehabilitation?

Jillian Matthew: That is not something that we looked at in detail—that information was drawn from the Health Improvement Scotland review of clinical standards for heart disease. It may be that some people are coping well and do not need rehabilitation, but I cannot comment further on that.

Tavish Scott (Shetland Islands) (LD): I return to the point about remote areas. I suggest gently that if, like me, you live in Bressay in Shetland, the time taken for the Scottish Ambulance Service to commission an aircraft to get to Shetland, and for you to have travelled by ferry and ambulance to Sumburgh—whether that takes 90 minutes, 120 minutes or 177 minutes—adds up to a lot of minutes. I can assure you of that.

My concern is about the regional model, which you have looked at closely. I take your point that that is just being rolled out. However, is the model not inherently dangerous for people who live in the most far-flung parts of Scotland, such as rural Dumfriesshire, and not just the deepest parts of Sutherland, to which Mary Scanlon referred? If the treatment you described is the best way to tackle these health problems, is the model not dangerous for anyone who does not live within 90 minutes of a regional centre?

10:30

Mr Black: That is an entirely understandable and reasonable question, but I am not sure that we, as auditors, are best placed to answer it. The report is a presentation of standards that are applied at the moment. I encourage you to take that question to the health directorates, if you are minded to do so. Ms Matthew may be able to say something about the clinical health risk associated with the regional model.

Jillian Matthew: It is worth reiterating that people in those areas still get good treatment. Delivering the most effective treatment within 90 minutes of diagnosis is the gold standard for people who have severe heart attacks, but it is a new treatment that has been available only over the past five or 10 years and has been introduced gradually. It is not something that you would expect to see in every single health board, as we are talking about fairly small numbers of patients. Consultants and doctors need to deal with a

certain number of patients to make the treatment safe. There needs to be a balance.

Tavish Scott: If you are auditing a service, there are some obvious areas—and you pointed to one that the convener asked about, on deprivation—where there are inherent difficulties. I guess that you audited those difficulties as part of the study, although I accept that this is a policy question. Have you come to the conclusion that the regional structure creates an inherent challenge to delivering the type of services detailed in your report, which could or should be available to everyone in Scotland, no matter where they live?

Jillian Matthew: The geography of Scotland creates a difficulty, given that the most effective treatment has to be given within 90 minutes of diagnosis. The Government is reviewing how the services are being provided, and may extend that period. We expect to hear something on that over the next few months.

Tavish Scott: I will wait with bated breath.

On another point altogether, data collection is a consistent theme every time the committee considers NHS reviews, not just in the past year but going back over many years. You make some fair observations about the difficulties that Audit Scotland encounters because of gaps in data. I ask the same question I ask every time: there is not much sign of improvement, is there? Your job is not made easier by the fact that those data gaps exist. What has NHS Scotland said to you about that legitimate concern?

Jillian Matthew: It is something that the NHS is always working on, but you can see that we have had considerable problems in compiling the report. It is also a reflection of how complex cardiology services are, because a lot of cardiology patients are also treated in other wards—general medicine and geriatric medicine, for example—so figures are difficult to quantify. However, there were examples of boards not having separate cardiology costs, or including them in general medicine costs, so we could not identify what was spent on cardiology wards.

There were also issues with workforce figures. We would have liked to look at productivity, as part of the efficiency review, but we were unable to do so. We have highlighted the issue to ISD Scotland, which collects the information.

Tavish Scott: Would it be fair to say that Audit Scotland would have found it easier to make recommendations about potential efficiency savings of £4.4 million if the available data sets were rather more exacting, full and complete?

Angela Canning: That is fair. We found particular problems with rates of day-case surgery. There is variation across boards that is more likely to be down to how the data has been recorded and collected, rather than there being a variation in the services provided, so there is more work to be done there.

Tavish Scott: Your point is that there is a lack of consistency across health board areas.

Angela Canning: Yes.

The Convener: To follow up on that, the point is that in looking at cardiology services, we are dealing with the second biggest killer in terms of disease in Scotland. I acknowledge that there have been significant improvements, but we still have the worst heart disease rates in western Europe. Our health service cannot tell us where the cardiology patients are or how many there are, or basic information about what happens in cardiology services. Is that not a cause for concern?

Angela Canning: As I think the committee has noted before, one of the issues that we tend to raise in health and other performance audit reports is the desire for better information. That information is not needed just so that we can audit it and tick a box. It is information that managers and clinicians use to look at areas where efficiency savings can be made, and to benchmark clinical performance and so on. It is a very important issue. ISD Scotland has some great clinical data, and that should be recognised. What we find lacking is data on cost, activity and quality.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I have a couple of points, one of which follows on from Tavish Scott's comments. I sat in on discussions on a number of reports and data collection was an on-going issue. There are two issues in that respect. First, there is the inconsistency in the collection of figures in the different NHS areas—I cannot see any real excuse for that. Secondly, realistically, the NHS is dealing with legacy systems, which were perhaps never intended to give the level of sophisticated reporting and statistics that we look for nowadays.

Given that data collection is mentioned throughout the report, perhaps that should be highlighted as a separate issue to the Scottish Government, to alert it to the need for data collection to be a core part of any enhancement when it invests in and develops NHS systems.

Mr Black: That is an entirely reasonable point and one that is well worth recording. We have had conversations with the NHS about the issue of data collection and information. The point that Mr Beattie makes is right—data that is collected must be fit for purpose. ISD Scotland, as Angela Canning mentioned, collects a wealth of information, but there is some way to go to ensure that the information that is collected is collected for

clearly defined purposes, and is presented and used well.

Another issue that we should all be aware of is patient confidentiality and the provisions of the Data Protection Act 1998. Quite often what we are talking about in that respect is how to link different data systems. For example, if people present with more than one condition, care needs to be taken about how that data is linked.

I absolutely recognise Mr Beattie's point about data collection; it is an important point. We need to be aware that there are a number of underlying issues, such as patient confidentiality and how data is recorded.

This may sound like a plea in mitigation for the health service, which it is not meant to be, but if you have a patient in, for example, a geriatric ward who presents with cardiac failure, that will not necessarily be picked up in the cardiology statistics. We need a balance between having systems that are fit for purpose and not overloading a system because of the need to record data.

The health service is getting better at data collection; it is on a journey and the systems are improving year on year.

Colin Beattie: I have a second question. One thing at paragraph 43 of the report jumped out at me in connection with specialist heart failure nurses. The report mentions that case loads vary from 50 patients per nurse in NHS Shetland to 140 patients in NHS Forth Valley. That is a huge variation. I do not know what the optimum case load for a nurse might be, but within that variation either NHS Shetland is getting a very good deal or NHS Forth Valley is getting a very bad deal. Where does the balance lie in that regard?

Jillian Matthew: We brought in some of those figures from another report. That report related more to community services, which we did not look at in detail in this report, which focuses on hospital services. We know from our discussions that there is a lot of pressure on resources for heart failure nurses in the community. The other report, which will be due out soon, has been examining overall services for heart failure in more detail.

We know that a lot of support services are needed in the community. Patients will come into hospital for treatment for heart failure, but as it is a chronic condition they will need a lot of support in the community. Heart failure nurses are important, but other services may be needed too. The report looks at just one part of that. The numbers depend on what the service model is in different boards, but we know that there is a lot of pressure on funding for those services at present.

Mr Black: I will build on that, if I may. As I am sure that members of the committee will have registered, the service is a good—and an important—example of preventative spend. As you can see, we are talking about a relatively small number of specialist staff.

One reason for making that particular point in the report—although, as Jillian Matthew says, it is slightly to one side from the main stream of the analysis—is that there is evidence that a limited investment in staff who are expert in dealing with heart failure, such as heart failure nurses, has beneficial consequences for the patient and for the NHS in reducing the likelihood of more serious occurrences later on. It must be a concern if some boards are saying that they are not sure that they can fund that in future.

Colin Beattie: Am I correct in saying that another report will be published that might give a little more information and background on that?

Jillian Matthew: Yes—voluntary organisations such as Chest, Heart and Stroke Scotland and the British Heart Foundation have been involved in it. That report is refreshed every year or every few years, so there will be a lot more information on the whole service and other things that are going on in the community.

Colin Beattie: Have you any idea of the timescale for that report?

Jillian Matthew: I am not sure; I think that it is imminent, but we can find out whether there is a publication date.

Colin Keir (Edinburgh Western) (SNP): My question relates to paragraph 40 on page 17, which relates to heart disease patients at risk of stroke who do not always get the appropriate drugs. Have you identified why that variation is occurring across the various boards? Can we identify the boards in which such a difference occurs?

Jillian Matthew: Again, that was taken from Healthcare Improvement Scotland's review of the clinical standards, because it was one of the standards that HIS was measuring. HIS might have further information on what the level was in each board, but that was not published as part of its overall report.

Some of the reasons for the variation include education. General practitioners are reviewing the patients and not always recognising that people with atrial fibrillation are at risk of stroke. The review also found that some people who were not at as high a risk were being prescribed the drugs, which was putting them at more risk—you do not want to be on blood-thinning drugs if you do not have to be.

10:45

Further work is being done as a result of the report because HIS was quite taken aback by the findings. A lot of people are being put at risk who should not be and a considerable number of people are not getting the drugs that they need. That is serious.

Paragraph 41 mentions that HIS will put a new indicator in the quality and outcomes framework against which GPs are measured. It will help GPs to decide whether a patient is at risk of stroke and whether the drug should be prescribed. Further work is being done to improve the situation.

Colin Keir: Do we know which areas come in for more criticism than others? Is there a breakdown of health boards in which there appear to be problems?

Jillian Matthew: I am not sure that HIS reports published that detail, but we could check. HIS will have further information if it has not been published.

Humza Yousaf (Glasgow) (SNP): A number of my colleagues have made important and salient points. I wonder whether you will allow me to be a bit selfish and focus on my own mortality for a moment. I have read and have been brought up hearing the statistic that ethnic groups in particular have higher rates of coronary heart disease and other heart ailments, to the extent that they are eight times more likely to suffer from heart attacks. That is an important point, particularly for cities such as Glasgow and Edinburgh.

I have two questions on that point, but you will probably not have an answer to one of them. Has any research been conducted into why those from ethnic groups are, in some cases, eight times more likely to suffer from coronary heart disease? Is it a lifestyle or diet issue? Is it genetic predisposition?

Secondly, do health boards, particularly Greater Glasgow and Clyde NHS Board, have a strategy for accessing that community and dealing with the specific needs of particular ethnic groups?

Jillian Matthew: It is a similar situation to that in the whole of Scotland. We know that it is worse, but we are not entirely sure why. We know that high risk is linked to deprivation but that does not explain wholly why rates are so high in Scotland.

Some ethnic groups are similar and research has been done, but again it has only given suggestions about why that might be. Research has shown a number of common factors, including poverty and poor nutrition in early life, that might lead more people to have heart disease. Obesity and insulin resistance, which increase the risk of diabetes, are related to diet, but different countries have different rates of heart conditions, so those results are not uniform across all south Asians either. Apart from that, it is not entirely clear why the situation should be as it is.

Humza Yousaf: What about those health board areas that have a high concentration of people from an ethnic group? In some parts of Glasgow, such as Pollokshields and Govanhill, 10 to 12 per cent of the population is from an ethnic background. Do those health boards have strategies to get information out to those communities and then to provide the appropriate treatment, particularly on the preventative side? Did you come across any of that during your study?

Jillian Matthew: We did not look at that because this work was focused on the hospital specialty side and cardiology. A lot of preventative work will be going on in the community, so we did not pick up on it as part of this study.

Mary Scanlon: I have a brief general question. Over the past eight years, spending on cardiology services in hospitals has gone up from £80 million to £146 million and death rates have fallen by 40 per cent. Have death rates fallen because of the 50 per cent increase in spend or because people have improved their lifestyles?

Jillian Matthew: It is probably a mix of both. As more treatments have become available and as treatment constantly improves, people are more able to survive heart attacks or other conditions and are living longer.

Lifestyle is also a factor; for example, the rate of smoking, which is a big factor, has fallen a lot. It is a mix of quite a few factors.

Mary Scanlon: So it is a combination of the increase in spend and improved lifestyles.

Jillian Matthew: That is right.

Mark Griffin: One of the bullet points in paragraph 42 of the report says:

"the level of implantation of cardiac resynchronisation therapy ... devices"

is lower than it is in Europe

"and ... significantly lower than in England".

Has the NHS provided any reasons for that? Is it down to effectiveness, value for money or some other consideration?

Jillian Matthew: The British Cardiovascular Intervention Society, which audits rates of different procedures across the United Kingdom, is aware of the issue but is not entirely sure about the reasons for it. It is quite well known that certain European countries are a bit more aggressive in their use of interventions than the UK; indeed, the rates for all procedures are generally a bit lower compared with some other countries.

Mark Griffin: Does the difference between the Scottish and English rates come down to a purely clinical decision?

Jillian Matthew: Again, the reason is not entirely clear but it might well just be down to differences in the way treatments are provided.

Willie Coffey: Going back to opportunities for making efficiencies, I note that, according to exhibit 12, those who live in island communities can be in hospital twice or three times as long as those on the mainland who are getting the same procedure. My attention was drawn to that because at a previous committee meeting we heard a more colourful explanation about why people in the Western Isles stay in hospital: there is no bus to take them home. I hope that that is still not the case—I know that the data is perhaps two years old—but nevertheless the report recommends that health boards pay attention to the issue. In any case, it is interesting to find out that those in the islands could be in hospital three times as long as those on the mainland getting the same procedure. I have no idea whether that is down to transport issues, family issues or whatever but there is clearly an opportunity to improve that situation.

The Convener: I, too, noticed that paragraph but bowed to Mr Coffey's longer membership of the committee in raising the matter. Does the same thing emerge in Audit Scotland reports on different NHS areas of work or is it unique to cardiology? Mr Coffey's comments imply that the issue comes up regularly. Is that true? Is it a theme? Is it always the same colourful places that keep people in hospital longer?

Angela Canning: In this case, the length of stay includes all the transfers, including the transfer from the island board to the mainland board for treatment and the transfer back for recuperation. That might be what is underpinning that particular cardiology information.

The Convener: But is there not an implication in the report that, even for the same procedure, for example implantation of a pacemaker, there is quite a big disparity—the island issue aside—in how long people find themselves in hospital? Is that true?

Angela Canning: Yes.

Willie Coffey: Not just in cardiology.

The Convener: It is not just the islands either. There is differentiation elsewhere, too.

Gil Paterson (Clydebank and Milngavie) (SNP): I have a few brief questions. I return to exhibit 8. Are there any shining examples in deprived areas that outpace the Scotland-wide chart? Are there any areas where the situation is a bit different from that which is shown in the chart? Is any area better informed?

Jillian Matthew: We have no information on that. In that example, the ISD has been able to link the number of procedures to deprivation, but much of the information does not have that level of detail attached to it, so we cannot consider that issue in detail.

Gil Paterson: My other question concerns a comment on page 17 about palliative care. The number of patients who are on a palliative care register is very low. Do you have any additional information on why very few people are registered?

Angela Canning: When we looked at palliative care services three or four years ago, we found that most people who are on a palliative care register have cancer. That reflects the history of where palliative care services came from and when they have been funded. Most patients who are on palliative care registers have cancer. Fewer folk with heart disease or stroke are on such registers. That issue requires to be tackled.

Gil Paterson: Is that because for a long time the emphasis has been on cancer patients rather than on folk with other life-limiting illnesses?

Angela Canning: I think that that is right. The situation reflects the history of palliative care services and what they were focused on.

The Convener: As no one else has any follow-up questions, I thank Jillian Matthew, Angela Canning and the Auditor General for their forbearance. We will discuss later in private how we will take forward our consideration of the report.

Public Audit Committee Report

"Major Capital Projects"

10:57

The Convener: Item 3 is the permanent secretary's six-monthly update on the Scottish Government's progress towards delivering the committee's recommendations in its "Major Capital Projects" report from 2009. Members have the correspondence and I invite comments or questions.

Willie Coffey: I am very happy to see the comment on page 2 of the letter about post-project evaluation. A big issue for the committee in the previous session was to ask the public services to examine performance after a particular piece of work has concluded and to build that in as standard process in developing plans for future work. It is particularly encouraging that the "Scottish Public Finance Manual" has been updated to make that a mandatory requirement, because the greatest opportunity for performance improvement is to look at how we have performed, to learn lessons from that and to build those into future planning.

Tavish Scott: I have a brief point. The table notes at the end of annex A mention the hub initiative. Is it relevant to ask for some detail about that in future? The hubcos amalgamate many different parcels of construction work in different parts of Scotland into sizeable chunks of work. That is not detailed in the correspondence. It would be helpful for the committee to understand what is going on there, so that we can pursue any issues. We are all being pretty heavily lobbied at the moment in some regard on how the hub initiative works in achieving value for money for the taxpayer. I wonder whether it is possible to tease that out a bit in the future.

11:00

The Convener: What is the appropriate way for that to be reported, given that this is a rolling, biannual report?

Tavish Scott: Indeed. Perhaps every six months the Scottish Futures Trust or Peter Housden, the permanent secretary, could detail the workstream of each of the six hubcos in global terms. I would not ask for that to be detailed down to the pence and pounds of particular projects, but it could be broken down into what the total projected spend in each hubco is for the period, which would allow us to see the scale of the expenditure going through these mechanisms for delivering public projects in Scotland.

Mary Scanlon: It was announced in 2008 that there would be a new prison in Inverness and that the budget for that was £40 million. I appreciate that there have been problems in getting the land for that, but we welcomed the announcement that there would be a new prison, because Inverness is the smallest and most overcrowded prison in Scotland, yet it seems to have fallen off the agenda. In future updates, could we have information on whether the Government still intends to build a prison in Inverness? Is it still on the agenda? I would just like to know what is happening with it, because it is not mentioned anywhere in this update.

The Convener: I am not sure whether you would have any more information on this than I do, but is the cost for that project more than £50 million?

Mary Scanlon: The cost was £40 million when the project was announced, so it should be more than £50 million now. When something like that has been announced, it is good to know where it is for future planning.

The Convener: It struck me that there has been quite a lot of discussion recently about a particular aspect of performance in major capital projects: the proportion of contracts that are delivered locally and—connected to that—what projects deliver not only in outcomes but in creating training opportunities and so on. That is an aspect of performance in the delivery of a project, because the Scottish Government has objectives in those areas just as it has objectives for delivery of the infrastructure, value for money and delivery on time. I wonder whether future reports could give us an indication about those kinds of impacts. It might be difficult to do that because we would be looking at quite a large scale, but it might be worth asking whether that is possible.

If the committee is agreed, we will ask about three things. We would like progress reports on individual hubcos and their workstreams; we would like information on projects that are in the infrastructure plan but do not appear in the report, presumably because they have not begun; and we would like to know whether it is possible to have reports on performance with regard to locally delivered contracts and impacts on areas such as the creation of training opportunities.

Willie Coffey: I understand what you are saying, but those sound more like finance and procurement issues that might be of greater interest to our sister committee. Historically, those issues came to us when performance issues arose on delivery—that is, on completion. That is why tables on such issues are attached to the kind of report that is in front of us—to give some visibility on what is going on out there. However, I do not think that there is a specific locus for us in the

procurement and financing aspects, as I recall from previous committees.

The Convener: I think, though, that it would be reasonable to ask what is going on in the hubco model, because it is pretty significant in terms of the whole capital programme.

My view is that there are aspects of the delivery of the infrastructure programme that are to do with the impact on the local economy. The Government has delivery objectives on budgets and timescales, but it also has objectives to do with the impact on areas such as creating opportunities. I take your point, but I think that it is reasonable for us to ask questions about that. The Government may agree with you and may feel that there is not a way of sensibly reporting on such matters, but I would quite like to ask it those questions.

Willie Coffey: I think that those are reasonable questions to ask, but I do not think that they are questions for us to ask. I think that they stray into issues to do with procurement, European legislation and so on, which probably lie in the domain of other committees rather than ours.

The Convener: Can we agree to ask them and see what the Government says? Its answer might well point us in that direction.

Members *indicated agreement.*

The Convener: As members have no other points to raise under that item, we will move on.

Section 23 Reports

"Reducing Scottish greenhouse gas emissions"

11:06

The Convener: Item 4 is consideration of another section 23 report. Through its previous convener, the committee wrote to the Scottish Government to ask for additional information on the Auditor General's report "Reducing Scottish greenhouse gas emissions". Members have the correspondence. I invite comments on that and on how we should proceed.

Tavish Scott: Some of this is pretty profound. I always thought that, once we passed the climate change legislation, there would be a day of reckoning as regards what it would mean in practice. The eminently fair reply that we have had from Graeme Dickson confirms that. About three paragraphs down, it says:

> "In the case of speed limit enforcement, the option of 100% compliance was chosen."

Does that mean that we will see automated cameras monitoring average speeds on all roads between Edinburgh and Inverness and on roads throughout the country? It might be useful for the committee to understand what the proposals will mean in practice. As Mr Coffey might observe, perhaps these are matters for other committees, but I think that the letter raises profound questions about how the proposals might work in practice.

It might be useful if our clerks could speak informally to Audit Scotland about how the committee will monitor what will be profound changes in how people across Scotland behave when it comes to transport. The changes might be more profound than we realised.

The Convener: I wonder whether there might be some value in sharing the correspondence with the Rural Affairs, Climate Change and Environment Committee, which I think has looked at these issues and has identified difficulties with the delivery of emissions reductions in transport, in particular. It could look at matters in more detail. Mr Scott's point is more about the fact that it might prove difficult—nay, impossible—to audit the success of the Government's plans.

Humza Yousaf: The Government says in its response that it is developing its report on proposals and policies, which is due to be published this year. Do we know exactly when it is due to be published? What is the timescale for publication? The report on proposals and policies might enlighten us or provide more answers.

The Convener: Do we know when the RPP is to be published?

Humza Yousaf: It might have some of the answers to the questions that Mr Scott is asking, although he might still be waiting with bated breath.

The Convener: Can we agree to draw the correspondence to the attention of the Rural Affairs, Climate Change and Environment Committee and to ask the Scottish Government when the report on proposals and policies will be published? That might be an opportunity for us to revisit the issues. They are not going to go away quickly.

Humza Yousaf: Our previous convener talked about demand-side transport policies and asked for a bit more information, but not much has come back in the response from Graeme Dickson. I do not know whether it is worth pushing it, but perhaps we should go down that route and ask the Rural Affairs, Climate Change and Environment Committee to look at it. The previous convener certainly put a strong emphasis on demand-side transport policies.

The Convener: We could suggest to the Rural Affairs, Climate Change and Environment Committee that it might want to consider it. I think that it produced a similar report recently.

First, we will draw the other committee's attention to the report and our view that it still does not say much about taking demand-side action to reduce transport emissions. Secondly, we will ask the Scottish Government when the report on proposals and policies is expected.

Members *indicated agreement.*

"Overview of the NHS in Scotland's performance 2010/11"

The Convener: Item 5 is correspondence from the Scottish Government on the Auditor General's report "Overview of the NHS in Scotland's performance 2010/11". The correspondence is with members and it refers particularly to the treatment of health improvement, efficiency, access and treatment targets. I invite comments from members.

Mary Scanlon: I raised the issue in committee because although the Audit Scotland report told us what targets had been achieved, it did not mention the targets that were abandoned because they had not been achieved. I now learn from Derek Feeley that every HEAT target has a defined point in time at which delivery should be achieved. I look at these things fairly carefully, and although I do not remember exact dates and times, I take Mr Feeley at his word.

There is no doubt about it: we need more clarity on HEAT targets. I mentioned two of those targets. The first was the reduction of sickness absence in the NHS to 4 per cent, which no board in Scotland has achieved although there has been a reduction over the years. The other was a 0 per cent increase in antidepressant prescribing; in fact, the increase has been more like 10 per cent and the paper says that the target has expired. I do not remember reading that—perhaps I need to look more carefully in the future.

Humza Yousaf: Although the paper mentions that the targets expire, it might be worth asking for clarification of Mr Feeley's point. Do they become standard targets? In the third paragraph of the paper, he says:

> "Work has continued with NHS Boards to support them in reducing sickness absence".

The 4 per cent target has not quite been achieved. I might be incorrect, but I take it from that that, although there is no longer a HEAT target, it has become standard practice to try to achieve that target. We might want more clarification of that. I agree with Mary Scanlon that it is bizarre that an organisation has a target with an expiry date but, when it does not achieve it, it just gives up on it.

Mary Scanlon: The target suddenly disappears.

Humza Yousaf: It seems bizarre.

The Convener: I was not party to the initial discussions on the report, but the two targets seem to have been treated differently. The sickness absence target has become a standard, so I suppose we would expect that NHS boards are still being held to that standard. The mental health target is different because, if I understand Derek Feeley's letter, it has been dropped and replaced by a target on the time from referral to treatment and access to psychological therapies. It does feel like a target that was going the wrong way and has just disappeared.

Mary Scanlon: It will also be about two years before the target on referral to treatment is implemented. In some parts of the Highlands, people can wait for between two and four years to see a psychologist. So, although I welcome the target, its achievement is quite a long way off. I welcome it because it is one of the first mental health targets that we have had in Scotland apart from ones for children.

The Convener: Mr Yousaf suggests that we should go back to Derek Feeley and ask for a bit more clarification. If the committee agrees, I am happy to do that.

Members *indicated agreement.*

11:15

Meeting continued in private until 11:52.

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