AUDIT COMMITTEE

Tuesday 14 September 2004

Session 2

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AUDIT COMMITTEE
15th Meeting 2004, Session 2

CONVENER

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

DEPUTY CONVENER

*Mr Kenny MacAskill (Lothians) (SNP)

COMMITTEE MEMBERS

*Rhona Brankin (Midlothian) (Lab)
*Susan Deacon (Edinburgh East and Musselburgh) (Lab)
*Robin Harper (Lothians) (Green)
Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*George Lyon (Argyll and Bute) (LD)

COMMITTEE SUBSTITUTES

Chris Ballance (South of Scotland) (Green)
Mr Ted Brocklebank (Mid Scotland and Fife) (Con)
Marlyn Glen (North East Scotland) (Lab)
Mr Andrew Welsh (Angus) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Caroline Gardner (Audit Scotland)
Barbara Hurst (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

John Aldridge (Scottish Executive Finance and Central Services Department)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Christine Lambourne

LOCATION

Committee Room 1

Scottish Parliament

Audit Committee

Tuesday 14 September 2004

[THE CONVENER *opened the meeting at 09:33*]

Items in Private

The Convener (Mr Brian Monteith): I ask all members to place their cards in the console in front of them. They do not have to do anything else; the system will work perfectly well after that. The cards have to be in the console for identification purposes.

George Lyon (Argyll and Bute) (LD): Is that in case we forget who we are?

The Convener: No, it is in case other people do not know who you are, but we all know that everyone knows who you are, George.

Welcome to the 15th meeting in 2004 of the Scottish Parliament's Audit Committee. It is nice to be in such a beautiful committee room, which I am sure will be witness to many important decisions that this committee and others take. I make the usual announcement about pagers, mobile phones, wristwatches that make a noise and so on: they should be turned off or silent. I welcome members of the public and media to the meeting. I have received apologies for early departure from Rhona Brankin.

We have a full agenda, but at 11 o'clock we will observe a minute's silence for the victims at Beslan. I will remind members as we approach that time. I also intend us to have a comfort break at some point. It will depend on the progress of the meeting but it may be most appropriate to have that break as we go into private session.

The first item on our agenda is to consider whether to take items 7, 8 and 9 in private. In item 7, the committee will consider its approach to the report by the Auditor General for Scotland entitled "Scottish Enterprise: Account management services to high-growth businesses"; in item 8, the committee will consider a first draft of our report on our inquiry into "Better equipped to care? Follow-up report on managing medical equipment"; and in item 9, the committee will consider its approach to the report by the Auditor General entitled "An overview of the performance of the NHS in Scotland". I may add that when we come to discuss those items, I will probably take items 7 and 9 first, because they will be discussions of what our work commitment might be and it will make sense to take them one after the other. I will then take item 8—the consideration of our draft report—last. Do members agree that we should take items 7, 8 and 9 in private?

Members *indicated agreement*.

"Overview of the National Health Service in Scotland 2002/03"

09:36

The Convener: Under item 2, we will consider a response from the Scottish Executive to our eighth report in 2004, which was on the "Overview of the National Health Service in Scotland 2002/03". I will be inviting committee members and the Auditor General to comment, after which we can discuss what action to take. There has been a lot of activity with regard to the NHS—we have had inquiries, there have been reports, and there are further reports coming down the line. I therefore thought that it might be better to ask the Auditor General to give his response first, so that we can have some context. After that, members can come into the discussion. I see members nodding, so I think that they agree with my suggestion.

I welcome the Auditor General, Robert Black, and his team to the meeting and invite him to respond to the Executive's response to us.

Mr Robert Black (Auditor General for Scotland): Thank you, convener, and I must say what a great pleasure it is to be in this building at last, in this magnificent committee chamber.

The response that the Scottish Executive Health Department has provided is very useful as an information base for the future. I am conscious that it has come as a result of the report that the committee produced in June; it is right to advise the committee that a further overview of the financial performance of the NHS will come out in December. The department's response contains new information that complements and responds to the committee's report.

This morning, the committee will consider my report "An overview of the performance of the NHS in Scotland", which also contains a lot of information on a similar theme, and the financial overview report will come out in December. Therefore, the committee may wish to consider how it will pull all that information together for the future. It may be appropriate for you to consider not taking any further evidence in relation to the information provided by the department until such time as we have more information on the financial performance of the health service as a whole.

There is much detailed information in the department's submission and, as might be expected, some of the numbers are different from numbers that we have seen previously and from some of the numbers in the performance overview report. That partly reflects the continuing dialogue with the department and the attempts to strengthen the information base; it also partly reflects the reality that we are dealing with a moving picture.

I hope that that context is helpful to the committee in deciding how it wishes to progress.

The Convener: Thank you—that was very useful in giving us a base for our discussions on this agenda item and for other discussions with regard to the NHS.

George Lyon: I pick up on the Auditor General's last point. You spoke about numbers in the Health Department's response that are different from those in your report and you spoke about a moving picture. Will you give a more robust explanation of what you mean by that?

Mr Black: I will need to turn to my colleagues from Audit Scotland to expand on that. We have not analysed in detail the response to the committee's report. The picture continues to change because there is so much change going on in the health service with regard to the estimates of the costs of pay modernisation, the consultant contract, the general medical services contract and so forth.

Caroline Gardner (Audit Scotland): We have been scrabbling through the pages of the department's response since George Lyon asked his question. As an example, in section 2 of the schedule that forms part of the response, there is a breakdown of additional funds that were provided to health boards in 2004-05 for the consultant contract and the GMS contract. On a first reading and with the analysis that we have been able to make so far, those figures look slightly different from the figures in the report. However, we need to go away and reconcile the two sets of figures to understand the basis for those differences.

As the Auditor General said, I suspect that the Health Department's estimates are becoming better refined as the contracts start to be implemented in individual health boards, and the figures are being clarified as they are based on real evidence rather than on assumptions. The two sets of figures will continue to converge over time as we get more clarity about what underpins them.

George Lyon: Forgive me if I have this wrong, but I remember that we asked previously for a costs projection to 2006. A number of the health boards that gave evidence to the committee gave us a tabular exposition of what they thought the costs were, but we got no answer back from the Health Department as to its view of the costs over the next two to three years. I note that the department's response covers only 2004-05 and that there is still nothing for 2005-06.

Ms Gardner: That is correct.

George Lyon: Is that because the department does not yet have that information?

Ms Gardner: You will have to ask the Health Department that question. However, I will jump ahead and refer to the Auditor General's report that is to be considered next on the committee's agenda. We have some estimates that we have agreed with the department for year-by-year costs through to 2005-06. The information is gradually becoming more available, but it is still moving.

George Lyon: Our report stated:

"the Committee concludes that the Department is not in a position to measure whether planned efficiencies will be delivered; whether the benefits of pay modernisation will be achieved; and whether the service to patients will improve as a result."

It seems that the Health Department has not addressed that question in its response. I was looking for mention of activity levels or the benefits that would flow from a more efficient way of working, but there is nothing. What is the Auditor General's view on that?

Mr Black: It is true that there is not much in the response, but the committee should pursue that with the Health Department if it wishes.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): Convener, are we to confine our comments at this stage to questions to the Auditor General or are you looking for more general discussion?

The Convener: Although we have had a dialogue about the general nature of the statistics, this is an opportunity to comment on the response without having to ask the Auditor General about it.

Susan Deacon: I am happy to take the opportunity to do that, although should the Auditor General wish to comment on any of my observations, I would be grateful for those insights.

I am struck by a number of points in the response. First, I echo what the Auditor General said in that the response provides a useful information base for the future. It provides us with a detailed account of a range of areas of activity in the department and a range of the department's expectations of what pay modernisation will achieve, for example. On one hand, that is welcome and it is good that we have the information, which was not shared with us in such detail before, because it shows that the process of scrutiny and committee examination works. On the other hand, I am bound to ask why it has taken so long to get some of that detail from the department. However, I will leave that sticking to the wall for now.

09:45

After reading the response in detail, although I am reassured about some of the work that is in place to measure and monitor—one of the main concerns of the committee and indeed of the Auditor General—I think that the answer to the question of how change will be achieved, driven and incentivised is still missing in the lengthy response. A great deal of process is identified in that regard, for example, and a great deal of emphasis is put on the work that is being undertaken by the centre for change and innovation, which I welcome. I note for the record that the centre was recognised as being necessary some time ago and not just in "Partnership For Care: Scotland's Health White Paper" and that a commitment was given in the Scottish health plan two years earlier, in 2000. I am pleased to see that centre motoring and developing its work. However, simply having a centre in place to develop such work will not deliver results. Something is still missing from the Health Department's response about how change and improvement will be achieved.

There are a lot of warm words in the covering letter from Ian Gordon of the Health Department. The letter says:

"Pay modernisation recognises the crucial importance of incentivising the staff of the NHS to deliver on the change agenda".

Those are laudable words and aspirations, but I am still left asking detailed questions about what those incentives are and, indeed, what the change agenda is in this context. Also, the second paragraph of that letter identifies a number of service improvements that are under way with which I agree, such as the development of one-stop clinics, allied health professionals working in the community and the development of managed clinical networks, but those measures are not new and neither is that direction of travel. I am conscious that I am speaking as the former minister in this portfolio, but I am not just pointing back to my time in that role, as I am also referring to the time before that and even to the period before the change of political leadership in 1997. What was not in place at that time was the investment to implement those changes, but the direction of travel and the desire to see service redesign and change in the health service has been with us at Government level for years, possibly even for decades.

The tone that runs through the response is that the department has suddenly discovered lots of things that need to be done and that it is now motoring on them. Nobody is happier than I am to see evidence of where change has taken place—as it has in many areas. However, I guess that my substantive point is that there is not enough in the

response from the department to give me confidence that change is happening in the NHS in Scotland at the pace and scale necessary or that the mechanisms are in place to ensure that such change happens. That is not just the $64,000 question but the £X billion question in Scotland.

However, although there are still unanswered questions, the response provides welcome information and clarification on a number of points. I am at a loss to know where the committee goes from here other than to add our insight and analysis to what will continue to be one of the major debates in Scottish politics for a long time to come.

Robin Harper (Lothians) (Green): I am not terribly happy about the response to our 12th recommendation, which was made in paragraph 68 of our report, in which we asked boards to pay

"particular attention to removing the duplication of functions and reducing management overheads."

A general commitment to produce efficiencies seems to exist in almost every branch of the NHS, except management. The tone that the response takes is that problems arise because different boards have different structures, so an overall target cannot be set. I would welcome the Auditor General's comments on the response. Could targets for reducing administrative costs not be set for boards individually?

Caroline Gardner: That would be a policy matter for the department. In theory, there is no reason why a target could not be set, but a much wider context of what the department is trying to achieve has been set out.

Rhona Brankin (Midlothian) (Lab): Could you remind us of or bring us up to date on work on the best-value framework in the health service? Where do we go from here on that?

Caroline Gardner: The situation throughout the Scottish Executive is that securing best value was made a duty of accountable officers back in April 2003, I think. Draft guidance was issued in April this year and was made available to accountable officers, and it is closely related to the guidance to and requirements on local government under the Local Government in Scotland Act 2003. However, much variation remains in how best value is applied in practice throughout the public sector outside local government. In Audit Scotland, we are developing our thinking on how we might assess how well public bodies are responding to the new duty, but it is fair to say that the duty is less well defined outside local government than it is in that part of the public sector.

Rhona Brankin: I presume that discussion continues about how best value should be delivered in sectors such as the health service.

Caroline Gardner: Implementation of the duty to secure best value is a matter for the Scottish Executive, its departments and non-departmental public bodies. We have discussed with them the draft guidance and our view of what audit might add to that, but that is still work in progress.

Rhona Brankin: I have said before and I will say again that I find it difficult to apply conventional best-value measures to the information that we receive—I am trying to get a handle on that. There seem to be many ways of measuring what goes on in the health service. Should doing that eventually become more simple and straightforward, or is that a vain hope?

Caroline Gardner: I am not sure whether best value is the answer to that problem. Best value involves a much wider set of questions about what the health service is trying to achieve, how it is organised to do that and how it monitors and reports on its performance. Agreement to priorities locally and to systems to show how well those priorities are being achieved will be a step forward, but the underlying problem of difficulty in obtaining information will remain.

George Lyon: We need to pursue two or three questions, but I guess that we will discuss some of those issues when we debate "An overview of the performance of the NHS in Scotland". Item 1 is that the Health Department has failed completely to address the fundamental questions that we have all been asking, which are how the success of pay modernisation is measured, what the objectives are and what information will be gathered to measure whether the objectives are reached. Those are simple questions. More than £2 billion extra has been put into the NHS and a measure of whether the system improves must be in place.

Activity levels are fundamental—we will discuss them in relation to the overview report—because the ordinary taxpayer out there thinks that they will have more activity from the service and shorter waiting times. That is not mentioned in the department's response.

I would be interested in having clarity about the increase in hours contracted to the service, which the response says is from 21 to 30 hours, and in finding out the number of consultants who work the bare 21 hours. Consultants have told me that the deal will reduce rather than increase the number of hours that they work, because the consultant contract was predicated on the experience south of the border, where private consultancy work was a much greater issue. I would like clarity on the number of consultants who currently work the minimum 21 hours and on the number who already work 30 hours a week, because in some ways they will receive the salary increase for working their current number of hours.

The response says that a major review of NHS statistics is being undertaken and I would like clarity on that. Will the Auditor General comment on that claim? I take it that the review's purpose is to answer some of the questions that we keep asking.

The response says that consultants could be paid twice under the old system. I would like clarity on what that was about. How big an issue was that under the old consultant contract?

The department also states that it is about to develop a new vision for the NHS. Some would say that that is a little late, but it would be interesting to see a bit more detail about what on earth that new vision will be about.

I would also like to know how many one-stop clinics have been established, because the department claims that that is a beneficial new development in the system.

The Convener: I am unsure whether the best route to take is to put that ball back in Audit Scotland's court.

George Lyon: If Audit Scotland could provide the information, that would be helpful.

The Convener: I will be happy to hear from Caroline Gardner in a second, but the scope of George Lyon's questions and members' comments is such that we are concluding that we will have to write a letter to ask questions for the Executive to answer directly. That is because questions have been asked about statistics and pay modernisation—Susan Deacon asked about that and George Lyon touched on it.

I invite Susan Deacon to speak before Caroline Gardner, so that we may be able to wrap up our discussion.

Susan Deacon: In my earlier stream-of-consciousness comment, I forgot to mention an issue on which I would very much welcome the response of the Auditor General or his team. Members may have noticed—I am sorry that the document's pages are not numbered, but I am referring to text at the bottom of roughly page 4—that a confirmation is given that

"a major review of Health and Statistics … has now been launched."

I say one cheer to that, because as we have all agreed, that is absolutely needed. I will reserve my two cheers, partly because the question is raised why the department has taken so long to undertake a review and has had to be dragged kicking and screaming into it.

Where will the review go from here? Does the Auditor General have any comment on or insight into how the department intends to develop it? Will Audit Scotland be involved? How will we ensure that we have in place robust—but I hope not over-engineered—data collection systems that give ministers and in turn the Parliament the performance information that is desperately needed for the NHS?

In the response, I see again much information about consultation and process. A huge number of people will be consulted about what the system is to look like. It strikes me that if ever there was an area in which what was necessary was not a huge amount of consultation but a bit of sharp action to put in place the systems, this is it. I would very much welcome comments from Audit Scotland, because I know that this is an area in which it has considerable expertise.

10:00

Caroline Gardner: I will respond first to the questions that George Lyon asked. We have a similar interest in the way in which the consultant contract is implemented and the way in which the benefits are gained. We are consulting on a study of the implementation on the contract, which will be carried out over the next 18 months and we will come back to the committee on that. That is probably the only way to answer George Lyon's questions, because the underlying information is simply not available nationally at the moment.

George Lyon: Are you suggesting that we cannot ask the Health Department how many consultants currently work the 21 hours under the old contract?

Caroline Gardner: Absolutely not. I am saying that we are consulting on a study on how the new consultant contract will start to deliver some of the changes to which the department refers in its response. The only way to explore detailed information on that and, for example, on the number of one-stop clinics available is to ask the department. I will ask Barbara Hurst to answer the question on the review of statistics and information.

Barbara Hurst (Audit Scotland): My understanding is that the information and statistics division of the health service kicked off work on that a while ago. We are keeping in touch. We have not conceptualised the work in the way in which the department has in its response to you, but we are certainly aware that it is going on. I am happy to do a bit of follow up work to find out what is happening and bring it back to the committee, if that would be helpful.

Mr Black: I have a comment to offer—I might be stating the obvious, but it is probably worth putting on record. As I am sure Susan Deacon will acknowledge, it is for management in the health service to determine what management information is needed to run the service. It is not

the role of anyone in Audit Scotland to second-guess the role of management. However, if we can provide support to help to ensure that the right sort of information is collected in a way that is both robust and informative about some of the performance issues, we will do so. That is a role that we are happy to play throughout the public sector but, ultimately, it is for management to determine what information it wishes to collect.

Susan Deacon: I just want to clarify a point. I am grateful for the Auditor General's response and, given Barbara Hurst's offer to find out more, I wonder whether we could get clarity about the department's definition of "early action". It says in the response that it will

"take early action where possible, and … make recommendations for further developments in a report in April 2005."

It will take the best part of a year to hear recommendations for possible further developments that will not have been actioned at that stage. The lag time for changing data collection systems is years, not months. It is in keeping with the discussion that the committee has had for us to get clarification, which I would very much like, on the early action that we can expect.

The Convener: It is clear that members feel that a number of questions have yet to be resolved. I propose that, although we have further NHS work before us, the route open to us is to draft a letter to the Health Department, including the *Official Report* of today's meeting and outlining the topics raised. At that stage, we will have to ensure that members are comfortable that the points that they are concerned about are being raised. I will then send the letter to the department on the committee's behalf seeking clarification.

I am not entirely convinced that we will get all the answers that members want. The response might simply reveal that some information is not being gathered or that the department is not at a stage to answer our questions. However, that might satisfy members, as it would reveal that the department does not know the answers. I can see no other way of satisfying members' demand for further information. It is the department's job to answer the questions; Audit Scotland can only point to what has been going on with regard to its process. As the Auditor General points out, Audit Scotland is not responsible for the information that is compiled. Would members be satisfied if the clerks drafted a letter on the committee's behalf? Normally we can just send letters off because we are quite clear about the points, but so many points were raised that we will need to circulate the letter first, so it might take a week before we have it ready. Is that agreed?

Members *indicated agreement*.

The Convener: That covers agenda item 2. Just before we move on to agenda item 3, I offer apologies from Margaret Jamieson, who is unable to make today's meeting.

"An overview of the performance of the NHS in Scotland"

10:05

The Convener: Item 3 is consideration of the report "An overview of the performance of the NHS in Scotland", which was published while we were in recess and on which we will receive a briefing from the Auditor General for Scotland.

Mr Black: The report, which came out on 5 August, is our first integrated report on the overall performance of the NHS in Scotland. We have compiled it by drawing on a range of information that is published by the health service in various ways. As I said earlier, the report complements our series of financial overview reports. The next of those overviews, which will relate to the financial year 2003-04, will be published in December this year.

It goes without saying that the NHS in Scotland is a large and complex organisation and it is hard to provide a comprehensive picture of performance. However, in the report we comment for the first time on the NHS in Scotland's performance against the objectives and targets set by the Scottish Executive. We have covered seven areas that we believe are important to NHS patients and the public in general and on which we could find reliable information. The main headings are: how the NHS is organised; how performance is managed; health improvement and public health; NHS resources; NHS efficiency; waiting times; and outcomes and joint working.

I suggest that the report provides evidence to support many of the committee's findings in its eighth report, which was published on 2 July.

It is pleasing for me to be able to report that the NHS in Scotland has already met some of its key targets and is on track to meet others. For example, targets to reduce the number of deaths from cancer, coronary heart disease and stroke have been met or are likely to be met. However, the NHS will need to do more to achieve some of the other targets by the deadlines set.

On the resources theme, as members know, the NHS in Scotland spent around £7 billion in 2002-03, which is equivalent to £1,400 per person. Spending is due to increase by around £2.7 billion over the three years to 2005-06, which is equivalent to £1.8 billion after the amount has been adjusted for inflation. It is difficult to track where the new money is being spent, but, as the evidence that the committee took before the summer demonstrated, much of the additional investment is likely to be absorbed by cost pressures such as pay modernisation and the rising cost of drugs.

On page 17 of the report, in exhibit 7, we summarise the information that came from the Health Department for the report on the estimated future cost pressures. I should say that those numbers are not audited, not least because they are projections, not expenditure incurred. However, we hope that it is helpful for the committee to have some indication of those figures.

On page 16 of the report we refer to the costs of the consultant contract in particular. We say that average consultant earnings are likely to increase by around 20 per cent as a result of the basic contractual commitments, according to the current cost projections. In the table on page 17 of the report you will see that the consultant contract is expected to absorb £63 million in 2003-04, £85 million in 2004-05 and £100 million in 2005-06, making £248 million in total by the end of that planning period. For that reason, the new consultant contract is a candidate for a future study, as Caroline Gardner said a little while ago.

Part 3 of the report examines the information that is available on all the cost pressures and on staffing levels and vacancies. Although new money is being made available, we suggest in the report that in a number of areas and disciplines the new staffing targets will be challenging for the NHS in Scotland to meet.

Part 4 of the report draws on available information to attempt to address the question of how efficiently the NHS in Scotland uses its resources. For example, although bed numbers are falling, Scotland still has more NHS beds per head of population than other parts of the United Kingdom. In the acute sector, Scotland has more beds per 1,000 people than England, but fewer beds than Wales and Northern Ireland. I should point out that that situation varies among acute specialties. However, compared with other countries in the UK, our continuing care sector still has the largest number of beds.

Occupancy levels have increased only slightly, which suggests that there is no overall problem with bed capacity in Scotland, certainly as far as the acute sector is concerned. However, the levels vary from 58 per cent in one acute specialty to 95 per cent in another, which means that there might still be too many beds in some specialties and excessive pressure in others.

Acute activity in Scottish hospitals has fallen slightly over the past few years and exhibit 17 on page 29 highlights the trend since 1991. It is interesting and—I suspect—quite important to note that overall activity in hospitals is showing early signs of decline just as the service is starting

to receive extra resources through the new pay deals and so on. The many reasons for that decline relate to changes in clinical practice and success in keeping people out of hospital. However, the data collection systems are not keeping pace with changes in patient care and it is difficult to find evidence to explain exactly what is happening. For example, we know that some patients who would previously have been admitted to hospital are now being treated as out-patients. In one census, the NHS recorded nearly 4.7 million attendances at out-patient clinics in 2002-03, which was around a 2 per cent reduction on the previous year. However, a recent survey carried out by Audit Scotland indicates that, in fact, there were more than 10 million attendances. That example highlights one of the areas in which information systems need to be urgently improved. Frankly, we are not entirely clear about the true picture in that respect.

Exhibit 17 also illustrates the quite marked changes in the pattern of admissions since the early 1990s. The number of planned admissions fell by almost 30 per cent while the percentage of emergency admissions rose by the same amount. That increase is accounted for mainly by older people.

We have included some analysis of cost data, which shows some wide variations across Scotland and among health boards in the costs per case. There are questions about the reliability of such data, and the NHS in Scotland needs to address the absence of robust and relevant cost data in certain important areas. Because such questions need to be tackled, members will not find that the report contains a great deal of comparative cost analysis.

In part 5, we examine the issue of waiting for care. The main message is that, although in-patient and day-case waiting-time targets are being achieved overall, work still needs to be done to achieve the waiting-time targets for the national priorities of coronary heart disease and cancer. In that respect, I find it very interesting and significant that in the year up to April 2003 the Golden Jubilee national hospital undertook many more procedures than was expected.

Part 6 summarises the available health outcome data. Health outcomes have continued to improve ever since the national health service was established and the rate of improvement shows no signs of slowing. We recommend that the Health Department might develop better outcome targets for the important area of mental health, in which the only main target is for reducing deaths from suicide.

The final section of the report considers the issue of joint working and the pressures on health and community care services as the number of elderly people increases. For example, almost all the increases in bed days occupied by emergency in-patients relate to people who are 80 or older, and more than 90 per cent of delayed discharges occur after emergency admissions. There are many fewer NHS long-stay beds, and average occupancy levels in care homes have risen to 90 per cent. The number of people who receive home care from councils has fallen by a third since 1995, but those clients are receiving more and more intensive services. Given the projected increases in the numbers of very elderly people and the fact that fewer people are receiving more intensive services, it follows that there is likely to be a capacity issue in future.

10:15

In conclusion, our report confirms that much is being done to improve health services in Scotland. However, a recurring theme—which the committee has already explored this morning—is that better information is needed to track the effect of increased investment and changes in service delivery. Better information is required on costs and activity across the whole health care system and on the quality of services from the perspective of patients. The national and local challenge for the NHS in Scotland is to ensure that spending increases lead to better outcomes and services for patients and to reduce the persistent health gap between affluent and deprived communities in Scotland.

As always, convener, my colleagues and I are delighted to answer members' questions.

The Convener: Thank you very much. Of course, the committee will discuss our response to the report later in the meeting. If members wish, they may now ask any questions that might be pertinent to the report and help our later discussion.

Rhona Brankin: Auditor General, you mentioned that local authority support for elderly people had fallen by a third in one sector. Will you expand on that comment?

Mr Black: On page 43 and 44 of the report—[*Interruption.*] I am sorry; I was being led up an alley. That matter is addressed in a short section from paragraph 207 onwards. Paragraph 209 says:

"Since 1995 the number of people receiving home care provided or purchased by councils has decreased by about a third."

That comment refers to council services, not to what is happening in the private care market. For a few years now, the local authority performance indicators, which we record, have shown quite a noticeable decline in the number of people who receive local authority home care services.

Paragraph 209 goes on to say:

"The number of home care hours has increased by around 13% since 1998",

which means that although the number of hours has been increasing the number of clients covered has been falling. As a result, councils are targeting home care on those who need most help. We point out in paragraph 209 that

"The number of clients receiving more than 10 hours of home care per week has increased by 50%, and two in five users now receive more than 19 hours of home care each week."

The general pattern is that local authorities are providing more intensive services, but to fewer people.

The report does not contain any information on what is happening outwith the local authority sector but, given the growing number of elderly people and the fact that intensive care packages are costly to deliver and resource-intensive, there must be a concern about capacity issues in future. Moreover, there is a question mark over what might be called less intensive care packages for the elderly who are becoming frail and need support to be maintained comfortably and well in their homes in order to avoid being admitted to hospital. That section of the report raises some probably quite significant issues.

Rhona Brankin: Yes, and the question is how to collect information about what has happened to people who might have received support in the past but who are not receiving any support at the moment.

Barbara Hurst: You are absolutely right. Over the summer, we published a report on commissioning community care services in which we started to explore some of those issues. We are also collaborating with the ISD in Tayside on a very detailed and interesting piece of work that examines how decisions made at one end of the system have an effect further along. We are calling it a whole-system approach to delayed discharge, but we are also trying to collect very detailed information that might answer some of your questions.

George Lyon: I want to confirm that I am getting this right. According to your figures, the system has experienced a 31 per cent increase in consultants since 1995, a 5 per cent increase in nurses and a 37 per cent increase in allied health professionals and we seem to have more beds per head of population than England and Wales, yet the amount of activity in the system is reducing. Has the Health Department made any attempt to explain why, given that there is a £2 billion increase in investment in the work force, activity levels are dropping? The number of day cases has plateaued since 1999 and is now heading downwards. That is extremely worrying and, economically, in some ways it is madness. Does the Health Department have a real explanation of what is going on in the system? Another factor is the Golden Jubilee national hospital, which treated 9,300 patients last year, yet there is no addition to the overall total activity in the system. What is going on?

Caroline Gardner: I will have a go first, and I will ask Barbara Hurst to pick up on the bits that I miss out.

We know that activity is tending to move from in-patient care down to day-case care and on to out-patient care. We also know that, as we have discussed already this morning, the systems for collecting information about which services are being displaced into out-patient care are not good enough. Let me give as an example a procedure such as a cystoscopy, which was regularly carried out on patients who were admitted overnight 10 years ago. Five years ago, cystoscopy was regularly carried out on patients who were admitted as day cases but now, in most cases, it is performed on patients as out-patients.

Our work suggests that information on out-patient activity is not collected systematically enough to be clear on the number of such procedures that are carried out. To complicate the issue further, a lot of that work is not carried out by consultants or doctors; it is carried out by nurses and other practitioners. We know that information about some of that out-patient activity is being lost. That said, that probably does not account for the entire gap. A number of theories are being promoted, not only in Scotland but United Kingdom-wide—at the moment they are no more than theories—about what is going on.

Barbara Hurst: We were interested in those figures, too. Obviously, the drop in hospital activity raised a number of questions. In particular, it links back into our earlier discussion about the poor information that is available to show us what is really happening in the health service. For example, in the day-case report we found that, in terms of targets for some of that activity, the results were very mixed. In addition to the lack of information, there are clearly underlying issues that we need to look at.

George Lyon: I come back to the point about the Golden Jubilee national hospital because it is crucial. All members of the committee thought that when we bought the Golden Jubilee national hospital its work would be additional to what was already being done in the service and would give us a lift in activity, but it is clear that that has not happened. That work must be a substitute for activity that was going on elsewhere in the system.

Caroline Gardner: It is not as straightforward as that, because of the other complexities. As well as cases being substituted or displaced out of in-patient care, it is likely that the case mix is getting more complicated because people who are now being admitted as in-patients are, on average, sicker than previous patients were, and lengths of stay are changing. The impact of delayed discharge is also important. A number of things are going on that mean that it is not a simple case of saying that fewer admissions mean that less health care is being delivered, but it is also true that neither the Health Department nor Audit Scotland can at this stage show how that new activity is made up compared to what was happening before.

George Lyon: I understand that, under the old purchaser-provider system, payment was made according to the activity levels in the system. What happened to that information stream? Was it discontinued?

Caroline Gardner: How much of that information is still available is a question for the Health Department. I do not know.

Susan Deacon: I will raise two issues, the first of which is still on the subject of activity levels. I am concerned that a myth is perpetuated all over the place that hospital activity levels are the key indicator of activity and even sometimes, by extension, of performance generally within the NHS. Therefore, I welcome all the observations that Audit Scotland has made about some of the shifts in activity and about how much is happening in the community and in other settings.

My point follows on from our earlier discussion and some of the comments that I made. How do we accelerate the process of getting an accurate picture? Could Audit Scotland do anything else in that regard? I have a concern about some of your reports on the NHS, as you still look at hospital activity levels a great deal. I am sure that your response to that would be, "Well, that is where the data exist and are collected." Through the audit processes, what could the organisation do to shift some of the measurement towards non-hospital-based activities, which, as you have said, account for a growing amount of activity within the health service?

Mr Black: I will give an initial response to that point and I am sure that Caroline Gardner will develop it and, if necessary, correct me.

If Susan Deacon looks across the piece at the range of studies that we have produced on the health service, she will see that they cover a diverse range of topics—everything from general practitioner fundholding to the management of medical equipment and studies of community care. A recurring theme in each of the studies has been the inadequate nature of the data that we find to work with. It is commonly the case that we have to capture and clean up information in order to provide a report to the Audit Committee. Therefore, I would not wish the committee to form the impression that somehow we simply operate on the data that are available; a lot of our effort goes into capturing data.

I think that we are having some success in providing support to the Health Department and health boards because, once we have collected data, that makes a useful framework that can be taken up by health service managers to bed down information systems that will be of value in the future. Occasionally, we revisit topics. We have revisited day-case surgery a few times, drawing on information that is collected by the department following on from the study that we did back in the 1990s.

My other general comment in response to Susan Deacon is that often the figures are not the answer to the problems—they raise questions, as much as anything else. As she rightly points out, analysing trends in acute activity raises questions about whether we are looking at the right things. For example, it raises the obvious question of the need to go below that level to understand what is happening in health systems. That is why we do a lot of studies that follow from the general overviews and start to drill down. We intend to drill down in the whole area of how the consultant contract is being managed because, on the surface, the information is not there to provide a good picture.

Barbara Hurst: It is fair to say that we share Susan Deacon's frustration about what we can and cannot look at but, as the Auditor General says, we try.

In our consultation programme on our future studies, there is a study on chronic disease management, which would provide a good opportunity to start to look at the treatment of people who would have been in hospital in the past but who are now being maintained in the community. I am hopeful that the quality and outcomes framework for the GMS contract should start to give us better information about what is happening in primary care. It is not all doom and gloom on that front. We are keen to explore how we can access some of that information.

Susan Deacon: I am grateful for the responses that I have received. It is worth reminding ourselves that this is not just an academic exercise to collect figures; the really frightening thing is that the data that are collected and used for performance measurement—in some cases they are even linked to people's pay—will drive what people give attention to, so my point is directly linked to George Lyon's fundamental

question about what the additional investment is delivering. I am conscious that we need to get all those things facing the right way in the health service.

Before I raise my second point, I will ask a further question about data collection and activity levels. Would you like to say anything about information technology systems? I am conscious that relatively little is said about IT in both Audit Scotland's reports and the various pieces of information that we have had from the Health Department. However, surely IT is the key not only to accurate and effective data collection systems but to efficient data collection systems. Nobody wants to give pressurised health professionals additional burdens of work in relation to filling in unnecessary forms, but we see in all sorts of other sectors that IT allows data capture to be woven into people's way of working. Data are captured as people go, through good categorisation systems and the like. As I understand it, we are nowhere near that in the health service, although south of the border a huge amount of energy and investment is going in to ensure that modern and effective ways of working are in place and that full use is made of technology. Would you like to comment on that? Are you examining that area? Do you agree that it is a critical dimension to the debate?

10:30

Barbara Hurst: I agree that it is a critical dimension. In most of the reports that we have brought to you during the past 18 months or so, the recurring theme is IT. We are keen to start to look at some of the strategic development that is going on and to link up with our colleagues at the National Audit Office, who are doing something similar in England. We intend to examine the matter—it is certainly in our consultation programme and I would have thought that it is a front-runner for us to pursue.

George Lyon: In paragraph 70, on page 16 of "An overview of the performance of the NHS in Scotland", you detail expenditure of

"£1.8 billion in real terms",

which is the expenditure that the Executive is putting in up to 2006. It is split into just over £1 billion for drugs costs, the consultant contract, the GMS contract, out-of-hours care and increased staffing; £250 million for primary care facilities and IT; and £90 million for tackling delayed discharge. That adds up to £1.4 billion, but you go on to say:

"this does not include … costs for implementing Agenda for Change or any additional costs arising from full compliance with the New Deal".

Further on in the report, you say that the estimated cost of the agenda for change is about £248 million—I take it that that is in real terms as well. That takes us up to £1.648 billion, which leaves only £152 million to cover the new deal for junior doctors or any unexpected pressures that come along. There is not much headroom. What are your views on that? Do you think that an extra bill will come in for the new deal for junior doctors?

Mr Black: Your summary of what the numbers tell us is accurate, although it should be borne in mind that they are projections and not actual numbers. The picture is clear: the new money, discounted for inflation, will largely be absorbed by pressures that are already in the system.

George Lyon: So there is no extra money at all for new investment, apart from what is accounted for.

Mr Black: We would not go that far, but there is certainly a lot of pressure in the system.

Rhona Brankin: I am interested in how users of the health service are engaged in determining whether it is improving. I am a reasonably regular user of the health service—whether clinics, hospitals, my GP or whatever—and I have never been asked what I think about the service. How is that work done and what plans are there to improve it?

Barbara Hurst: You would need to ask the Health Department about that. When we started scoping the report, we were interested in including information on that, given that a patient-centred service is one of the key priorities of the health service, but we did not find much information. In most of our studies, we are keen to include a patient or user view of the service. We know that that is difficult, but we expected to find more information when we tried to collect it.

The Convener: In Paragraph 117, on page 24, under "Management and administration staff", a number of statistics are given on the increase in the number of staff, particularly on the clerical side. There has been a drop in the number of senior managers, which is not a surprise given that there has been a degree of reorganisation. My understanding is that the overall growth in the number of administrative personnel is greater than the growth in the number of clinical staff. We have heard questions about measuring outputs, and we know that some clinical staff have been recruited because of issues such as the working time directive and so they do not necessarily lead to an increase in output. Can you shed more light on why the administrative and clerical side seems to be growing at such a rate even though the people who are trying to run the service are looking for greater output on the clinical side?

Barbara Hurst: Initially we were not going to add that paragraph to the report, because we were trying to consider the targets, but for completeness

we thought that we should add it. I am not sure that we can shed much light on it, except that there are some issues around definitions. Sometimes there is movement—for example, someone who has been categorised as a nurse becomes a nurse manager—but that would not explain the clerical staff issue. The issue relates to the point that Robin Harper made about the reductions that would be expected to follow unified systems. I suspect that there might be some reductions under the shared services project, which examines bringing together back-room functions such as payroll and human resources. I am afraid that I cannot add any more than that at the moment.

Caroline Gardner: We can say that if the increase in administrative and clerical staff is less than the increase in total costs, the obvious inference is that the increase in clinical staff is greater, simply because 70 per cent of total costs are direct staffing costs. However, as Barbara Hurst said, there are some definitional difficulties that make it difficult to make a straightforward comparison of the two.

The Convener: That exhausts our questions. Under a later agenda item we will discuss how to respond to the report. I thank the Auditor General and his colleagues from Audit Scotland for answering our questions.

"Supporting prescribing in general practice"

10:38

The Convener: We move on to agenda item 4. We are running a little behind time because of the committee's keen interest in the foregoing items, so it would be helpful if we could pick up the pace a little on items 4 and 5.

Under item 4, the committee will consider the follow-up response from the Scottish Executive to our third report in 2004, which was entitled "Supporting Prescribing in General Practice – A Progress Report". I remind members that we took evidence on the matter as far back as September 2003 and we published our report on 28 January.

Susan Deacon: I do not want to repeat too much of what I have said. Although I strongly endorse the direction of travel in the area, I note again that the pace of change is not fast enough. That is reinforced by some of the statistics that the department has shared with us in its response, for example some of the percentages that are given on e-referrals and e-discharges to select just a couple. When we originally considered the report, I spent some time looking in detail at what the Department of Health in England was doing in the area. The targets and levels of attainment are in excess of where we are in Scotland. We have to be willing to examine that and get behind why it is the case. There may be good reasons for it, but I am concerned. That is linked to the IT issues that I have mentioned.

I note that page 4 of the department's response refers to the e-health strategy that is being pursued. I examined that strategy in some detail. It was refreshed or renewed or rewritten or relaunched or re-something earlier this year. It struck me as yet another reiteration of some laudable aims, with some good work going on around it, but there is an awful lot of heavy process and discussion when what is needed is significant acceleration of the roll-out of IT developments in the NHS in Scotland.

I am sorry; I am skating over a range of areas and I am conscious that people who are involved in the projects are jumping up and down saying, "No, there's more to it than that and we are moving forward further and faster." If that is the case, that is fantastic, but the department's response to the report leaves me with two concerns about pace and IT.

George Lyon: I reinforce the two points made by Susan Deacon. The pace of change and the development of IT systems north of the border

seem to be lagging well behind what is happening in England and Wales. Some of the information that we have been given reinforces that view. It is the common theme in a lot of the discussions about the health service.

Rhona Brankin: The committee will not be surprised to hear that I am going to talk about alternative and complementary medicines. I remain surprised that the Scottish Executive does not have information about the range of homoeopathic and other complementary and alternative medicines that is available in Scotland. It states that some NHS regions provide homoeopathic treatments, but there is no attempt to understand whether users of the health service would find them beneficial. The health service has to make decisions about what is clinically safe—there is no doubt about that—but there is an increasing body of evidence on the effectiveness of alternative and complementary medicines. In Scotland, we are light years away from examining the potential benefits to patients and also the savings on conventional prescriptions.

Robin Harper: I have an observation that ties in with one of Rhona Brankin's points. It would be extremely useful to know about the level of patient satisfaction with homoeopathic services.

The Convener: Auditor General, do you have any comments to add on the Executive's response?

Mr Black: No.

The Convener: Members have expressed their opinions about the Executive's response, but the question is how we take that forward. Members' expressions should be sufficient at this stage. It is up to members to take up any points individually but, as a committee, I suggest that we simply note the response. If the issues or related issues come before us again, we can raise our concerns. Is that agreed?

Members *indicated agreement.*

Scottish Further Education Funding Council

10:45

The Convener: Item 5 concerns the Scottish Further Education Funding Council. The committee is to consider a follow-up response to our fourth report, "Scottish Further Education Funding Council – Performance management of the further education sector in Scotland". Members have the response before them. The committee and Audit Scotland have carried out significant activity in the area over the years. Our report was published on 18 March and we considered a response from the Executive at our meeting on 8 June. Do members have any comments?

George Lyon: I have a couple of observations. Eddie Frizzell goes to great lengths to defend the current accountability of colleges, claiming that the funding council has a range of powers to influence how colleges account for the money that is spent. The evidence to the committee so far is that that does not seem to work terribly well.

On unit costs and financial performance indicators, Eddie Frizzell gives us a long explanation about how unit costs could be misused or misinterpreted because of the way in which they are presented. He goes on to state:

"unit costs would signpost the questions to be asked but would not necessarily themselves provide the answers."

At least it would be nice to be able to ask the questions. We are all grown up and adult enough to be able to draw out what the reasons might be for differing unit cost levels. That would add to the debate, rather than subtract from it.

Eddie Frizzell seems to be at pains to state that he wants to meet us informally to explain why we do not understand what is going on. That might be worth considering. I would also like to see what information the Executive has collected on unit costs and benchmarking. That would be useful and would reassure us that it is getting to grips with the subject. I do not know whether that could be done at a private informal meeting. I leave that to other committee members to decide.

The Convener: I have some comments on your points, in particular on having an informal meeting. Members will recall that at one of our away days we took the view that it would be useful to discuss how we can improve dialogue with accountable officers. In an effort to do that, we intend to meet John Elvidge at some point. A letter to that effect has been drafted and will be sent to John Elvidge soon.

It is better that we follow that process of meeting the senior accountable officer to explore the mechanisms that might be put in place, rather than organise an informal meeting with an accountable officer at this stage, when we have not worked out what protocols might be most appropriate to protect the interests of the accountable officer as well as the legitimate interests of this committee, which is here to hold accountable officers to account. We might have a meeting in future, but perhaps not just yet, before we have exhausted our lines of inquiry on the best procedure.

If there are no other comments, I intend to draw a line at this stage, after I invite the Auditor General to give his view.

Mr Black: I have nothing to add.

The Convener: Is there any future work on the further education sector that it might be worth letting the committee know about?

Caroline Gardner: Yes. Our plan is that, in about 12 months' time, in late 2005, we will produce another round-up of what is happening in further education, considering both the financial performance of the colleges and the role of the funding council in pulling that together. That is our timescale for coming back to you with further work.

The Convener: Thank you for that. I suggest that we note that response and draw a line under the agenda item. We may or may not revisit the issue of further education and the funding council at a later date. Is that agreed?

Members *indicated agreement*.

Scottish Executive (Format of Accounts)

10:51

The Convener: We move to agenda item 6 and we are beginning to pick up our timing again, which is good. I welcome John Aldridge from the Scottish Executive, who is here to give us a briefing. We are to consider a proposal by the Scottish Executive to discontinue producing and publishing resource accounts covering core departments. John Aldridge, who is a finance director, will give us a short briefing to explain why that is proposed before we discuss our reaction to it.

John Aldridge (Scottish Executive Finance and Central Services Department): I am grateful for the opportunity to talk about why we are asking the committee for its agreement to our proposal to cease publication of the Scottish Executive core accounts. I hope that the paper that I submitted explains the rationale behind our proposal; however, it might help if I go over some of the key points.

We want to make the accounts as easy to use as possible. Accounts are never the easiest of documents to understand. Accounting conventions mean that sometimes it is not as straightforward as we would like to set out the figures simply if we are to continue to provide a true and fair view of the financial position of the Scottish public finances and if we are to abide, as far as possible, by generally accepted accountancy practice. We are trying to do what we can to simplify the presentation and to make the accounts as understandable as possible.

At the turn of the year, it was quite gratifying when the accounts hit the headlines for the first time. That does not normally happen—the accounts tend to be ignored—and from that point of view, it was quite gratifying that people were paying attention to them. On the other hand, that event brought home to us the fact that there is an element of confusion between the core and the consolidated accounts, both of which we publish. Inevitably, the two sets of accounts contain different figures for spending against budget, as they relate to a different boundary. Although the two sets of figures could be reconciled, the process is complicated and not straightforward to communicate. We have to produce consolidated accounts because consolidated accounts give a full picture of spending within the whole Scottish Executive accounting boundary. However, the core accounts are, in effect, a subset of that.

Therefore, we propose that the core accounts should no longer be published.

I would like to reassure the committee on one point. We are keen to ensure that, in ceasing to publish the core accounts, we do not reduce the amount of useful information that is made available to the public or anybody else who wants to read the accounts. We are working with Audit Scotland to ensure that, if the proposal goes ahead, the same amount of useful information will still be available to those who look at the accounts.

The issue of timing has been raised. I strongly support any move to bring forward the date of publication of the accounts. We have a statutory deadline of 31 December. Last year, we just made it, but I am keen that we do better than that this year. We are working well with colleagues in Audit Scotland to accelerate the audit and are taking a number of steps to do that. We hope to be able to publish the accounts earlier this year; however, I cannot give a firm date as the audit is still under way. We will endeavour to make further progress in future.

I hope that that has helped to give some background to the Executive's position. I am happy to try to answer any questions that members may have.

The Convener: Thank you very much. Do members have any questions?

Susan Deacon: I have not a question but a brief comment. I have neither seen nor heard anything that causes me to disagree with the proposal. I note that part of the reason for the change is to make the information more accessible to the public, which I welcome. However, I wonder whether, as well as examining ways of presenting the data in a more accessible way, the Executive is also thinking about the language that is used. Much of the documentation that is produced is still riddled with jargon that could probably be lost or changed without reducing the substance of the data. I wonder whether that is part of what the Executive is thinking about.

John Aldridge: Yes, indeed. That is something that we are considering in the same context. The aim is to make the accounts as understandable as possible, which relates to the language as well. We are sometimes constrained by accountancy conventions and rules governing the language that we have to use in the accounts but, in so far as it is within our power, we will try to make the language as simple as we can.

George Lyon: Is it the Executive's intention to discontinue the core accounts completely or just not to publish them?

John Aldridge: The work that is currently done in examining the finances of the core departments will still be done—it will have to be done—but it will not be brought together in a single document as it has been in the past.

George Lyon: But the information will still be available to the Finance Committee or to this committee.

John Aldridge: Indeed. One of the aims is to ensure that there is no reduction in the amount of useful information that is available.

George Lyon: That is fair enough.

The Convener: In what way would members or committees be expected to source that information? Would it be simply by writing to departments or by asking parliamentary questions?

John Aldridge: A lot of it will be brought together in the consolidated accounts and presented there. If any information is not there to which members wish to have access, they can write to us and we can make that information available to them. However, we hope that there will not be a great need for that.

The Convener: Okay. Thank you very much. I am conscious that, in about two and a half minutes, we will hold a minute's silence. I intend that we should do that in public rather than in private; therefore, I intend that, with the agreement of the committee, we finish this item just before that. After that, we will move into private session for the next item. As members have no further questions, I ask for observations or comments from the Auditor General regarding the proposed change.

Mr Black: On balance, the presentation of two sets of accounts is more likely to confuse public accountability than to illuminate it. Therefore, I welcome the direction in which John Aldridge suggests that the Executive would like to go. As he mentioned, we understand that there will be no loss in the quality and range of the financial information that is available. Against that background, the proposal has our support.

I share John Aldridge's view—and we hope and expect—that having a single set of consolidated accounts might allow us all to achieve an earlier conclusion of the audit, which has to be in the interests of improved accountability. Therefore, the proposal has our support.

The Convener: Okay. I would like to clarify one point. If the committee agrees to the change, will it take effect from the next set of accounts that are published?

John Aldridge: Yes, indeed.

The Convener: Okay. Thank you. Does the committee agree to the proposal that the accounts covering the core departments of the Scottish Executive be discontinued?

Members *indicated agreement*.

The Convener: I thank Mr Aldridge for answering our questions. That has been most helpful.

11:00

The Convener: We will now observe a minute's silence for the victims of Beslan.

11:01

Meeting suspended until 11:22 and thereafter continued in private until 12:16.

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