Public Audit Committee

7th Report, 2014 (Session 4)

Report on Accident and Emergency - performance update

Published by the Scottish Parliament on 15 December 2014
Public Audit Committee

7th Report, 2014 (Session 4)

CONTENTS

Remit and membership

Report 1
Executive Summary 1
Introduction 2
Background 2
  Waiting time target and standard 2
  The purpose of A&E waiting time targets 4
  Unscheduled Care Action Plan 5
Demand for A&E 7
  Referrals to A&E 7
Waiting in A&E 11
  Waiting for a full clinical assessment or for a specialist 12
Admission from A&E 19
  Bed occupancy 19
  Delays in discharging patients 20

ANNEXE A: EXTRACT FROM THE MINUTES OF THE PUBLIC AUDIT COMMITTEE 23

ANNEXE B: ORAL EVIDENCE AND ASSOCIATED WRITTEN EVIDENCE 25
Public Audit Committee

Rermit and membership

Rermit:

The rermit of the Public Audit Committee is to consider and report on—

(a) any accounts laid before the Parliament;

(b) any report laid before or made to the Parliament by the Auditor General for Scotland; and

(c) any other document laid before the Parliament, or referred to it by the Parliamentary Bureau or by the Auditor General for Scotland, concerning financial control, accounting and auditing in relation to public expenditure.

(Standing Orders of the Scottish Parliament, Rule 6.7)

Membership:

Colin Beattie
Willie Coffey (until 27 November 2014)
Bruce Crawford (until 26 November 2014)
Nigel Don (from 27 November 2014)
James Dornan (until 27 November 2014)
Hugh Henry (Convener)
Colin Keir
Ken Macintosh
Gil Paterson (from 27 November 2014)
Mary Scanlon (Deputy Convener)
Tavish Scott
David Torrance (from 27 November 2014)

Committee Clerking Team:
Clerk to the Committee
Jane Williams
Assistant Clerk
Gary Cocker
Committee Assistant
Tom Williams
The Committee reports to the Parliament as follows—

EXECUTIVE SUMMARY

1. NHS boards in Scotland are facing a number of pressures whilst striving to improve the safety and quality of patient care. Whilst NHS performance against Accident and Emergency (A&E) waiting time targets should not be considered in isolation, it provides a barometer by which to assess how successfully the NHS is meeting these pressures.

2. Since 2004 there has been a Scottish Government target (which became a standard in 2008) that 98% of patients should wait no longer than four hours from arrival to admission, transfer or discharge (the 98% standard). Performance by the NHS in Scotland against this standard improved until December 2009 when it fell from 97.2% to 93.5% in December 2013 before rising to 94% in June 2014. In April 2013 the Scottish Government introduced a new interim target of 95% of patients being treated within four hour by the year ending September 2014 (the 95% interim target). Performance against this target by the NHS in Scotland, for the year to September 2014, was reported by ISD Scotland as 93.4% with 9 of 14 NHS boards meeting the 95% interim target.

3. In its report the Committee has sought further information from the Scottish Government on its review of the 95% interim target as well as what support it is providing those boards which did not meet this target. We note that the Scottish Government retained the 98% standard but in the meantime introduced a 95% interim target. We have therefore requested confirmation of whether the 98% target remains appropriate and achievable, given the Scottish Government’s comments that some patients may need to wait in A&E longer than four hours.

4. The Committee welcomes the additional funding (£27 million over three years) provided by the Scottish Government to support the National Unscheduled Care Action Plan (NUCAP) but has sought clarification from the Scottish Government as to how NHS Boards are expected to release a further £23 million over three years to reinvest in this plan. We have also
asked Audit Scotland to provide an update on progress made and outcomes achieved by NUCAP.

5. We have sought updates from the Scottish Government in a number of areas where it is undertaking work including guidance on redirecting patients; evaluation of GP assessment areas, and implementation of the UK Greenaway review proposals for postgraduate medical training. In addition we have sought clarification from the Scottish Government on how it proposes to better understand the reasons why self-referral patients attend A&E, case mix and mortality rates and how it is supporting hospitals to move away from the standard practice of week day working in some parts of the hospital service.

INTRODUCTION

6. This report sets out the Public Audit Committee’s (the Committee’s) findings in relation to its scrutiny of the Auditor General for Scotland’s (“AGS”) report “Accident and Emergency – Performance update” (“A&E report”)¹ published on 8 May 2014.

7. In this report the Committee explores the evidence it received on how NHS boards and the Scottish Government are seeking to improve performance in A&E. We also provide comments on and seek further information on current activity aimed at improving the key parts of the patient journey from arriving at A&E, treatment in A&E and admission from A&E.

8. The Committee would like to thank all those who provided it with evidence, details of whom are provided in Annexe A.

BACKGROUND

9. In Scotland there are 31 A&E departments which provide essential services within the NHS, typically assessing and treating patients with serious or life-threatening injuries or illnesses. The AGS reported that around 1.35 million patients attended these departments in 2012/13 at a cost of £163 million. There are also 64 minor injury units (MIU) in Scotland that provide treatment to 266,439 patients a year at a cost of £25 million.²

Waiting time target and standard

10. In 2004 the Scottish Executive established a target that, by the end of 2007, 98% of A&E patients should wait no longer than four hours from arrival to admission, transfer or discharge. This applied to A&E as well as MIU.³ In March 2008 this target became a standard to treat and discharge or admit 98% of

² Accident and Emergency-Performance update, paragraph 1 and paragraph 11
³ Accident and Emergency-Performance update, footnote 2
patients within four hours of arriving at A&E (hereafter referred to as “the 98% standard”).

11. In the quarter ending March 2010, 96% (365,949) of patients were seen within four hours compared with 88% (334,907) in quarter ending June 2006.

12. The AGS reported that since Audit Scotland's last report in 2010 (entitled Emergency departments) performance against the 98% standard fell from 97.2% in December 2009 to 93.5% in December 2013, although there was an improvement during 2013. In evidence the Scottish Government observed that “the figure of 94% has been quoted for the published data to June 2014.”

13. The AGS reported that due to the variation in services that are provided in A&E departments across the country, there is no single factor explaining the deterioration in waiting time performance since 2008/09. The following can affect waiting time performance—

- pressure on the availability of hospital beds from an increasing number of patients being admitted as emergencies and delays in patients being discharged from hospital
- increasing complexity of care
- local policies on emergency admissions
- local policies on informing A&E patients about alternative services
- the time of day that patients are discharged from wards
- staffing pressures.

14. The Committee also heard evidence that waiting times performance can be affected by the availability of home care and care home places, in some areas, which can delay the discharge of patients from hospital whilst they wait for appropriate care outside the hospital. In addition the AGS reported that overall demand for A&E and Major Injury Units (MIU) had increased from 1.57 million attendances in 2008/09 to 1.62 million in 2012/13.

15. In April 2013, the Scottish Government introduced a new interim target of 95% of patients being treated within four hours by the year ending September 2014 (hereafter referred to as "the 95% interim target").

16. At the time of the Committee taking evidence (in October 2014) on the A&E report, the Scottish Government was unable to advise whether it would be able to

---

4 Accident and Emergency-Performance update, paragraph 1
6 Accident and Emergency-Performance update, key messages 1.
7 Scottish Parliament Public Audit Committee, Official Report, 8 October 2014, Col 3
8 Accident and Emergency-Performance update, paragraph 22
9 Accident and Emergency-Performance update, paragraph 10
10 Accident and Emergency-Performance update, paragraph 11
hit this target as the figures for September 2014 would not be released until November 2014.\textsuperscript{11} The AGS, however, reported that a number of boards would find it hard to meet the 95% interim target by September 2014.\textsuperscript{12}

17. On 25 November 2014, Information Services Division (ISD) Scotland reported that NHS in Scotland performance against the 95% interim target for the year to September 2014 was 93.4%, the same as that at the 95% interim target start date in April 2013. Of the 14 NHS boards, ISD Scotland reported that 9 boards met the target milestone of 95% (NHS Borders, NHS Dumfries and Galloway, NHS Fife, NHS Grampian, NHS Highland, NHS Orkney, NHS Shetland, NHS Tayside and NHS Western Isles).\textsuperscript{13}

18. The Committee acknowledges the considerable improvements that were achieved with A&E waiting times between the introduction of the target in 2004 and 2010 (see paragraph 11).

19. The Committee, however, also notes that despite improvement in NHS boards’ performance during 2013, overall performance against the 98% standard deteriorated from 97.2% in December 2009 to 93.5% in December 2013. It is also disappointing that the NHS in Scotland performance for the year to September 2014 (the timescale for achieving the 95% interim target) was 93.4%.

20. We acknowledge that 9 of 14 NHS boards met the 95% interim target but request further information from the Scottish Government on how it is supporting the remaining 5 NHS boards to meet this target.

21. The Committee notes that the Scottish Government will review the 95% interim target after September 2014 and we request further information from the Scottish Government on the outcome of that review.

The purpose of A&E waiting time targets

22. The AGS observed that focussing on a specific indicator such as the 95% interim target is not an end in itself but rather an opportunity to look at the whole system.\textsuperscript{14}

23. The Scottish Government echoed this explaining that the target is part of activity around the quality of improvement methods, scrutiny and the delivery of a quality service. They stressed that at no time, however, should the target supersede clinical judgement.\textsuperscript{15} Witnesses also confirmed that the 95% interim target does not measure the clinical appropriateness of those patients being in hospital.\textsuperscript{16}

\textsuperscript{11} Scottish Parliament Public Audit Committee, \textit{Official Report}, 8 October 2014, Col 4
\textsuperscript{13} Data sourced from ISD Scotland at: \url{http://www.isdscotland.org/Publications/index.asp}
24. The Committee heard from NHS Lanarkshire that the target should not be considered in isolation but rather that it is necessary to take a balanced view of the system. As an example NHS Lanarkshire highlighted that whilst its A&E performance against the 95% interim target had room for improvement, its waiting times performance for other specialities outwith A&E such as stroke was very good.17

25. In response to questions about whether the 95% interim target is appropriate the Scottish Government explained that whilst it was challenging, it also provided impetus to improve performance and that—

“it is clear that emergency medicine consultants think that the four-hour target is a good one, which gives the 5 per cent flexibility for those who need to be in A and E for longer.”18

26. The Committee concurs with the AGS that the performance of A&E departments can be an important indicator of pressure on the system as a whole.19

27. The Committee noted that in order for the NHS to meet the 95% interim target in 2012/13, of those who arrived at A&E that year, it would have required to admit or discharge a further 22,852 patients within four hours. The Committee is therefore concerned that without a step change in activity and service redesign by NHS boards, the 98% standard may not be met by the NHS for some time to come.

28. Given its observation that there is a clinical need for 5% flexibility for those patients who need to stay in A&E longer we would ask the Scottish Government to confirm whether the 98% standard remains appropriate and achievable (and if so, by when). We would also request an update from the Scottish Government on the performance of NHS boards against the 98% standard.

Unscheduled Care Action Plan

29. In February 2013, in response to the deterioration in performance the Scottish Government launched the National Unscheduled Care Action Plan (NUCAP). This plan is supported by £50 million funding over 3 years of which £9 million each year will be provided by the Scottish Government whilst NHS boards are expected to invest over £23 million of their cash-releasing savings over the three years. This plan aims to address the challenges NHS boards face in delivering emergency and urgent care.20 It aims to support improvement, transformation and sustainability of unscheduled care performance and complements the Scottish Government's programme for health and social care integration.21

20 Accident and Emergency-Performance update, key message 3 and paragraph 53.
21 Scottish Government written submission, 12 August 2014.
30. Each of the 14 territorial health boards has in turn produced and submitted to the Scottish Government a local unscheduled care action plan (LUCAP).\textsuperscript{22} The Scottish Government is monitoring NHS boards’ progress with the initiatives outlined in their LUCAPs against a range of success measures including reductions in patients waiting longer than four hours and a reduction in A&E attendances.\textsuperscript{23}

31. The Scottish Government outlined a range of actions that had been taken in the first year of the action plan (2013/14) including the recruitment of additional A&E consultants, additional bed capacity over the winter period, the rollout of digital white boards to improve patient flow as well as a number of pilot projects aimed at preventing frail patients attending hospital and improving discharge procedures.\textsuperscript{24}

32. The Scottish Government explained that LUCAPs for 2014/15 are intended to capture a range of proposals related to improving A&E services and that—

"These will be considered by the Programme Governance structure, and where endorsed, will be implemented on a Scotland wide basis where appropriate."\textsuperscript{25}

33. Dr Roelf Dijkhuizen of NHS Grampian also called for a redirection of focus in the NHS in Scotland towards unscheduled care or—

"the front door of our services. The front door of our services is every GP practice in our community, the GP out-of-hours services-the GMED service in Grampian-all the way up to the high dependency unit. Our organisational focus is on waiting times and on elective care-the other side of the health service. There is huge public demand for that-understandably so-but we must be careful, because the most vulnerable people in our society are dependent on access to unscheduled care services and we have not really managed to focus our energy on that."\textsuperscript{26}

34. The Committee welcomes the additional Scottish Government funding provided to support NUCAP. However given the challenging pressures facing the NHS\textsuperscript{27}, we request further information from the Scottish Government on how it expects NHS boards to release £23 million over three years to be reinvested in unscheduled care.

35. The Committee also requests further information as to when, following evaluation of the LUCAPs for 2014/15, it will share with NHS boards good practice on the effective models of A&E services (as recommended by the AGS\textsuperscript{26}).

\textsuperscript{22} Scottish Parliament Public Audit Committee, Official Report, 14 May 2014, Col 2342.
\textsuperscript{23} Accident and Emergency-Performance update, paragraph 53
\textsuperscript{24} Scottish Government written submission, 12 August 2014.
\textsuperscript{25} Scottish Government written submission, 2 June 2014
\textsuperscript{26} Scottish Parliament Public Audit Committee, Official Report, 1 October 2014, Col 18.
36. The Committee also seeks clarification on how the Scottish Government proposes to monitor the sustainability of improvements delivered through LUCAPs.

37. The Committee notes the AGS’s comments that it was too early to comment on the impact of this action plan as significant changes to services will take time to deliver.  

38. The Committee therefore invites the AGS to provide an update when Audit Scotland next reports on unscheduled care on:

- the progress made and the outcomes delivered by NUCAP and the additional Scottish Government funding (£27 million over three years),
- the progress made by NHS boards in delivering local initiatives on unscheduled care and achieving the Scottish Government’s success measures, and
- the extent to which LUCAPs propose action in relation to other services such as GP services.

DEMAND FOR A&E

39. Demand for A&E and MIU combined has risen by 31% over the past 5 years, primarily due to increasing attendances at MIUs which have grown by 34% from 2008/09 to 2012/13. The Committee heard that A&E attendances vary significantly across Scotland, with some A&E departments seeing a significant increase in attendances whilst attendances at others have decreased.

40. The Committee explored with witnesses the key drivers for demand for A&E services including the ways in which patients may access A&E departments.

Referrals to A&E

41. The AGS reported Information Services Division (ISD) data which shows that most people who attend A&E (66 percent) refer themselves (self-referral) whilst GP referrals make up 10% of attendances and NHS 24 referrals make up around 4%. This however varies across A&E departments.

42. The Committee heard that there are however inconsistencies in how A&E departments record self-referral, as—

"some record self-referrals who come in by ambulance as self-referrals, whereas others record them as 999s."

43. In addition GP referral for admission is a new code to the ISD datamart over the past 18 months. The AGS explained that there is ongoing work with boards on

---

29 Accident and Emergency-Performance update, key message 3
30 Accident and Emergency-Performance update, paragraphs 11-13
31 Accident and Emergency-Performance update, paragraph 15
the new code for GP referrals for admission and Audit Scotland would expect to see an improvement in the quality and range of information provided to the datamart over the next few months.

44. The Scottish Government acknowledged that the data was “weak” and was not coded particularly well in the NHS. The Scottish Government also added that—

"we are not good at collecting information from patients about why they made the choice that they made."

45. The Scottish Government explained that the data on sources of referrals to A&E is not routinely collected for publication and so is not subject to the standards and strictures that would apply if it was. That said, the Scottish Government would make clear to NHS Chief Executives that the consistency of data collection on the sources of referrals to A&E must improve.

46. The Scottish Government also confirmed that Information Services Division will carry out additional work with NHS boards to ensure the definitions of ‘self-referral’ and ‘999 emergency services referral’ can be interpreted consistently.

47. The Committee considers it important that NHS boards understand the impact different sources of referrals have on A&E attendances. This demand data can then inform NHS boards’ decision-taking on reducing inappropriate attendances at A&E. It will also provide a starting point for trying to understand why patients make the choices they do about where to seek treatment.

48. The Committee therefore seeks an update from the Scottish Government on the outcome of the work by ISD on the definitions of self-referral and 999 emergency services referral and how it proposes to support NHS boards to collect accurate and robust data on all the sources of referrals to A&E departments.

49. The Committee also requests clarification of what action, if any, the Scottish Government proposes to take to better understand the reasons why self-referral patients make the choice to attend A&E departments.

50. The AGS reports that there is wide variation among NHS boards in the percentage of emergency admissions that go through the A&E department. Overall, around 98 per cent of NHS Ayrshire and Arran’s emergency admissions go through an A&E department compared with 34 per cent in NHS Tayside.

51. Admission rates from A&E to hospital also vary considerably by NHS board. The AGS reported that different approaches were taken to admitting patients who are referred to hospital by their GP with some patients admitted directly to a ward.

---

36 Scottish Government written submission, 7 November 2014
37 Accident and Emergency-Performance update, paragraph 34
or special admitting units whilst other go through A&E before being admitted. Higher admissions from A&E departments are linked to weaker performance against the standard.  

52. GP referrals to A&E departments fall into two categories: GP referrals for A&E treatment; and GP referrals for admission. In 2012/13, GP referrals for A&E treatment made up almost six per cent of A&E attendances and GP referrals for admission made up almost four per cent. GP referrals for admission vary between hospitals and there is some evidence that A&E departments with higher GP referrals for admission perform less well against the 98% standard. The AGS observed that this may be because these patients have more serious health conditions.  

53. The AGS reported NHS Tayside performs consistently well against the 98% standard. The Committee heard from NHS Tayside about its policy of GPs referring patients directly to wards or to special admitting units without first attending the A&E department. In addition, NHS Tayside has had a redirection policy since 1998 whereby at the first point of triage—

“we identify patients who would possibly be better served by seeing a GP, pharmacist or optician. A senior decision maker has a conversation with the patient and, if necessary, redirects them to the correct place.”

54. NHS Tayside explained that this approach has sent the message to the public that A&E is for emergency cases rather than non-urgent cases. Since the HEAT Target T1043 NHS Tayside had seen a reduction in attendances of about 4%. NHS Grampian has also adopted a redirection policy. Since co-locating it’s out of hours service alongside Aberdeen Royal Infirmary it has found that 60% of the patients sent through to its out of hours service did not require to be seen within 16 hours and could be seen the next day.  

55. NHS Tayside explained that through its work on social marketing and redirection, the feedback received was that there is confusion about how to access a GP out of hours, how to access NHS 24 and 111 as well as how quickly calls are responded to.  

56. NHS Tayside was now exploring with GP practices the enhanced multidisciplinary team model and using an electronic tool to help it look at risk and

---

38 Accident and Emergency-Performance update, paragraph 34 and 35  
39 Accident and Emergency-Performance update, paragraph 34-36  
40 Accident and Emergency-Performance update, case study 1  
41 Accident and Emergency-Performance update, paragraph 35  
42 Scottish Parliament Public Audit Committee, Official Report, 1 October 2014, Col 34.  
43 This health target is: To support shifting the balance of care, NHS boards will achieve agreed reductions in the rates of attendance at A&E between 2009/10 and 2013/14. Source: Scottish Government website at: http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/AEattendances  
44 Scottish Parliament Public Audit Committee, Official Report, 1 October 2014, Col 34.  
45 Scottish Parliament Public Audit Committee, Official Report, 1 October 2014, Col 34.  
to share information between health and social care so to provide the right information at the right time to support patients.  

57. NHS Lanarkshire also highlighted its age specialist service emergency team (ASSET) which involves moving hospital care into houses where the patient is cared for at home by visiting health professionals and family. The Scottish Government reported that—  

“according to ASSET's most recent data it has reduced over-75 admissions from 70 to 11 percent.”  

58. The Scottish Government confirmed that it will be carrying out an evaluation of hospitals with GP assessment areas to determine how best to roll this model out. Guidance on the NHS Tayside experience of signposting was issued to NHS boards earlier in 2014. This guidance will now be refreshed in light of the first six to nine month's experience.  

59. The Committee heard about other activity the Scottish Government is undertaking to influence the choices patients make about where to seek treatment. This includes an NHS 24 campaign to be run over winter 2014/15 to help people understand what the most appropriate routes to treatment might be. The role of the Scottish Ambulance Service in attending calls and then in some cases treating patients was also highlighted in evidence to the Committee. In such cases there is no need for patients to attend hospital. The Scottish Government has been speaking with NHS 24 and the Scottish Ambulance Service about what more can be done to assist people to understand where their health concerns can be best treated.  

60. A key part of addressing the pressures on A&E services has to be reducing the number of people who inappropriately attend A&E departments but who could be treated in or redirected to other parts of the health service if these services were available at the time. In that regard, the Committee acknowledges the good practice that goes on in some NHS hospitals to tackle this issue.  

61. We welcome the revised guidance to all NHS boards on redirecting patients (arising from NHS Tayside’s experience). However, we request further information from the Scottish Government on what action it is taking to further encourage NHS boards to review the redirection guidance and implement this policy where appropriate.  

62. We also seek information from the Scottish Government on what NHS Boards are doing to ensure that sufficient capacity exists in other parts of
the health service to support those patients who could be redirected away from A&E.

63. The Committee also requests an update from the Scottish Government on when its evaluation of GP assessment areas will be completed as well as a summary of the outcome of that evaluation.

WAITING IN A&E

64. The AGS reported that the number of patients who waited more than four hours in December 2013 (8,300) is considerably higher than when Audit Scotland last reported in December 2009 (3,659). Similarly the number of patients who waited longer than 12 hours in A&E has also increased from 398 patients in 2008/09 to 1435 patients in 2012/13 albeit that there had been a significant improvement in December 2013 (42 patients) compared with December 2012 (297 patients).

65. In evidence to the Committee, the Scottish Government confirmed that between November 2013 and March 2014 (following introduction of the NUCAP) there was a 66% reduction in patients remaining in A&E for more than 12 hours and less than 1% of all patients remained in A&E for longer than eight hours.

66. The AGS also reported that there was a peak increase across A&E departments in the number of patients who are discharged or admitted just before the four hour target (from 3.3% [45,000] of all attendances in 2008/09 to 5.3% [70,000] of all attendances in 2012/13). The AGS explained that national data does not indicate whether patients are being admitted to hospital inappropriately. Indeed the data shows that 51% of patients admitted in the last 10 minutes stay 3 days compared with 14% of patients admitted in the last 10 minutes who stay one day when the opposite might be expected if patients were being inappropriately admitted to meet the 95% interim target. On that basis, the AGS concluded that it was unlikely that these patients were being inappropriately admitted.

67. The AGS also reported that the median wait across A&E departments has increased from 99 minutes in 2008/09 to 126 minutes in 2012/13. The AGS commented that this increase is “certainly an indicator that there is pressure in the system” which whilst bad for those people who might have been seen in an hour and are now waiting two or three hours “might mean that there is more appropriate triaging and that the care people get is more tailored to their needs.”
68. The AGS report also noted that there “is no evidence that A&E departments with higher admissions in the last ten minutes perform better against the standard.”

69. The most common reasons that NHS boards report for failing to achieve the A&E 98% standard are:

- waiting for a bed;
- waiting for a first full clinical assessment;
- waiting for a specialist.

70. The Committee explores the reasons behind “waiting for a bed” in its next section on admission from A&E.

71. The AGS reports that “wait for a full clinical assessment” accounts for 21% of delays (this has trebled from 6,395 patients in 2008/09 to 20,942 in 2012/13) and that “wait for a specialist” accounts for 10% of delays (this has doubled from 4,580 in 2008/09 to 10,025 in 2012/13).

**Waiting for a full clinical assessment or for a specialist**

72. The AGS explained that delays due to waiting for a first full clinical assessment may be due to issues with patient flow but may also—

“relate to staffing in the A&E department. Fifty per cent of ‘wait for first full clinical assessment’ delays occur between 9 pm and 4 am, peaking at 1 am. NHS boards need to ensure staffing levels are flexible enough to cope with varying demand. Data for A&E medical staffing is available nationally at NHS board level only, so this means we are not able to comment on how staffing levels at A&E departments affect local performance.”

73. The A&E report also highlighted the impact that waiting for the opinion of a doctor in the relevant speciality to which the patient is being admitted can have on waiting time. Waits for this specialist input ranged from 2% of delays at Galloway Community Hospital to 24% at Dr Gray’s hospital.

74. The Committee heard from NHS Tayside that, following analysis of the number of attendances by hour of the day and day of the week, it had redesigned its staff shift patterns to match expected demand. It also successfully made the argument to hospital management—

“that having a senior doctor within the emergency department making a decision early on in a patient’s journey prevents admissions-and, more importantly, unsafe discharges. It also prevents a lot of referrals. When we studied the system, we found that we were effectively reducing referrals from...”
the unit for medical admission by 25 per cent. That has a huge impact for the organisation and a positive impact for the patient."\(^{66}\)

75. It has also ensured that other senior decision makers in the acute medical assessment unit, surgical receiving unit and paediatric receiving unit are available for extended periods over 7 days a week. By taking a whole-system approach, NHS Tayside explained that flow through the A&E department had been improved. It was now investigating how it might extend the hours that other services such as diagnostic services are available across 7 days.\(^{67}\)

76. NHS Grampian explained its innovative approach of using physician assistants to support the day to day care of patients in emergency departments which, whilst not replacing senior decision making, has improved patient flow. This approach also motivates physician assistants and has delivered savings given it is more costly to employ consultants.\(^{68}\)

77. The Scottish Government confirmed that as part of the first year of the NUCAP, it had established the flow programme to improve the way patients move through the health system. New techniques to improve patient flow were also being piloted in four boards including importing from the Institute for Healthcare Optimization the best international experience and advice on how to set up the programme.

78. There are three components to the flow programme:

- better utilisation of operating theatres;
- improving management of the peaks of the elective surgery programme so that it is better able to meet unexpected peaks in unscheduled care;
- managing some of the natural variation in unscheduled care such as the time of day patients are discharged.\(^{69}\)

79. The Committee heard from the Scottish Government that this programme was about sustainable seven-day services to improve access to routine diagnostics at weekends and to get patients discharged at weekends, rather than having to wait until the next week to get those investigations.\(^{70}\)

80. The Scottish Government also highlighted how it was sharing best practice across the NHS through “improvement programmes, using improvement science, the early years collaborative and the person-centred care programme, and we have the learning systems that create the opportunity for practitioners, in particular, to share best practice.”\(^{71}\)

\(^{67}\) Scottish Parliament Public Audit Committee, Official Report, 1 October 2014, Col 20-23.
\(^{68}\) Scottish Parliament Public Audit Committee, Official Report, 1 October 2014, Col 7.
\(^{71}\) Scottish Parliament Public Audit Committee, Official Report, 8 October 2014, Col 25.
81. The Scottish Government recognised that there has been variable uptake across NHS hospitals of protocols that allow senior A&E staff to admit patients directly to hospital. NHS boards have therefore been asked, as part of their development of LUCAPs for 2014/15, to construct capacity management plans and promote speciality flow for each hospital. The Scottish Government considers this will—

“ultimately provide greater autonomy locally for senior hospital staff to make appropriate decisions.”

82. The Committee agrees with witnesses that a key part of improving patient flow in A&E is ensuring the early input from experienced medical staff. The evidence from NHS Tayside is that this approach ensures that the right type of care is provided quickly and it also prevents inappropriate admissions and discharges.

83. The Committee, however, notes witness comments regarding the standard practice of weekday working in some parts of the hospital service. We seek further information from the Scottish Government on how it is supporting NHS boards to address this challenge and to move towards a pattern of working which better supports more effective patient treatment and better patient flow.

84. Given the variable uptake across the NHS of protocols which allow senior A&E staff to admit patients to hospital, we also recommend that the Scottish Government monitor the implementation of capacity management plans and speciality flows by NHS boards to determine whether uptake improves.

Medical workload tool

85. There was some debate in the Committee about the extent to which mortality in A&E departments may be higher at weekends compared with weekdays. Whilst a number of different studies were cited and different views provided on the conclusions reached in those studies one issue highlighted was the need for further research to be undertaken especially in relation to the case mix or severity of illness of patients attending A&E.

86. Professor Fergusson of NHS Grampian explained that “We know that people are more likely to die if they go into hospital at the weekend—there is good evidence to suggest that”. He added later that mortality rate is a marker of how effective the system is and not a measure of clinical appropriateness.

87. In evidence Professor Leitch from the Scottish Government confirmed that “there is an increase in mortality rates at the weekend, compared with weekdays.” However he observed that “the difficulty is that nobody measures

---

72 Scottish Government written submission, 2 June 2014
73 Accident and Emergency-Performance update, case study 1
76 Scottish Parliament Public Audit Committee, Official Report, 1 October 2014, Col 20 and 27.
severity of diagnosis so nobody knows how sick the patients are when they arrive.\textsuperscript{78} In this regard he observed that the increase in weekend mortality could be due to those patients being sicker or with more complex health issues, there being more trauma or due to greater alcohol use on Fridays and Saturdays.\textsuperscript{79}

88. The AGS highlighted that more generally there is some evidence that A&E patients have more serious conditions than in previous years and more older people are attending. However there are limitations in the data held on case complexity and the length of patient stay -referred to as “patient flow”- due to the differing methodologies used by A&E departments to record patient flow.\textsuperscript{80}

89. The Scottish Government explained that an emergency medical workload tool was being piloted with a number of boards and it was planned to roll it out on a national basis in 2015. The tool would be used by all A&E staff to help plan staffing levels but also as a means of managing workload as it will measure—

“not just the volume of patients coming through the door, but the case mix and the severity of the conditions from which those patients are suffering.”\textsuperscript{81}

90. The Committee agrees with the Scottish Government that patient safety in A&E departments is important 7 days a week. We therefore request further information from the Scottish Government on what action it is taking to understand A&E case mix and mortality rates. In particular we would welcome information from the Scottish Government on:

- the extent to which the medical workload tool will contribute to a better understanding of case mix and mortality rates in A&E and in hospitals more generally; and

- what support it is providing NHS boards to improve the consistency in the methodologies they use to measure patient flow.

91. The Committee would also welcome further clarification of how the Scottish Government will ensure that the data collected through the workload tool is collected on a consistent basis to enable comparisons across NHS hospitals.

Staffing in A&E

92. NHS Grampian elaborated on the impact of available staffing on patient flow—

“the earlier you get a senior clinical opinion of the patient when they present at hospital, the more likely you are to make the right decision early in the journey and get the patient to the right doctor and facility. Having a senior opinion early on in the pathway is very important in reaching the four-hour target, and if you


\textsuperscript{80} Accident and Emergency-Performance update, paragraph 25

are finding it difficult to recruit people who can give a senior opinion, you will be at risk of delaying the assessment.”

93. The AGS reported that the number of emergency medicine consultants in post across NHS boards has increased by 63% from 94.8 WTE posts in September 2009 to 154.5 WTE posts in September 2013. More recently ISD confirmed to the Committee that, as of 30 June 2014, 20.5 emergency consultant vacancies were unfilled from a total establishment of 184.1.

94. The number of emergency medicine doctors in training has however fallen from 347.7 WTE in September 2009 to 300.0 in September 2013. This, the AGS commented, partly reflects the change towards services being delivered by fully trained doctors.

95. The Committee heard that there were a number of factors contributing to the difficulties in recruiting senior A&E staff including that A&E was less attractive to senior medical trainees with only a 29 per cent fill rate for senior trainees going into the speciality.

96. NHS Tayside observed that this problem with training positions was not evident at the beginning of training, but down to attrition rates during the training. The Committee heard that as part of Modernising Medical Careers, introduced across the UK in 2006/07, trainees were being asked to make decisions early on about which specialities to go into so as to better match consultants with vacancies. NHS Tayside observed that this meant that—

“People come into A and E as a junior trainee. They work fairly intense rotas, with lots of out-of-hours shifts and night shifts. As part of their initial training, they then go on to other specialties, which are slightly less intense. They might think that they have seen the middle graders and consultants in A and E working quite hard, and they might not be sure that that is how they want to work.”

97. Witnesses agreed that other aspects of the A&E department working environment can also deter senior trainees. One example given was that during their training, trainees learn to treat patients with immediate ailments but then find that in reality these skills are not fully utilised in A&E as it “acts as the safety net for anything that falls between the healthcare cracks in the region.”

---

83 Scottish Government written submission, 7 October 2014
84 Accident and Emergency-Performance update, paragraph 46
86 Modernising Medical Careers is a programme for postgraduate medical training introduced in the United Kingdom in 2005. The programme replaced the traditional grades of a medical career before the level of consultant.
98. In that regard NHS Tayside explained that improving flow through A&E
departments and reducing crowding will improve job satisfaction and staff retention
as trainees see that they will deliver the care that they were trained to deliver.  

99. The Committee heard of the different approaches which have been
successful in NHS Tayside in recruiting and retaining A&E consultants. This
included improving its A&E environment by defining its A&E service: what it is
there to do and what it is not there to do. NHS Grampian is seeking to adopt this
approach to encourage people to work to their skills and improve recruitment and
retention.

100. NHS Tayside had also better matched its consultants’ working patterns to
patient demand. This approach was agreed with hospital management and led to
a more collaborative working environment where —

“Our trainees see that we have a jointly owned model, in that our executive
team buy into what we do and recognise that the four-hour target is a
measurement of the system, not just of the department. The doctors see that,
and they want to come and work there.”

101. The Scottish Government confirmed that it is working with the NHS to ensure
relevant information on staffing levels and skill mix in A&E is available to inform
boards’ workforce decisions. A review of the available data sets should be
completed by September 2014.

102. The Scottish Government also confirmed that postgraduate medical training
has been the subject of a review (the Greenaway review). That review had
concluded that more generalist doctors are better able to treat an ageing
population and the increasing numbers of people with multimorbidities. The
Scottish Government explained—

“we are in a transition period, because we are beginning to explore how we
might implement the Greenaway review... That would offer benefits not only to
the NHS in providing a more flexible medical workforce, but to the trainee
doctors in that they would be recruited to broad-based training schemes
involving groups of conditions-such as women and children’s health-the training
would bridge primary and secondary care, and there would be more
opportunities for them to opt out of one particular course of training if they
thought that it would not suit them. Therefore, there would be more flexibility in
the workforce that we produced for the NHS and more flexibility for doctors,
because they would not be locked into a specialist route.

103. A UK steering group had been established and a number of stakeholder
events are currently being held, the views from which will inform the Scottish
Government’s decision about how the Greenaway report should be implemented
in Scotland.

---

91 Scottish Government written submission, 2 June 2014
104. The Scottish Government also confirmed that it is working with NHS boards and the Royal Colleges on ways to improve recruitment and is considering the need for extended roles within a range of professions (e.g. nursing, paramedics, Allied Health Professionals) with associated decision support aided by new technology.\(^93\)

105. The Committee notes that a decision has yet to be taken on how the Greenaway review outcomes are to be implemented. The Committee would therefore request an update from the Scottish Government on how it proposes to implement the Greenaway review recommendations once that decision has been reached. In particular it would seek clarification of how its proposals for implementation will improve the recruitment and retention of postgraduate medical trainees in A&E.

106. The Committee notes that work by the NHS and Scottish Government on skills and staffing levels in A&E was due for completion in September 2014. We therefore request an update on the outcome of this review, and confirmation of the timescale when benchmarking information and guidance on staffing and skills sets for A&E departments will be made available to boards.

107. We would also welcome further information on the work being undertaken with boards and the Royal Colleges to improve recruitment as well as the work on extended roles, including when the outcome of these considerations is expected.

Financial incentives

108. NHS Grampian highlighted the detrimental impact on recruitment in Scotland of the financial incentives offered to consultants elsewhere such as in England. Scotland cannot compete with such incentives as it has agreed national terms and conditions, national agreements and national pay rates for consultants. In Scotland, a variation order has to be obtained from the Scottish Government in order to alter the terms of the national pay agreement.

109. Witnesses\(^94\) did not advocate providing such an incentive given this simply moves recruitment difficulties from one specialty to another. However the impact of the national contract in deterring service redesign was highlighted by NHS Grampian. It ran a successful pilot of a paediatric unscheduled care service, whereby consultants were available by video conference to remote and general hospitals. However NHS Grampian was not able to obtain a variation order to alter the pay made to those consultants who participated in the pilot. As a result it had to come up with an inventive way to pay those consultants through NHS Tayside.\(^95\)

110. NHS Tayside also expressed concerns that the national contract did not reflect the current changes in working conditions for newly qualified A&E consultants who are often asked to work night shifts and weekends. It was suggested that such consultants may question whether they were being fairly

\(^93\) Scottish Government written submission, 12 August 2014
\(^95\) Scottish Parliament Public Audit Committee, Official Report, 1 October 2014, Col 11.
remunerated given they receive the same rate as other consultants who are on call at home.\textsuperscript{96}

\textbf{111. The Committee requests information from the Scottish Government on the extent to which it considers the national contract adequately recognises the changing working conditions of consultants, particularly those working in A&E and supports service redesign by enabling innovative working practices to be adequately rewarded.}

\textbf{ADMISSION FROM A&E}

112. The AGS reported that 27\% of all patients attending A&E are admitted to hospital for further care\textsuperscript{97} with performance against the waiting time standard tending to be better for A&E departments that have lower admissions from A&E to hospital. Patients who needed to be admitted wait longer in A&E than those who are treated and discharged home.\textsuperscript{98}

113. The AGS reported that—

“there is no simple explanation for why more patients are now waiting more than four hours in A and E. A and E departments are part of a much bigger health and social care system and pressures across that system can lead to patients being delayed in A and E. For example, many A and E patients need to be admitted to hospital and delays can be down to a hospital bed not being available right when it is needed. That might be because another patient is waiting to be discharged from hospital later in the day and so is still occupying the bed that the new patient requires.”\textsuperscript{99}

114. In 2012/13, around 38\% of delays were reported as “wait for a bed”, up from 25\% in 2008/09.\textsuperscript{100}

115. The Committee explored with witnesses the reasons why patients may have to wait longer in A&E for a bed.

\textbf{Bed occupancy}

116. The Committee heard of a range of factors that can reduce the overall number of beds available to be occupied by A&E patients including ward closures due to seasonal illnesses such as norovirus as well as the overall reduction in the number of acute beds. Most NHS boards highlighted bed occupancy and the challenges of having enough beds available at the right time to meet demand as a significant pressure in the 2013/14 LUCAPs.\textsuperscript{101}

117. The AGS confirmed that the number of acute beds had been reduced by 7\%, from 17,374 in 2008/09 to 16,223 in 2012/13, mainly in acute surgery as more
surgery was being delivered on a day-case basis. The average occupancy rate of acute hospital beds has increased from 82.1 to 83.5% over the same period, although this varies by different specialities and at different times. In acute medicine, the average occupancy rate in 2012/13 was 85%. These are often the wards to which patients from A&E need to be admitted to. In addition, in 2012/13, six NHS boards had an average occupancy of over 85%. The AGS reported that NHS boards with lower average occupancy rates were more likely to perform better against the 98% standard.\(^\text{102}\)

118. The Scottish Government highlighted that the first year of NUCAP (2013/14) had seen action taken to provide additional bed capacity to manage the surge in demand for beds over the winter period.

119. The Committee notes from the AGS report that research suggests that occupancy rates higher than 85% can carry risks. For example, hospitals could experience bed shortages at these times and this can have an effect on the quality and safety of patient care.\(^\text{103}\) The Committee requests further work is undertaken by the Scottish Government on the availability of beds and occupancy rates.

120. Whilst we welcome the provision, through the NUCAP, of additional bed capacity during winter 2013/14, we request an update from the Scottish Government on what support it is providing to NHS boards to manage bed occupancy throughout the year.

Delays in discharging patients

121. The AGS reported that the process that hospitals have for discharging patients from wards also affects A&E performance. Attendances at A&E departments are highest on Mondays and Tuesdays with delays due to people waiting for a bed more likely on these days, since fewer inpatients are discharged at weekends. Discharges from hospital generally take place in the afternoon with “wait for a bed” delays highest at 6 pm.\(^\text{104}\)

122. The AGS explained that afternoon discharges would have an effect on those who arrive at A&E departments in the morning. For example, the 4 hour standard or target would not be met where an A&E patient arrives at 9 am, is assessed as requiring admission to a bed but which does not become available until 2 pm.\(^\text{105}\)

123. The Committee also heard that there is also an issue with patients remaining in beds who are considered as no longer requiring clinical care, but who cannot be discharged as they are waiting for support from local community services such as complex care packages, home care or adaptation to housing.

124. NHS Lanarkshire confirmed that on a typical week it can have 219 such patients waiting on discharge. It explained that it had established an integrated

---
\(^{102}\) Accident and Emergency-Performance update, paragraphs 39-41
\(^{103}\) Accident and Emergency-Performance update, paragraph 40
\(^{104}\) Accident and Emergency-Performance update, paragraph 43
\(^{105}\) Scottish Parliament Public Audit Committee, Official Report, 14 May 2014, Col 2339 and 2440.
discharge hub in each of its hospitals so that the discharge process is not either a social work or a health event.\(^{106}\)

125. NHS Tayside, seen as a model of good practice, also faced similar issues with typically 90-110 such patients waiting for further support in the community.\(^{107}\) It also had established integrated discharge hubs and enhanced recovery to try and speed up the discharge process but that it—

“often came down to the availability of specific care in quite small locations to provide the care.”\(^{108}\)

126. The Scottish Government identified some of the barriers to discharging patients early can be the availability of adjustments to be made at home and the availability of necessary medicines (and support on how to use them at home). In that regard the Scottish Government project to support greater 7 day working across hospitals includes the links with social care staff.\(^{109}\)

127. The Scottish Government explained that years two and three of the NUCAP will focus on sustaining improvement but also whole system approaches—

“creating local Community Partnerships where hospitals and primary/community care services are aligned... in line with our approach to integration of health and social care.”\(^{110}\)

128. In that regard the Scottish Government highlighted that Integrated Authorities, established in 2015/16 will work to ensure the transition into and out of hospital is smooth and timely. Integrated Authorities will also work to reduce preventable attendances at A&E and hospital admissions. In 2014/15, £7.5 million has been provided by the Scottish Government to support the work required to establish these Integrated Authorities.

129. The Scottish Government also explained that it had been encouraging boards to consider the discharge hub at NHS Fife, following its successful launch, to see how their processes could be improved. More recently NUCAP has had a strong focus on effective and appropriate time or day and weekend discharge processes.\(^{111}\)

130. The Committee recognises that delays in discharging patients not only affects the patients concerned but also impacts on the whole system including increasing the time patients may wait in A&E for a bed.

131. It is therefore important that those patients, who may require further support in the community in order to be discharged, are identified early and appropriate support made available. This relies on health and social care services working effectively together. The Committee would therefore seek

\(^{106}\) Scottish Parliament Public Audit Committee, Official Report, 1 October 2014, Col 16.
\(^{109}\) Scottish Parliament Public Audit Committee, Official Report, 8 October 2014, Col 31 and 32.
\(^{110}\) Scottish Government written submission, 12 August 2014
\(^{111}\) Scottish Government written submission, 2 June 2014
further information from the Scottish Government on the relationship between the initiatives and priorities set out in LUCAPs by NHS Boards and the priorities agreed by Integrated Authorities.

132. The Committee also reiterates its comments at paragraph 83 regarding action to deliver extended and 7 day hospital services, where appropriate.
ANNEXE A: EXTRACT FROM THE MINUTES OF THE PUBLIC AUDIT COMMITTEE

11th Meeting, 2014 (Session 4) Wednesday 14 May 2014

Section 23 report - Accident and emergency - Performance update: The Committee took evidence on the Auditor General for Scotland report entitled "Accident and Emergency - Performance update" from—

Caroline Gardner, Auditor General for Scotland; Tricia Meldrum, Senior Manager, and Catherine Young, Project Manager, Audit Scotland.

The Committee agreed to receive written evidence from Audit Scotland on issues raised in discussion.

Section 23 report - Accident and emergency - Performance update (in private): The Committee considered the evidence received at agenda item 3 and took evidence from—

Caroline Gardner, Auditor General for Scotland.

The Committee agreed to write to the Scottish Government on issues raised in discussion.

13th Meeting, 2014 (Session 4) Wednesday 11 June 2014

Section 23 report - Accident and Emergency: Performance update: The Committee considered its approach to correspondence received by the Scottish Government and Audit Scotland on the Auditor General for Scotland's report entitled "Accident and Emergency: Performance update". The Committee agreed to seek oral evidence from the NHS Boards and the Scottish Government Accountable Officer on issues raised in discussion.

15th Meeting, 2014 (Session 4) Wednesday 1 October 2014

Section 23 report - Accident and Emergency - Performance update: The Committee took evidence on the Auditor General for Scotland report entitled "Accident and Emergency - Performance update" from—

Dr Roelf Dijkhuizen, Medical Director, and Professor James Ferguson, Consultant in Emergency Medicine, NHS Grampian; Ian Ross, Chief Executive, and Alan Lawrie, Director of Acute Services, NHS Lanarkshire; Lorna Wiggin, Director of Acute Services, and Shobhan Thakore, Consultant in Accident and Emergency, NHS Tayside.

The Committee agreed to seek further written evidence from NHS Boards on issues raised in discussion.
Section 23 report - Accident and Emergency - Performance update: The Committee considered the evidence received at Agenda item 2 and took evidence from—

Angela Canning, Assistant Director; Tricia Meldrum, Senior Manager, and Catherine Young, Project Manager, Audit Scotland.

16th Meeting, 2014 (Session 4) Wednesday 8 October 2014

Section 23 report - Accident and Emergency - Performance update: The Committee took evidence on the Auditor General for Scotland report entitled "Accident and Emergency - Performance update" from—

Paul Gray, Director General Health & Social Care and Chief Executive NHS Scotland, John Connaghan, Director for Health Workforce and Performance, John Matheson, Director Finance, eHealth and Pharmaceuticals, Professor Jason Leitch, Clinical Director, The Quality Unit, and Dr Aileen Keel, Acting Chief Medical Officer, Scottish Government.

Section 23 report - Accident and Emergency - Performance update (in private): The Committee considered the evidence received at Agenda item 2 and took evidence from—

Caroline Gardner, Auditor General for Scotland; Angela Canning, Assistant Director, Tricia Meldrum, Senior Manager, and Catherine Young, Project Manager, Audit Scotland.

The Committee agreed to request written evidence from the Scottish Government on issues raised in discussion and to consider a draft report, in private, at a future meeting.

19th Meeting, 2014 (Session 4) Wednesday 3 December 2014

Consideration of draft report (in private): The Committee agreed various changes to the report as well as the arrangements for agreeing final changes. The Committee then agreed the arrangements for publication of the report.
ANNEXE B: ORAL EVIDENCE AND ASSOCIATED WRITTEN EVIDENCE

Please note that all oral evidence and associated written evidence is published electronically only, and can be accessed via the Public Audit Committee’s webpages, at:
http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/29860.aspx

11th Meeting, 2014 (Session 4) Wednesday 14 May 2014

ORAL EVIDENCE
Caroline Gardner, Auditor General for Scotland; Tricia Meldrum, Senior Manager, and Catherine Young, Project Manager, Audit Scotland.

15th Meeting, 2014 (Session 4) Wednesday 1 October 2014

ORAL EVIDENCE
Dr Roelf Dijkhuizen, Medical Director, NHS Grampian; Professor James Ferguson, Consultant in Emergency Medicine, NHS Grampian; Ian Ross, Chief Executive, NHS Lanarkshire; Alan Lawrie, Director of Acute Services, NHS Lanarkshire; Lorna Wiggin, Director of Acute Services, NHS Tayside, and Shobhan Thakore, Consultant in Accident and Emergency, NHS Tayside.

Angela Canning, Assistant Director, Audit Scotland; Tricia Meldrum, Senior Manager, Audit Scotland and Catherine Young, Project Manager, Audit Scotland.

16th Meeting, 2014 (Session 4) Wednesday 8 October 2014

ORAL EVIDENCE
Paul Gray, Director General Health & Social Care and Chief Executive NHS Scotland, John Connaghan, Director for Health Workforce and Performance, John Matheson, Director Finance, eHealth and Pharmaceuticals, Professor Jason Leitch, Clinical Director, The Quality Unit, and Dr Aileen Keel, Acting Chief Medical Officer, Scottish Government.

Caroline Gardner, Auditor General for Scotland; Angela Canning, Assistant Director, Audit Scotland; Tricia Meldrum, Senior Manager, Audit Scotland, and Catherine Young, Project Manager, Audit Scotland.

WRITTEN EVIDENCE

- Scottish Government to the Public Audit Committee, dated 07 November 2014 (187KB pdf)
- Public Audit Committee to the Scottish Government, dated 13 October 2014 (120KB pdf)
- Scottish Government to the Public Audit Committee, dated 07 October 2014 (128KB pdf)
• NHS Lanarkshire to the Public Audit Committee, dated 15 September 2014 (129KB pdf)
• Scottish Government to the Public Audit Committee, dated 12 August 2014 (139KB pdf)
• Scottish Government to the Public Audit Committee, dated 02 June 2014 (208KB pdf)
• Auditor General for Scotland to the Public Audit Committee, dated 30 May 2014 (101KB pdf)
• Public Audit Committee to the Scottish Government, dated 15 May 2014 (146KB pdf)
Members who would like a printed copy of this Numbered Report to be forwarded to them should give notice at the Document Supply Centre.

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by APS Group Scotland

All documents are available on the Scottish Parliament website at:

www.scottish.parliament.uk

For details of documents available to order in hard copy format, please contact:

APS Scottish Parliament Publications on 0131 629 9941.

For information on the Scottish Parliament contact

Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@scottish.parliament.uk