The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 2 December 2015

Session 4

Wednesday 2 December 2015

CONTENTS

PUBLIC AUDIT COMMITTEE
20th Meeting 2015, Session 4

CONVENER

*Paul Martin (Glasgow Provan) (Lab)

DEPUTY CONVENER

*Mary Scanlon (Highlands and Islands) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Nigel Don (Angus North and Mearns) (SNP)
*Colin Keir (Edinburgh Western) (SNP)
*Stuart McMillan (West Scotland) (SNP)
*Tavish Scott (Shetland Islands) (LD)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*David Torrance (Kirkcaldy) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Nick Bennett (Scott-Moncrieff)
Stephen Boyle (Audit Scotland)
Caroline Gardner (Auditor General for Scotland)
Fraser McKinlay (Audit Scotland)
Michael Oliphant (Audit Scotland)
Kenny Wilson (PricewaterhouseCoopers)

CLERK TO THE COMMITTEE

Anne Peat

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Public Audit Committee

Wednesday 2 December 2015

[The Convener opened the meeting at 09:31]

Decision on Taking Business in Private

The Convener (Paul Martin): Good morning. I welcome members of the press and public to the 20th meeting in 2015 of the Public Audit Committee and I ask everyone present to ensure that their electronic items are switched to flight mode so that they do not affect the committee's work.

Agenda item 1 is a decision on taking business in private. Do members agree to take agenda items 5 and 6 in private?

Members *indicated agreement.*

Section 23 Report

"NHS in Scotland 2015"

09:31

The Convener: Agenda item 2 is on the section 23 report "NHS in Scotland 2015". I welcome Caroline Gardner, the Auditor General for Scotland; and from Audit Scotland Fraser McKinlay, director of performance audit and best value; Tricia Meldrum, senior manager; and Michael Oliphant, project manager. I understand that Caroline Gardner has a short opening statement to make.

Caroline Gardner (Auditor General for Scotland): Good morning. Fraser McKinlay will lead the briefing session on my behalf, so I hand over to him.

Fraser McKinlay (Audit Scotland): Good morning. Members have in front of them our annual overview report on the national health service in Scotland, which looks at the performance of health boards and comments on the many challenges and pressures that the NHS faces. It also looks ahead and assesses what progress the Scottish Government is making towards its 2020 vision of enabling everyone to live longer, healthier lives at home or in a homely setting.

The NHS continues to be one of our most valued public services. It delivers a wide range of high-quality healthcare services to thousands of people across Scotland every day, but it will come as no surprise to the committee that the NHS system is under significant pressure. Our report highlights tighter budgets, rising costs, increasingly demanding performance targets and greater demands on its services. In recent years, the cost of delivering health services has increased significantly, and that has coincided with a period of constrained public finances. Together, those pressures signal that fundamental changes and new ways to deliver healthcare in Scotland are required now.

Spending by health boards was £11.4 billion in 2014-15. That accounts for around a third of Scotland's total budget. Overall, we found that boards managed their finances well, given the scale of the pressures that they face, and that they ended the year with a very small underspend of around £10 million. However, many boards relied on one-off savings, and two boards required extra financial support from the Scottish Government to break even.

Our report highlights that all territorial boards, which are those that deliver the front-line services,

"are finding it increasingly difficult to meet performance targets and standards",

and that

"The national performance against seven out of nine key targets and standards has deteriorated in recent years."

It says:

"Ongoing financial pressures, combined with greater activity and demand, made achieving targets and standards more difficult."

The report also says:

"The number of people working in the NHS in Scotland is at its highest level",

but

"The ability to attract, recruit and retain medical professionals"

on a permanent basis

"is one of the biggest challenges facing the NHS today."

The reasons for the difficulties include the rural location of some boards, competition between boards for special staff, and greater demand from staff for more flexible working arrangements. Our report highlights that boards are

"hiring more temporary staff to help keep services running",

but that that approach

"is increasingly expensive and only provides a short-term solution. In 2014/15, NHS boards spent £284 million on temporary staff, an increase of 15 per cent"

on the previous year.

Looking ahead, we found that the Scottish Government has not made sufficient progress towards achieving its 2020 vision. There is some evidence of new approaches to delivering healthcare, but it is unlikely that all the necessary changes will be in place by 2020. The Scottish Government plans to continue working towards the vision and has launched a national conversation on the future of healthcare in Scotland. However, there is a need for a clear change in pace if the Government's ambitions are to be realised within the set timescale.

We make a number of recommendations in the report, which focus on improvements that the Scottish Government and boards should make as they continue to work towards longer-term ambitions for healthcare in Scotland.

Finally, members will recall that in December last year the committee published its own report on accident and emergency and invited the Auditor General for Scotland to provide an update on A and E by the end of this year. We have therefore brought a briefing paper on A and E, which shows that performance against the A and E waiting time target deteriorated over the winter of 2014-15 but then improved over the summer. However, some NHS boards are still not meeting the target, and the NHS is now moving into the more challenging winter period—although, judging by the weather, I think that we are probably there already. Since the Auditor General last reported, the Scottish Government has implemented a better and more structured approach to improving unscheduled care and sharing best practice.

As always, the team and I are very happy to answer the committee's questions. Thank you.

The Convener: Thank you.

I will open the questions for the Auditor General. I refer you to paragraph 50 of the report, where you advise us that there is an increasing reliance on the use of the private sector to meet performance targets. Can you give us specific examples of how companies in the private sector have been used?

Caroline Gardner: Certainly. As the report says, we have seen the private sector being used for two main reasons. One is to ensure that waiting times targets are being met as far as possible, and the other is to provide special services that are not otherwise available in the NHS. Michael Oliphant will give you some specific examples.

Michael Oliphant (Audit Scotland): The private sector is used to increase short-term capacity, particularly where boards need to get access to specialist treatment. Quite often, that is for a small number of cases that are highly complex or for individuals who require complex care, perhaps with a higher ratio of carer to patient. The cases can have complex rehabilitation requirements or severe mental health issues, and they tend to involve spend on smaller specialist hospitals, such as Huntercombe hospital in Edinburgh or the Murdostoun brain injury rehabilitation and neurological care centre in Wishaw. That is where a lot of that spend goes.

The Convener: How specific is that? You are saying that, in general terms, that is the way that it has been brought forward. Is public sector capacity in the NHS available that is not being used while the private sector is being pulled in to meet the targets?

Michael Oliphant: An element of the private sector spend is used for short-term capacity issues to help meet waiting times. That can involve private sector organisations using facilities over the weekend and patients using private sector facilities themselves. However, most of the spend is for the specialist treatment that is required in very complex cases. The NHS will be able to provide some element of support and care for those cases, but the private sector helps out with increasingly complex cases.

The Convener: You said that the Government is failing to meet the 2020 vision targets that have been set. Will you give us some specific examples of that and the lack of direction of travel that you have set out?

Caroline Gardner: I think that it is primarily a question of pace. I ask Fraser McKinlay to pick up the specifics on which we based that conclusion.

Fraser McKinlay: As you will know, the 2020 vision is all about ensuring that people can have care in a home setting. When we look at the evidence across the system, we see some pockets of good practice in that area, but not at the kind of scale and pace that we need. In particular, resources are not being shifted from acute services in hospitals—dealing with people when they walk through the door at A and E and other places—into the community in a big enough or fast enough way. That is the main point.

The Convener: Does a political decision need to be taken, or is it a management decision on the part of various boards?

Fraser McKinlay: The report tries to set out the fact that the Government has a lot of things under way that are designed to help the situation, including the integration of health and social care. We are publishing a report tomorrow that will come to the committee in a couple of weeks. It will update the committee on progress on the integration of health and social care.

Politically and managerially, the Government is putting in place things to help the transition. However, given the ambition of the vision, achieving it by 2020 is looking extremely challenging. The Government is now looking beyond the 2020 vision. It has started the national conversation, which is about looking to the 10 or 15-year period beyond that. We expect to see some stuff coming out of that by next spring. However, the national conversation is not going to fix the issues or deal with the pressure that we are experiencing at the moment.

Mary Scanlon (Highlands and Islands) (Con): To be fair, "looking extremely challenging" is a bit of an understatement. When I read the report, I thought that the situation was looking very depressing.

Having been in the Scottish Parliament since 1999, I noted that the recommendations on page 6 were the same recommendations that I read in 1999 or 2000, when Richard Simpson and I were on the Health and Community Care Committee. We are seeing exactly the same things. Boringly, I read the report from beginning to end. I was looking for a few gems of progress, but there was nothing there.

I am sorry to strike a depressing tone, but exhibit 3 on page 19 says:

"The national performance has declined in seven of the nine key waiting time targets".

I find that deeply worrying. The following page shows that the worst decline was in child and adult mental health services and that the health board that meets the least targets is NHS Grampian. It is no coincidence that that is the poorest funded board in terms of the NHS Scotland resource allocation committee funding formula—I think that its funding is more than 2 per cent less than it should be. Is there a direct correlation between that lack of funding and the fact that it is unable to meet so many targets?

The other point that stood out to me concerned CAMHS in Tayside, where there was a reduction in targets met from 79.9 per cent last year to 35 per cent this year. We all know that investment in mental health in children saves thousands if not millions of pounds in adulthood, so it is worrying that we are missing that window of opportunity in children. What does Audit Scotland do in these circumstances? We can understand 1 per cent or 2 per cent changes happening from year to year, but a change from 79 per cent to 35 per cent is deeply distressing and worrying. What do you do with serious outliers like that? What should we be doing? What should NHS Tayside be doing? What should the Government be doing?

Fraser McKinlay: I think that you have set out the people who should be doing things in reverse order. Clearly, the board has the primary responsibility for improving performance against targets. It is worth saying that the overall performance around CAMHS—you will see that a number of those services took a dip this year—is partly due to a more challenging target being set for the time that someone has to wait. Michael Oliphant might have some specifics on the Tayside number.

Mary Scanlon: The national figure is 81 per cent, which is pretty poor, but 35 per cent has to be pretty worrying.

Michael Oliphant: By way of comparison, in paragraph 47, we talk about the target becoming tougher during 2014-15. The comparable figure to the Scotland figure for the CAMHS target that you see in exhibit 4 is 88 per cent. That means that there is still a decrease, but it is not the same as it would be if the figure was 81 per cent.

09:45

Mary Scanlon: Okay. We are talking about the NHS—

Fraser McKinlay: I was going to ask my colleagues whether we have the specifics of the Tayside team. Do we?

Michael Oliphant: No, not in this report.

Fraser McKinlay: We can have a look at that, Mrs Scanlon. In answer to your question about what should be done, as I am sure that you are aware, all the HEAT—health improvement, efficiency and governance, access and treatment—targets are managed closely both within boards and within the Scottish Government. When there is such a performance dip, we would expect a plan to be put in place to turn around the situation. We will see what we can do to find out a bit more about that.

Mary Scanlon: Will you ask NHS Tayside what it is doing to address that very worrying situation?

Fraser McKinlay: Yes.

Mary Scanlon: Okay. I have two questions that I have asked when you have been here previously. I tend to keep a bit of an eye on sickness absence rates. I was surprised that the Scottish Ambulance Service has the highest rate. Its rate has been consistently high over a period—the information is in paragraph 67 on page 29. For many years, the Ambulance Service's rates have been higher than those of other service in the NHS apart from, I think, NHS 24. Why is its rate above 7 per cent? Why is the Ambulance Service such an outlier?

I will ask about another favourite topic of mine, which the committee has asked you about quite often: backlog maintenance. I direct you to paragraph 95 on page 39. Despite all the assurances that it would be addressed, it is pretty disappointing that the backlog maintenance requirement is £797 million. We are most concerned about backlog maintenance with significant risk, which accounts for 35 per cent of the total amount, or £279 million.

I think that I am right in saying that "significant risk" refers to risk to not just staff but patients. We have a requirement of about £280 million for backlog maintenance with significant risk. Why is that figure still so high, given all those assurances? Will you define, for my memory, what "significant risk" means in terms of health and safety?

Fraser McKinlay: I will answer your question about sickness absence first. We cited high levels of musculoskeletal complaints as the main reason for the high rate. That is about how ambulance service staff have to work and the unique demands that are put on them. As you say, the rate seems to be stubbornly high, and we would expect the board to continue to look at ways of mitigating that. At the same time, we need to accept that working as a paramedic or in ambulances is a very physically demanding job.

You are absolutely right, and you make an interesting point about the similarity of the recommendations that we have made over the years. On the one hand, we make no apology for that—we will keep plugging away and making the same points—

Mary Scanlon: It was not a criticism.

Fraser McKinlay: I know, and I did not take it as such. Those issues are very important to us and they are becoming even more important.

There have been areas of progress and improvement. If we look back over the period, we see that waiting times, for example, are better now. More recently, we see a squeeze and all the pressures to which we refer. A significant pressure is, undoubtedly, backlog maintenance. It is a classic case of spinning lots of plates at once. As we mentioned in the report, we are investing in new assets, buildings and hospitals to make them more fit for purpose in a 21st-century health service. At the same time, we are dealing with increasing demand, rising costs and making inroads into backlog maintenance.

I am not absolutely sure about the "significant risk" question, so I will ask Michael Oliphant whether he can help with a definition of that. If not, we will come back to you with one.

Michael Oliphant: I do not have a definition to hand. The Scottish Government publishes the details as part of its assets and facilities report. I think that the next one is due out early next year, if the timeline is the same as it has been for previous years.

Mary Scanlon mentioned the figure of £279 million for backlog maintenance that is considered to be significant risk. Of that figure, £80 million relates to properties that are expected to be disposed of in the next five years and £65 million relates to replacements that are planned for the next five years.

In the report that I mentioned, the Scottish Government has a plan in place for reducing the backlog over the next five years. The nature of backlog maintenance means that there will always be an element of it. The Scottish Government's focus is to bring it down as much as possible. It is looking to a five-year horizon in which to make some large movements on that.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I want to take the backlog issue a little further. I note that 96 per cent of the estate is described as high risk as opposed to significant risk. It would be interesting and useful if we could get figures that show the turnover. NHS boards will be dealing with the high risk that was there,

but new high risk will be coming in and your report does not make that clear.

Given the fact that there was a 57 per cent reduction in capital between 2008-09 and 2014-15, I am surprised that you did not comment on the consequences of that for the maintenance backlog. If we are not investing sufficiently in new structures because of such a massive reduction in capital, which I know is partly a result of the UK Government's reduction and also transfers to revenue, there will be consequences.

It might be useful to get a slightly fuller report on the inputs and outputs and the consequences of the capital risk. Do you want to comment just now or come back to us on that?

Fraser McKinlay: I am happy to comment briefly.

The question is a good one. Every year when we do the overview report on the NHS, we are always looking for things that we might want to drill into a bit further for future work on behalf of the Auditor General. We can look at maintenance and managing the estate as part of our programme development activity. I am happy to take than on board.

Dr Simpson: That would be useful. It would also be useful if we could divide out the unused buildings. Those buildings might have public safety issues but, even if there is a high risk within the building, that does not affect clinical care. I am really interested in the part of the estate that is fit for purpose; that is in your report, but the percentage is not very high—I think it is at about 65 per cent.

I will turn to my main point. We have this debate about the health budget and whether it is increasing or decreasing. Of course, both figures are in your report, which shows the 0.7 per cent real-terms reduction in overall health spend in Scotland between 2008-09 and 2014-15. That is an overall reduction in capital and revenue, with an increase in revenue and a decrease in capital. How will the 2.2 per cent increase in revenue relate not to real terms, which is what you have given us, but to the fact that the NHS deflator is always different and always higher?

I know that the deflator varies a bit. Pharmaceuticals, for example, have not been increasing by the expected amount, although recently there have been big increases. However, I am trying to get a handle on that NHS deflator, and you have not commented on that at all. I know that it is difficult, but we should have a figure from you for what the NHS deflator has been over this period of time. The statement of a real-terms reduction is obviously a big political issue as well as a concern to the public that spending on health has gone down in real terms. Can you give us a further comment on the NHS deflator?

Fraser McKinlay: I will ask Michael Oliphant to come in on some of the specifics. I am always struck at how the answer to a simple question such as, "Is the money going up or down?" can be very complicated. You have just explained that extremely clearly, Dr Simpson.

We say in the report that costs are increasing. We have reported in the past about the specific nature of inflation in the health service. We will take the feedback on board for future reports, but it is important for us to use numbers that are absolutely reliable, robust and understandable, and that everyone can recognise and sign up to. As you said, coming to a figure for NHS inflation is quite tricky.

That said, Michael Oliphant might be able to help with any specifics.

Michael Oliphant: Healthcare inflation is perhaps a bit more volatile than the gross domestic product deflator would be, but the GDP deflator is probably better recognised when looking at the overall budget figures.

The health budget largely relates to staff costs, which would fall in line more with the GDP deflator than the healthcare indexes would show. A key component as to why specific healthcare inflation might be more variable is drugs costs. It is mentioned in paragraph 27 that, looking ahead, boards are

"planning for average cost increases in primary and secondary care drugs of five and 16 per cent respectively."

We are looking at a drugs budget of £1.4 billion; it is still a decent chunk of the overall NHS budget but you would not be able to apply those rates to the whole budget.

Dr Simpson: No. I understand. The hepatitis C costs are one of the major factors in the pharmaceutical budget.

On the workforce, I am quite impressed by the agency versus bank staff costs. Agency staff costs at £42.97 per hour are three times the cost of using bank staff. However, if we look at the helpful exhibits that you have given us on that, we see that the number of hours done by bank staff have not risen, yet the number of hours done by the agency staff have. One of the highest rates per hour for agency staff was £57 in NHS Dumfries and Galloway.

From a financial perspective, is there potential for putting on a national cap, as has been done in England? Would that work? Also, what should the boards be doing to convert some of those agency staff into bank staff, which would produce considerable savings? The number of hours

worked by agency nursing and midwifery staff increased by 53 per cent in 2014-15.

The vacancy rates have been deteriorating every year since 2011 and the increase in vacancies is accelerating not decelerating, so it is an area that really concerns me. Can you make any suggestions as to how the boards should be addressing the issue or how the Government should be addressing the issue nationally—other than the national locum provision, which I think is one of your recommendations?

Fraser McKinlay: The vacancy rates concern us too, Dr Simpson. We focused quite heavily on the workforce issues this year because we have recognised in the past couple of years that it is an increasing pressure. As Michael Oliphant said a minute ago, the NHS is a people business in a lot of ways.

First, it is not for us to say whether a cap is a good thing or a bad thing. That is a policy decision, rightly, for Government. I will say that, before we get into a conversation about caps, there is a lot that could be done, and you have just mentioned some of them. In particular, being able to convert some of the agency staff into bank staff would save quite a lot of money and would be a good place to start. Agencies are used to plug some short-term gaps, and that needs to be done sometimes, but shifting the balance would be important.

We make a recommendation in the report about the need for a more co-ordinated and national approach. One of the things that struck us, looking at the plans in more detail, is that given that it is a national service—delivering broadly the same services across the country—we might have expected more by way of national co-ordinated workforce planning. That is why we made that recommendation; we will be interested in seeing the Government's response.

Dr Simpson: There is the new workforce plan. I do not want to be too critical but it seems fairly nebulous. It is all very aspirational and there is not much detail. Revitalising the bank system and having better retainers and supported training, a bit of which is done already, might work—treating it as an auxiliary workforce rather than the traditional bank system that I used to be involved in.

I would like to come back in later, but I think that I have had my say for the moment.

Colin Beattie (Midlothian North and Musselburgh) (SNP): Exhibit 3 on page 19 of the report has a line on delayed discharges—an issue that has exercised this committee in the past. The progression from 2012 to 2015 looks like a fairly dramatic deterioration, but the target has become very challenging—it has gone from 42 days to 28 days to 14 days. Has there been a deterioration in the patient experience, as the headline figures would seem to indicate, or is it simply that the target has become more challenging and more difficult to meet?

10:00

Fraser McKinlay: It is difficult for us to know whether the patient experience has deteriorated. The patient survey that we mention in the A and E report suggests that, overall, patient satisfaction and experience are improving slightly. However, as you say, the target for delayed discharge, which people recognise is a major problem for individuals and the system, has been toughened up significantly. That is partly why the performance is as you see it. Michael Oliphant might help me with the exact reference, but we also say in the report that the number of people who experience very long waits has been increasing, which cannot be a good thing.

It is difficult for me to say that the situation is definitely one thing or the other, but there is no doubt that it is no coincidence that the delayed discharge target is one of the two that have been significantly toughened up in recent years.

Colin Beattie: Delayed discharge arises for a variety of reasons, but to what extent is it caused by the partners?

Fraser McKinlay: Again, it is difficult to be specific about that, but it is clear that delayed discharge is a systemic issue. It is not just about the hospital or social work; it is about everything working together. As I mentioned earlier, the integration of health and social care is, in part, designed to help with that.

The Scottish Government has been investing in reducing delayed discharge, and we think that there are some examples of good practice that can be shared more widely and more quickly. However, you are absolutely right: delayed discharge cannot be fixed by one bit of the system on its own. Everybody needs to work together to improve it.

Colin Beattie: You state in paragraph 40:

"Between March 2010 and March 2015, inpatient cases ... increased by 13 per cent".

To what extent has that impacted on bed nights? Has it put any strain on available beds? Does it have a knock-on effect on delayed discharges?

Michael Oliphant: We do not have any specific analysis that would back that up, but we certainly flag up as another pressure in the system the fact that, as well as demanding targets, the NHS has rising activity and there is rising demand for healthcare. In-patient cases and out-patient appointments are examples of places where we

have seen increased demand for healthcare, and that just adds to the pressure in the system.

Colin Beattie: It is clear that an increase in in-patient cases will impact on overnight stays, the time spent in hospital, the availability of beds and, potentially, delayed discharge as well.

Caroline Gardner: We are doing some detailed modelling for a report that is due for publication in 2016 around changing models of health and social care, which I think will shine some light on both of your questions.

The system is complex, and there are trends pulling in different directions. For adults with acute needs, lengths of stay are continuing to shorten. There are also increasing levels of day surgery. However, on older people, there is a group who, once they have been admitted, are difficult to discharge safely. The issue is not just social care to get them home properly, but health and social care services to avoid the need for admission in the first place, where possible.

It is a really complex system, but I hope that the work that we are preparing will give a bit more insight into what is happening.

Colin Beattie: Throughout the report, there is mention of the need for "greater flexibility" in managing finances. What do you mean by that?

Fraser McKinlay: We mention that regularly in the report. I have heard it said that meeting the financial targets at the year end is a bit like landing a jumbo jet on a penny piece—it is a very difficult thing to pull off. As we explain, there is quite a lot of movement in year, and a lot of things happen towards the year end to try to balance the books.

What we are saying about flexibility is that, if boards did not have to do that balancing every year, they could take a longer-term perspective on investment and consider where to invest in different services or redesign how healthcare is delivered. That would give them a little more room for manoeuvre and freedom to plan into the longer term.

We have a section in the report that talks about new powers coming to the Scottish Parliament and, ultimately, the Scottish Government. As well as giving the Government the potential to raise more taxes, that will give it a bit of flexibility to use existing money for the health service more flexibly. The Auditor General has recommended that for a number of years, and we are still very keen on the idea.

The Government has made some moves to that end—for example, boards can now keep surpluses that they make in the year—but we think that there is more to do. If the Government is, as it were, trying to ride both horses of keeping the service running from day to day and investing in and redesigning services for the future, it is critical that something is freed up.

Colin Beattie: In paragraph 25 on page 15, you talk about non-recurring savings. You say:

"25 per cent of boards' savings in 2014/15 were non-recurring".

Obviously, that is a concern from the point of view of sustainability. Are you satisfied that the boards are addressing that and that they are aware of the need for non-recurring savings to be replaced by recurring savings?

Fraser McKinlay: My short answer would be that I think that boards are aware of the need to address that but that they are finding it very difficult to do.

Michael Oliphant: I think that that is it. Quite often, if we look at some of the projections on recurring and non-recurring savings in the local delivery plans, the balance probably looks a lot more favourable on the recurring side but, as the financial years get closer, the non-recurring element increases to more than what was anticipated. There is variability across the boards, as you would expect, but it is a key pressure. Ultimately, boards would like to redress that balance more in favour of recurring savings, as that is better for their longer-term financial sustainability.

Colin Beattie: If we look at the headline figure, it does not look as if there has been a great deal of progress over the past two or three years. Is there an underlying trend? You very much look at trend analysis. Is there an underlying trend of improvement?

Fraser McKinlay: Again, I will ask Michael Oliphant to come in.

Michael Oliphant: As we said, the pressure continues to exist. The key thing is that the non-recurring savings can be made only once, and so there is a limit to the extent to which non-recurring savings, whereby boards look to sell assets and so on, can be used. Boards have used them quite a bit over the past few financial years, so in future it will be even more challenging for them to find such savings. That means that there will be more pressure on boards to find recurring savings to ensure that they meet their savings targets.

Fraser McKinlay: We say in the report that the non-recurring savings figure of 25 per cent is 4 per cent higher than it was last year and 3 per cent higher than two years ago. I know that that is not going very far back, but it might signal at least the beginning of a trend. Later on in the meeting, the committee will consider reports from the Auditor General on specific boards where that is very much part of the story.

Although we are by no means saying that one-off savings are a bad thing—if a board can sell off a surplus asset or building and get a capital receipt, that is a good thing—our concern is about the extent to which boards are relying on them to break even. There is at least one board, a report on which the committee will consider later on in the meeting, where that has been the case.

Nigel Don (Angus North and Mearns) (SNP): Good morning, colleagues. I will start with a plea. I go back to exhibit 3 and the data on delayed discharges. I understand that you are having to report against targets that are moving but, to me, the numbers in that table turn out to be meaningless because the target has moved. Is it possible that you could generate data that sticks to the same target over a period so that we have comparative long-term figures, even if they do not relate to the Government's target at the time? In asking that question, I recognise that the Government might report against its current target and not against the old target, so the answer might be that it is simply not possible to do that, but that does not help members.

I turn to—

Caroline Gardner: Can I respond to that? It is an important point.

Nigel Don: Please do.

Caroline Gardner: The underlying data is available, and we can certainly show you what is happening across Scotland and by health board against the targets. However, the broader point that we make in the report is that the system as a whole is under pressure for reasons that we all understand. We are concerned that it is not clear what the effect is of tightening targets such as the one on delayed discharge and the one on A and E performance. The extent to which that tightening adds to the pressure on the acute system and has knock-on effects for the wider community system is important and much less visible. That is one of the reasons why we have reported in the way that we have.

Nigel Don: That is a very fair point.

I want to go back to the point that Michael Oliphant made about the reasons for using the private sector. Could you give me some thoughts on whether what you saw seemed reasonable and appropriate? Clearly, most boards will not have very specialist facilities. Did that seem to be a reasonable use of facilities and resources?

Fraser McKinlay: I hope that you do not think that I am ducking the question, but that might not really be a question for us because a lot of the decisions are clinical ones and so it is not really for us to comment on their reasonableness. Another observation is that we are talking about a very small amount of money proportionately to the overall budget, although it is still a significant chunk and it has increased.

As Michael Oliphant said, the fact that some private services are being used to manage the capacity issues and waiting time pressures is one thing, but it is also about clinical decisions on the best place for treatment, and it is not really for us to make a judgment on that.

Nigel Don: The fact that you are not saying that it is inappropriate is probably all that I need to hear.

I will move on to long-term affordability. You commented earlier on the problem of meeting the financial targets at the year end, which you likened to landing a jumbo jet on a very small space. The end-of-year financial planning is plainly ludicrous, as it is for every large organisation that has to plan annually. You have spoken about the need to get over the year-end issues, and of course we plan on a two or three-year basis and maybe five if we are lucky.

With the benefit of your long experience, do you agree that even that is not sensible and that the changes that we need to make to the NHS need to be planned over 10 or 20 years? Boards sometimes need to be able to do that. If we give them carte blanche, everything will undoubtedly be pushed back for ever until the board members have all retired—one does not need to be cynical to see how that might go. Sometimes, however, it will surely be appropriate to have a 10-year financial plan. For a very big hospital, anyway, that is surely the case.

Fraser McKinlay: Yes, I think that we would agree with that. Although it would be beneficial to have more flexibility at the year-end, that lack of flexibility is not a reason for boards not trying to plan for the longer term.

The report recommends that boards need to look beyond the three to five-year horizon, which many boards do, to the five to 10-year horizon and possibly even beyond that. We now understand quite a lot about demographic pressures and how they will change. Of course, that involves making all sorts of assumptions but, as we say in the report, boards should be able to plan for the best, worst and most likely-case scenarios, and we absolutely encourage them to do that.

Nigel Don: I want to come back to the workforce planning issue. In paragraph 56, and probably in other places, the report mentions the demographics of the workforce and the length of time that it takes to train doctors. Should we not simply be planning around those who are available?

Fraser McKinlay: I am sorry, but I am not sure that I understand the question.

Nigel Don: I assume that someone is trying to plan the NHS around the services that they think they want to deliver. I just wonder whether it should be planned around the services that might actually be deliverable given the staff who will be available.

Fraser McKinlay: If I understand the question correctly, I think that both need to be done. That is the challenge that I described earlier as riding two horses.

We know what the vision for 2020 says and, as I said, we will see what the national conversation brings out. Because of the changing demographic, the kind of healthcare that is required in 20 or 30 years will probably not be the same as the care that is required today. Therefore, as well as managing the system now and dealing with the pressures that we currently face, boards also need to be redesigning services so that they will be more fit for the world in 15 or 20 years. That has to include considering the kind of people that the NHS employs, the balance of those people and the skills that they have. Boards need to look to the future as well as managing the day-to-day issues.

Stuart McMillan (West Scotland) (SNP): I did not see any information in the report regarding the implications of the move to the European system of accounts 2010, or ESA10. How much effect did that have on the capital situation and on new buildings and the backlog maintenance?

Michael Oliphant: As far as we are aware—certainly for the projects at the Dumfries and Galloway hospital and the Royal hospital for sick children in Edinburgh, which we mention in exhibit 10b—that is part of on-going discussions that the Scottish Government is having with the Treasury. At the moment, they are planned as non-profit distributing projects, but we understand that the talks are still on-going and that there has been no decision around their status.

10:15

Stuart McMillan: Okay. Nigel Don touched on the issue of delayed discharge, and I was going to ask about the comparison, but I will move on to workforce planning. I do not disagree with the comments in the report about work to decrease agency costs for the NHS. There are, however, major events that take place in the country. For example, last year's Commonwealth games were not just about building new infrastructure to host the games, because a huge amount of workforce planning for the games took place throughout the public sector, for which there were costs. How many of those additional costs will have been factored into the report?

Fraser McKinlay: Michael Oliphant will keep me right on this, but I do not think that we specifically picked out that kind of event. When we reported on the Commonwealth games, we looked at the additional costs. As luck would have it, Michael Oliphant did that report as well, so he will be able to tell you more. However, from memory, that report said that we did not identify many significant additional costs to other public sector partners as a result of the games, albeit that we might have expected to. However, that was not what we found.

I guess in any year stuff will happen, although perhaps not something as significant as the Commonwealth games. We therefore look at the longer term to identify whether there is a trend in the use of agency staff that really could be managed.

Stuart McMillan: I imagine that people might want to join an agency rather than become a direct employee of NHS Scotland for a variety of reasons, one of which would be the potential for flexibility in dealing with their individual circumstances. It would be very difficult for anybody running the NHS in Scotland to attempt to manage the issue effectively or well, if people want to join an agency rather than become a direct employee. How could NHS Scotland manage that effectively?

Fraser McKinlay: There is no doubt that people will have all sorts of reasons for choosing how and where they work. I suppose our starting point is exhibit 8, which shows that the cost of using agency staff is going up and that there is a very significant cost difference between using agency staff and NHS staff. Specifically, the average hourly cost for agency staff was £42.97, and that for NHS staff was £15.62. We are not suggesting that we will necessarily reach the position where no agency staff are used at all, but shifting that balance will save some money and that has to be a good thing—I guess that that is our challenge. We are not suggesting that it is easy for any part of the NHS—it is not an easy system to manage. However, it seems to me that the cost differences are really quite significant and that therefore more needs to be done to try to shift the balance.

Stuart McMillan: I reiterate that I do not disagree with the points that are made in the report regarding work to reduce costs, but I recognise that individuals join an agency to fit their own circumstances—perhaps family circumstances—and that that is a really challenging thing to try to address.

Tavish Scott (Shetland Islands) (LD): First, on all those mentions of jumbo jets, I am really

grateful that you are the national auditor, Mr McKinlay, and not the pilot who will take me home this weekend.

I have a couple of questions. The first one follows on from Mary Scanlon's point about mental health services. I was told on Monday night at a meeting of parents in Lerwick who are dealing with mental health services for family members that NHS Shetland is discharging people to avoid not meeting its HEAT target. Did you come across any evidence of that when the work on the report was being undertaken?

Fraser McKinlay: Not specifically. It was a national overview, so we tended to use nationally available data in the accounts and such things. Therefore, we would tend not to get into the detail.

Tavish Scott: Where would the detail appear, if anywhere?

Fraser McKinlay: If people had concerns about how waiting times were being managed, they would blow the whistle, I think.

Tavish Scott: It is an audit issue, because it is to do with being accurate about what is going on. I genuinely do not know how we tackle it or find out the reality. I have heard an anecdotal story and have found eight cases that I can point to, but I would be worried if it was happening right across Scotland.

Fraser McKinlay: Sure—as would we. It is important that the people who have concerns raise them through the appropriate channels.

Tavish Scott: Yes. Okay.

I refer to paragraph 72 and agency staff, which is an issue that Richard Simpson rightly raised and which Stuart McMillan also mentioned. Two things strike me. First, there are specific rural issues, which you have mentioned. There are rural and island board issues to do with locum, agency and bank costs, all of which are going the wrong way; indeed, the numbers are even worse in rural parts of Scotland.

You answered Nigel Don's question about a five to 10-year horizon. There does not seem to be any real focus on the specific problems for rural and island boards that are clearly very costly to the NHS. Have you pushed that point with the Government or the NHS at the most senior level? Have you said, "Right. In workforce planning terms, there's a specific problem here. What is being done about it?"?

Fraser McKinlay: I think that the Government and boards—particularly the boards that deal with pressures in the islands and remote and rural communities—are absolutely aware of the point and are absolutely trying to do things to manage the issues. We mention in the report the innovative things that some boards are doing to try to attract and recruit people, but we also mention that boards are quite often in competition for the same sort of people.

The point that we make in the report is that boards cannot fix the problem that in isolation. That is why the recommendation about national workforce planning is directed at the Scottish Government. There are things that boards can and should do, for sure, but a national co-ordinated approach is needed. We think that more can be done around national workforce planning to make it more targeted and focused to deal with some of the immediate pressures in a way that has an eye to what healthcare will look in 10 years' time.

Tavish Scott: Sure. Paragraph 77 of the report says that

"Local workforce plans ... do not give an overview of national workforce issues or trends and do not provide solutions across boards, or nationally, to problems such as difficulties in recruiting and retaining staff."

That is fundamental, is it not? I would tend to agree with Mary Scanlon if those things are not happening—I do not know whether you mean that they have not happened in the timespan that is covered by this particular Audit Scotland report or whether it is a long-term issue. We have been at the matter for 15 years, and you make a pretty fundamental finding in paragraph 77 about what is not working.

Fraser McKinlay: In paragraphs 78 and 79, we go on to give a bit more detail about what the Government has done and why we think that that is limited and that more needs to be done at a national level. The six priority actions for 2015-16 that we mention at the top of page 33 are fine and good, but we think that the approach needs to go further because of the sense that it is still a bit too focused on individual boards and what they can do rather than on taking a nationally co-ordinated approach.

Tavish Scott: None of those six actions relates specifically to rural and island boards, which face the highest costs. Given the costs and problems that, as you rightly say, boards have been totally aware of—I know that they are aware of them—would it be legitimate and fair to say that there should be another bullet point that specifically recognises that?

Fraser McKinlay: The issue needs to be specifically recognised somewhere, but whether that should be through another bullet point is for someone else to decide. There are very particular issues in rural areas, and there are particular pressures on other parts of the system, too.

Dr Simpson: I have one question and a couple of comments.

When the Health and Sport Committee looked at finance and got the finance directors in front of us, we tried to drill down into the costs of having a 100 per cent guarantee as opposed to a 90 to 95 per cent guarantee. They and Paul Gray certainly admitted that the struggle to achieve a 100 per cent legal guarantee, on which we are failing 10,000 Scots a year—we are not successfully achieving it—has massive marginal costs.

Again, I am somewhat surprised that, although the overview is very good on bank and agency staff—it shows the costs in that area—it does not show the other costs, as far as I can see. Maybe I missed that bit, because we have a lot of papers to read. The finance directors were either not able or not prepared to give us that information on an area where we know there is a constant struggle. We know anecdotally of locum costs of £3,000 for one session—that was in the press recently. Those are massive costs.

Mr Oliphant referred to the private sector. Leaving aside Huntercombe and the Murdostoun brain injury unit, which are an appropriate use of the private sector, there is an overspill that is used for private operations on bunions and other such things, where there is no real clinical urgency but a target must be met. I really would like to know the cost of that, or at least I would like to have some idea of the cost. Is there any way that you can—or could in future—give us that information? Could you require the boards to provide such information, given that they must know it?

Fraser McKinlay: I will ask Michael Oliphant to comment on the specifics of whether we can figure out the additional cost that is involved in meeting those targets. We have said in the overview report and in previous reports that we recognise that there is a disproportionate effect from focusing on delivering on the last few percentage points of a target. That is one of the things that make it more difficult for the system to redesign the way in which it delivers healthcare. We said that in 2013-14, and in the overview report we make the point about challenging targets more generally.

Your make a very fair point about the extent to which we have gone into the specifics of that area in the overview report.

Michael Oliphant: Finding out the cost, or the marginal cost, as Dr Simpson described it, would be difficult. It is actually quite difficult to look at the cost of meeting one target in isolation—for example, the cost to the NHS of meeting a delayed discharge target—because the targets are very much interlinked. It would be very difficult to separate them out to get an accurate figure for the cost. Some analysis could perhaps be done to provide an indication, but we would need to explore that with boards to get a sense of the data on costs that they might use.

As Fraser McKinlay mentioned, at paragraph 51 of the report we draw out the point that the Scottish Government and boards put extensive effort into meeting the targets. We flag up that there needs to be a balance between focusing on short-term targets and looking at the longer-term transformational change that is required for the NHS. It is important that the right balance is struck.

Dr Simpson: Perhaps I am being very simple, but if boards are spending the money on trying to reach that last 1 or 2 per cent of a target, they will not have the money for transformational change.

Can we get an update at some point on daycare? You did a very good report on daycare, which showed huge variation between boards. I do not know whether you intend to produce an update on that—perhaps I can write to Ms Gardner on that point and on other questions.

Nigel Don: I want to follow up the point about marginal costs, which are crucial to any economic model. I appreciate that, as auditors, you go looking for the data that is already out there and try to analyse it. If the marginal costings in the NHS are not available, should someone be asking for some research so that they are? That information is surely absolutely crucial to the economic model.

Caroline Gardner: I will step in to echo the frustrations that Ms Scanlon and Dr Simpson have expressed today. It feels as though, for as long as I have been involved in public audit in Scotland, we have been talking about poor cost information in the NHS.

Michael Oliphant is absolutely right: over and above the amount that is spent with private sector providers to meet waiting time targets, it is very hard to come up with the total cost of the NHS's contribution to meeting those targets and other priorities. Having that better data is fundamental to enable boards to make the shifts that we know are needed; otherwise they will not keep up with the pace of the financial pressures and the demographic and other demands on the system.

Mary Scanlon: Various colleagues have mentioned the workforce and vacancies. I am quite worried about the figures for consultant, nursing and midwife vacancies. Exhibit 6 on page 26 shows that there has been an 87 per cent increase over the past year in vacancies that are open for six months or more. Paragraph 58 drills down further into that. The report looks at referral and treatment targets for cancer of 62 days and 31 days, but most patients are worried—as I would be; I hope that it does not happen to me—not so much about the first doctor that they see but about whether their treatment will lead to a good

outcome and whether they will have a good survival outlook.

I apologise for going back, but for as long as I can remember—for more than 10 years—there have been shortages in clinical radiology, and 12 per cent of the posts in that area are still vacant. I am worried that the actual targets are pretty meaningless. The first time someone sees a doctor, that is fine, but I would be worried about whether I would get my treatment on time, whether it will treat my cancer and whether I will have a good outcome.

10:30

In future, can we look at the impact of vacancies on survival rates, which we do not look at just now? My information is a bit out of date, but I think that I am right in saying that the survival rates in Scotland are quite poor in comparison with those in the rest of Europe, and I wonder how much the vacancy rates affect that.

The vacancy rate is 17 per cent for general acute medicine and 12 per cent for radiology. Perhaps in future, rather than looking at the fairly meaningless targets, we can look at the outcomes. That is not what we are seeing just now. I am only here for another four months, but that is something that the Auditor General could look at in future.

We need more stark figures about survival. We have had more than 10 years to work with universities to get more radiologists, but the situation is still as bad as it ever was. If people going for cancer treatment know that there are 40 vacancies, they will worry.

Caroline Gardner: That is a timely question, as our team is currently in the process of planning what we want to include in next year's overview report. It is like painting the Forth rail bridge: we are constantly starting on the next version.

I take your point about there being scope for more information about outcomes in the report. Equally, it is important—particularly for this committee—to keep a clear focus on inputs: on the money and on the other things that deliver services. We will look at how we can deliver that in ways that are meaningful—as you can imagine, the relationships are quite complex.

The Convener: Before we move to item 3, I will suspend the meeting for a few minutes to allow for a change of witnesses.

10:32

Meeting suspended.

10:37

On resuming—

Section 22 Reports

"The 2014/15 audit of NHS 24: Update on management of an IT contract"

The Convener: Agenda item 3 is consideration of three section 22 reports: "The 2014/15 audit of NHS 24: Update on management of an IT contract"; "The 2014/15 audit of NHS Tayside: Financial management"; and "The 2014/15 audit of NHS Highland: Update on 2013/14 financial management issues". We propose to take each report in turn. We will receive an opening statement before members then have an opportunity to put questions individually on those statements. I understand that the Auditor General for Scotland has a brief opening statement to make on NHS 24.

Caroline Gardner: Thank you, convener. Again, Fraser McKinlay will lead on my behalf in briefing the committee. Nick Bennett, who is at the end of the row here, is the appointed auditor for NHS 24, on whose annual audit reports my report is based. He will help us to answer any questions that the committee may have.

Fraser McKinlay: First, it is worth briefly highlighting that the external auditors of the three health boards gave unqualified opinions on the 2014-15 accounts, which means that they were satisfied that the accounts provided a true and fair view and that there were no significant errors in them. However, we have prepared the section 22 reports because we believe that there are issues of significant public interest that have been highlighted in the auditors' reports to the Auditor General, and the Auditor General felt it important to bring those to the attention of Parliament and the public through this committee.

I will turn first to the report on NHS 24. I am sure that the committee will be well aware of the issues arising from the implementation of a new information technology system in NHS 24. In October 2014, the Auditor General reported under section 22 on some of the issues in NHS 24 but, due to legal action that was under way at that time with one of the external IT suppliers, Capgemini, the report was fairly brief. Now that the mediation process has been completed and the legal action has been withdrawn, we are in a position to give you a fuller update.

NHS 24 started work on the future programme back in 2009. It was originally due to go live in June 2013, but it was subsequently delayed to October 2013 and then postponed due to the new

system's failure to meet critical patient safety performance measures.

Since then, through the legal process and subsequently, NHS 24 has worked with both suppliers involved—Capgemini and BT—to develop the system and try to resolve the patient-handling performance issues. The board agreed at its February 2015 meeting to a two-phase approach to implementation. The first phase was implemented on schedule in October. As I am sure the committee will be well aware—it certainly will have been so since we laid the section 22 report in Parliament—the board has subsequently decided, because of concerns over the system's performance and patient safety, to delay implementation until 2016, particularly to ensure patient safety over the winter period.

Clearly, the programme's costs have increased significantly—total costs have risen by 55 per cent to £117.4 million compared with the outline business case cost of £75.8 million. The cost covers the 10-year contract period, and the increases are due to the changes in the contract specification and the costs associated with the delays.

The board continues to incur significant costs in running the existing systems. NHS 24 incurs about £450,000 in additional costs for each month that the future programme is not operational. If implementation is not successful, double-running costs will increase still further during 2015-16.

NHS 24 has included the cost of implementing the future programme in its financial plans. However, given the scale of the challenge, the auditor's view is that delivering the financial targets will be difficult and will largely depend on achieving significant in-year efficiency savings.

We would be delighted to answer any questions that you have on the report.

The Convener: You refer to contract management in paragraph 15. A challenge that we always face when we consider section 22 reports is whether anything could have been forecast or foreseen. My contribution is along similar lines to Mary Scanlon's during the previous agenda item. We have been referring to IT reports in this Parliament since it was formed in 1999. The lack of specialist knowledge comes up in every single report. Surely those who were planning the IT system's requirements should have been able to recognise that they did not have the necessary specialist knowledge and that they would have to go through the appropriate procedures so that they did not have to rely on the private contractors. If a company were running the programme, it would be bankrupt. It would not have public money to keep on pumping into it. Is there an issue concerning those who are managing the project?

Fraser McKinlay: We absolutely recognise and share that frustration. You took evidence just recently from the Scottish Government on "Managing ICT contracts: An audit of three public sector programmes" and I think that you have the chief information officer coming next week as part of your witness panel on that issue.

It is enormously frustrating that we continue to see the same mistakes being repeated. I had a conversation with my team yesterday about whether there was anything more or different that we could do as auditors because, as you say, we have been saying the same things a number of times. I would also say that the responsibility lies with the people who are planning and managing the projects. It is surprising that, at the outset of such a significant IT programme, some of those lessons were not learned. As you say, we see lots of the same issues repeated here to do with experience, optimism bias and a whole bunch of stuff. It is disappointing and problematic that NHS 24 has to spend such a lot of public money on getting the system fixed.

When we reported previously, it looked as though the project would be delivered. Of course, now we know that it has not been delivered. The other point to make to the committee is that Nick Bennett and his team, with my team in Audit Scotland, will continue to keep a very close watch on what happens with the new system. Some specific review work is under way and we expect to see that reported on soon. We will look to see what the detailed plans are for implementing the system. Clearly, the Auditor General has the option of reporting back to the committee.

The Convener: The issue for me is having a clear pathway to who is responsible for how the contracts are prepared and for the recruitment. Would that be the chief executive or the digital team? Who are the individuals or individual responsible?

10:45

Fraser McKinlay: Ultimately, the accountable officer for NHS 24 is accountable for everything that happens in the board. That is where I would start. Clearly, there is then a question about the way in which significant public sector IT projects are supported by the wider environment, and that is where the Scottish Government and the digital team come in. We also have NHS National Services Scotland, which has a big procurement function and is experienced in IT, so there is a wider system question about how we bring the experience in the system to bear on big contracts such as this one.

The Convener: Do you accept my point that, if this was a private company, it would be bankrupt?

We cannot keep pumping public money into something that is clearly not working, but that is what has happened here. People have said, "There's public money, so let's just prop it up." That is what is going on here, is it not?

Fraser McKinlay: I will ask Nick Bennett to come in and offer a view. I suppose that the specific answer to your question is that it depends on the private company. Some private companies might have gone bankrupt, whereas some bigger ones might also have had to throw money at the problem. I do not think that it is necessarily the case that the private sector always gets this stuff right.

Nick Bennett (Scott-Moncrieff): NHS 24 is a special health board and is relatively small compared with some of the other health boards. A project that costs a forecast £117.4 million is considerably above its annual expenditure.

Mary Scanlon: I am trying to understand this. Paragraph 7 states:

"It subsequently became apparent that there were flaws within the contract documentation, including the performance measures specified in the tender negotiation documents not appearing in the final contract agreement."

Who drew up the contract documentation? Whose fault is it? Was the NHS at fault? Did it not specify clearly what it wanted? Was Capgemini at fault because it did not meet the specifications that were in the contract? I did not quite understand the comment that

"there were flaws within the contract documentation".

Will you clarify that?

Fraser McKinlay: Again, I will ask Nick Bennett to come in in a moment. Basically, I think that there was a gap and a difference in understanding between NHS 24 and the contractor about what it was supposed to deliver, and when—

Mary Scanlon: I apologise for interrupting. Should that not have been sorted out before? If someone is going to build a house, they will come to an agreement about where the bricks will go before they start. Should that not have been sorted out before any money was paid over?

Fraser McKinlay: Yes, it should. Absolutely. I think that what happened was that some of the stuff in the original tender documentation about performance standards had not been transferred into the contract documentation. That is what NHS 24 discovered, but that came to light only when it was trying to implement the system in 2013. NHS 24 was saying, "This isn't working like we said that it was supposed to," and Capgemini was saying, "Well, actually, it's working like it says it is supposed to in the contract."

Mary Scanlon: If there were flaws in the documentation, the project should not have gone ahead until they were ironed out. The accountable officer should have said, "Let's get this straight so that we know exactly how we are going to spend the money before you make a start."

Fraser McKinlay: Again, I agree. The problem was that they did not identify that there were flaws until much later in 2013, when they tried to implement the system.

Mary Scanlon: At that point, who discovered that there were flaws?

Nick Bennett: The discovery came because there was a difference of opinion between the contractor and NHS 24. The contractor believed that it had supplied the system that it tendered for and NHS 24 felt that there were patient safety requirements that had not been met. At that stage, the differences between the contract that was intended and the contract that finally went out were identified.

Mary Scanlon: Convener, I hope that I am not straying on to dangerous ground, but I understand that the matter has been in court. I think that it was at the High Court. Has any decision been made? Have judges made any ruling? It seems that NHS 24 is left with brokerage of over £20 million, costing it about £500,000 a year in additional costs. Were any costs found against Capgemini or did the High Court find in favour of Capgemini, with all the costs falling to the NHS and the public purse?

Nick Bennett: As part of the overall agreement, the legal case was withdrawn by NHS 24.

Mary Scanlon: It would not have withdrawn the case if it thought it was going to win. Why did it withdraw it? I am sorry, but I have not followed the case in detail.

Fraser McKinlay: It is very complicated. At paragraph 9 of the report, we try to set out a little bit of what happened. NHS 24 went through a whole series of contractual processes because in a contract such as this one there are escalation procedures. In June 2014, NHS 24 served what is called a default notice, which could have led to NHS 24 terminating the contract. However, instead of doing that, NHS 24 decided to go into mediation, to undertake some diagnostic work and to work with the contractors to try to salvage the project. That was the judgment that the board made at the time—it decided to try to build on rather than lose the £37.9 million that had been invested by that point.

Mary Scanlon: So NHS 24 had already spent £38 million. Am I right in saying that Capgemini is still working on the project and that BT has been brought in as well?

Nick Bennett: Yes, both suppliers are part of the project.

Mary Scanlon: I am just trying to understand—apart from the £21 million Scottish Government loan that NHS 24 has been lumbered with, will something satisfactory come out of the project?

Fraser McKinlay: That is the million-dollar question. We will need to keep a very close eye on it.

Mary Scanlon: It is a bit more than a million-dollar question—the convener is saying that it is quite a few million.

Fraser McKinlay: Indeed. It is a several-million-dollar question. When we wrote the section 22 report, we envisaged having this conversation with you about a system that was up and running. That would have been bad enough, given how much it had cost and the significant overruns and so on, but that is not where we are. It is even more problematic and worrying for us that NHS 24 has spent what it has spent to date and is running up costs of £450,000 a month in keeping the current systems going.

NHS 24 has worked hard with the supplier and our sense is that, contractually and in its relationship with the supplier, it is in a better place than it was. However, clearly it was a big decision that was not taken lightly to in effect pull the plug on the system once it had gone live in October—for all the right reasons, I have to say. If there were concerns about patient safety, you would expect NHS 24 to make that decision.

Mary Scanlon: The system is only 55 per cent over budget, compared with the common agricultural policy payments system, which is 300 per cent over budget, so, realistically, it is not too bad. However, it is still a serious issue within the NHS. Do you have a crumb of comfort to offer? Will the flaws in the documentation and arrangements between Capgemini, BT and NHS 24 be solved in the months ahead?

Fraser McKinlay: We are not in a position to say that today. I can say that NHS 24 is taking the issue seriously.

Mary Scanlon: I should hope so.

Fraser McKinlay: Indeed. It has responded as we would expect. The chief executive has asked for a detailed review to be undertaken. Nick Bennett, as the auditor, will get sight of that review report soon, we hope. We should then have a better understanding of what happened at go live. When the detailed implementation plan—for when NHS 24 wants to try to reimplement the system in 2016—comes through, we will be looking carefully at that as well. However, given the history of the project, it would be a brave man or woman who would give any assurance on how it is all going to end up.

Dr Simpson: You have answered one of my questions. The costs are £450,000 per month, so when the system was abandoned in October, those costs started again and they will run until the system comes in and they may even run a bit beyond that. We are not going to get the system until the spring—it is going to be another four, five or six months—so NHS 24 will require another £3 million or £4 million of brokerage.

Nick Bennett: My understanding is that the system will not go live before the end of June 2016.

Dr Simpson: When I was involved in dealing with IT projects—not at this scale, I am glad to say—that involved developing software systems, we used an iterative process. In other words, you started with a basic goal, which you agreed with the contractor, and then started to develop it, using your clinicians to test the system as you went along. That was before you got to beta testing, which is the point at which the final system is being tested before launch. I therefore find it astonishing that we have got to this point in this particular situation. I understand the original problem, which was that the tender documents and the contract documents did not match, but I do not understand what happened subsequently. In terms of your overall view of information and communications technology, what systems are used to try to prevent this final thing that has happened?

Fraser McKinlay: Like you, we do not fully understand what happened subsequently, either. For us, the challenge is that, at the time the report was written, the iterative process of testing that you describe had taken place—the system has clearly been around for a long time and a lot of work has been done on it. One of the things that the board will now be examining is why that process did not pick up some of the stuff that became quite clear over a particular weekend of operation, once the system went live.

As you know, it is difficult to fully replicate a live environment, so systems can be fully tested only once you press the button. However, what has been striking about this situation is that some of the performance issues were so significant that it is surprising that they were not picked up sooner. You would expect teething troubles and the odd glitch, but the fact that NHS 24 got to the point of pulling the plug on the system altogether within a few days clearly shows that something went wrong in the testing process. However, we do not know what that was yet.

Dr Simpson: Paragraph 25 of your report mentions several reviews of the programme: a

gateway review; an independent review by Ernst & Young; and an independent lessons learned review by PricewaterhouseCoopers—I do not know who paid for all of those, by the way. It is astonishing that, even with all those reviews, we are still constantly being faced by ICT problems.

Mr Bennett made the point that this is a small board with a focused purpose and, I suspect, almost no experience in ICT whatsoever. To me, the fault lies right at the top. Why was a contract of this sort not reviewed by the most senior part of the digital section of the Government? The gap between the contract and the tender was such a fundamental error that it should have been picked up by the chief information officer—we can ask him about it next week. You must be concerned about the situation. If it happens with one project, it could happen with another. We are handing these projects out to the nine special boards that we have—we are a tiny country, yet we have nine special boards. If each of them tries to run an ICT project in these circumstances, we will be faced with these problems again and again.

The Convener: I advise colleagues that we are supposed to be focusing on the Auditor General's report. There will be some policy issues that we can take up with the Government representatives and possibly other people. We need to be careful.

Fraser McKinlay: First of all, it is worth saying that some of the arrangements that we described to you in relation to our last ICT report were not in existence when this all kicked off in 2009. I absolutely agree that, if you have relatively small organisations without the experience of doing things at this kind of scale—as Nick Bennett said, the system is costing more than NHS 24 has to spend every year—you would expect a degree of external support and help to be not only offered but required. I am sure that that is one of the things that the Government will be considering.

Nigel Don: I would like that point to be expanded on, Mr McKinlay. We have already considered ICT contracts in general and have asked the Government about the arrangements—particularly the governance arrangements—for them. I think that several of us went on record as saying that the arrangements seemed extremely complicated. It is tempting to say, looking at these cases, that the arrangements might not be working incredibly well. Richard Simpson has already picked up on paragraph 25, which seems to show large bills being run up with consultants of one sort or another telling us things that are probably pretty obvious, because we can see them anyway.

On reflecting on all of that, of which the issue that we are discussing is but a small part, I wonder whether the Scottish Government's ICT structure is appropriate or whether it is beginning to look inappropriate. If it is inappropriate, is that because of its complexity? Is the issue perhaps that we just do not have the skills and we believe that the contractors should have the skills and the Government should not? What is the audit perspective on all that?

11:00

Fraser McKinlay: The audit perspective is what we said in the report—the report is very recent, so that remains our view. The arrangements are still pretty new. If the arrangements for delivering IT projects were effective, we would expect them to be managing such things. We are not yet in a position to say whether those arrangements are right or wrong or whether they are working—because they are relatively new—but clearly we would expect the governance of digital things in this country to avoid stuff such as this happening in future. The frustrating thing is that the report gives yet another example of where those arrangements have not worked.

Nigel Don: What fraction of ICT contracts do not work? There is a risk that we focus on the ones that we see as a failure in some sense. I presume that quite a lot of contracts out there have worked.

Fraser McKinlay: That is a good question, but I am not sure that I have the answer to it. As auditors, we tend to be professionally sceptical—that is how we describe it. When things go so badly wrong, that approach is obviously in the public interest. It is a fair question and I will take it away and see what we can dig out.

Nigel Don: Thank you. In fairness to those concerned, it might be nice to know how many contracts have gone well, because I suspect that it is quite a large number.

Colin Beattie: Paragraph 9 mentions the board's decision

"not to jeopardise the £37.9 million investment already made."

I have considerable past experience of quite large IT projects, and I know that it is a classic error to continue to throw bad money after good. Was the board's decision at that point reasonable?

Fraser McKinlay: That is a great question. Obviously, we have the benefit of hindsight and, as you say, sometimes the best decision that a board can make is the decision not to not proceed with something and just take the hit. I will ask Nick Bennett to say a little more about the circumstances at the time, but I genuinely think that that is a question for the board. It took a judgment, based on all the information that it had, that the system could still be made to work.

In that context, it is worth saying that what NHS 24 is trying to achieve is a good thing. No one

argues that the future programme is ill conceived as a concept. I guess that the board was seeing a significant prize, because the new system will be an important part of not just how NHS 24 operates but how the whole NHS system operates. It is part of managing the pressures in that system, which we discussed earlier. We should not underestimate the scale of a decision to pull the plug on the programme at that time.

Nick Bennett might have a bit more detail on that.

Nick Bennett: NHS 24 had taken on a future programme director, who was quite experienced and who undertook a full risk assessment in relation to whether the board should proceed with the system. The risk assessment was comprehensive, so I would not be critical of that decision at the time.

Colin Beattie: Was the board aware of the potential increases in costs at that point? Did it take those on board?

Nick Bennett: The board had already incurred £37.9 million of costs, so there were additional costs that are included in the figure of £117.4 million, which represents the full 10-year cost of running the service. Therefore, at that point, the board knew that there would be additional costs to be incurred.

Colin Beattie: Did the board know that the total would be £117 million compared with £75.8 million?

Nick Bennett: No—not at that particular time.

Colin Beattie: So the board took the decision without actually knowing how much it would cost to go forward.

Nick Bennett: At that stage, the board did not anticipate that the cost would be £117.4 million.

Colin Beattie: How much did the board anticipate that the cost would be?

Nick Bennett: I do not have those figures to hand.

Colin Beattie: It would be interesting to know that. About the only good thing in the report is that services to patients were not affected.

The last sentence in paragraph 10 says:

"A review of the contractual obligations is currently on going",

and paragraph 14 says that the auditor's opinion is that

"the financial implications remain significant and on going."

What is the risk going forward? Is there any clue as to whether there is a financial risk or a performance risk?

Fraser McKinlay: I think that my answer would be, yes, there will be both those things. Nick Bennett has reported and will continue to keep a very close eye on financial risk specifically in relation to the project and the knock-on impact that that will have on the board and its ability to continue to break even at the end of the year. Clearly, the brokerage repayment schedule is an additional pressure that the board will have to live with and deal with. Of course, we have already said that we know that the board will incur additional costs in running the existing system and, presumably, in doing whatever needs to be done to get the new system up and running. That is absolutely a financial risk.

As you said, it is not so much that we think that there is a performance risk in terms of how the service is being delivered, because it is managing to keep going as it has done. The performance risk is probably more one of opportunity cost, because what the future programme was designed to deliver is not being delivered yet. As Nick Bennett said, we do not expect it to be delivered and operational within the next six months. The longer that goes on, the longer we do not have a system that can help to provide a better service.

Colin Beattie: Paragraph 7 refers to flaws in the contract documentation. Who actually had responsibility for the contract negotiation?

Nick Bennett: At the time, it was NHS 24.

Colin Beattie: Did NHS 24 do it itself? Did it get any outside lawyers, for example, to review the contract details? As far as I can see, the issue is not just that bits were missed off in the specifications of what was to be delivered, but that there were flaws in how the document was put together in relation to the delivery terms and all the rest of it.

Nick Bennett: External lawyers were involved by NHS 24, but I think that the internal procurement processes were not comprehensive enough. It did not undertake a complete read-through of all the key documents, and the sign-off and checking were inadequate.

Colin Beattie: Are you talking about NHS 24?

Nick Bennett: Yes.

Colin Beattie: NHS 24 did not read the documents.

Nick Bennett: A full read-through was not done, so NHS 24 did not identify the elements that were missing from the revised contract.

Colin Beattie: Is it not a little bit odd that the contract was not read? I used to read my contracts.

Nick Bennett: It is a bit odd. A page turn should have been done on the various documents to

make sure that they were complete and comprehensive, but that did not happen.

The Convener: Can you clarify the cost of the contract? NHS 24 did not read through the contract document, but what was the cost of the contract that it signed for?

Nick Bennett: The total cost of the future programme is forecast to be £117.4 million.

The Convener: Would it have been the accountable officer who signed off that contract?

Fraser McKinlay: To be fair, £117.4 million was not the cost at the time. When the contract was signed, the outline business case was anticipating a cost of £75 million, but that is still a lot of money.

The Convener: Would it have been the accountable officer who signed off the contract?

Nick Bennett: Yes.

Fraser McKinlay: Yes.

The Convener: The accountable officer signed off a contract document when neither he nor anybody else in the organisation had read through the entire document. [*Interruption*.] Can we have some order, colleagues?

Nick Bennett: I am not saying that the contract was not read through at different stages, but when the contract was signed, a page comparison was not done to make sure that some of the elements that were included in the original outline business case had been properly copied into the final contract document.

The Convener: Okay.

Tavish Scott: That is fascinating, Mr Bennett. Did the three reviews that you and Mr McKinlay described earlier find exactly the point that you have just made? Did they look into why that contract did not include those details?

Nick Bennett: I do not believe that that was picked up by those reviews.

Tavish Scott: So what did those reviews achieve, if anything?

Nick Bennett: I think that they highlighted the fact that there were weaknesses in the overall governance of the project. Changes were made as a result of that and more expertise was brought in. I mentioned that the future programme director was brought in, which was a positive development.

Tavish Scott: But the system is still not up and running and it is still costing £450,000 a month, so we may have brought in one new person, but it has not made any difference to delivering the project, has it?

Nick Bennett: Currently, that is the case.

Tavish Scott: I want to clarify the numbers. You said that the current estimated cost is £117.4 million. Is that the real number, as of today? Is that still the number that we are working from?

Nick Bennett: That was the forecast cost when the section 22 report was drafted.

Tavish Scott: Just remind me of when that was.

Fraser McKinlay: I do not have the exact date, but it was in October and it was before we knew that the plug had been pulled. As we said earlier, we anticipate that that number will go up, because we will not have the system for another six months or so, at best. That forecast was made on the basis of the system going live in October.

Tavish Scott: So there will be an additional cost of £450,000 per month from October all the way through to June—that is what Mr Bennett said. That is the current estimate; in other words, we are talking about an additional cost of at least £4 million.

Fraser McKinlay: Is that right, Nick?

Nick Bennett: I think that that is subject to negotiation as well. I understand that the impact on the financial cost in 2015-16 will be £1.1 million.

Tavish Scott: Who is paying for that extra £450,000 a month? Is the Scottish Government paying that to NHS 24?

Nick Bennett: Again, I understand that negotiations are going on between NHS 24 and the Scottish Government about how that will be financed. There could be an extension of brokerage.

Tavish Scott: I just wanted to clarify that it is public money that is being used; the extra cost is not being paid by Capgemini or BT, which are the suppliers.

Nick Bennett: No.

Tavish Scott: Why not?

Nick Bennett: I think that we will have to wait to find out what lessons are learned and the reasons for the delay before we can come to a conclusion.

Tavish Scott: Is this going to end up in court, given how far over budget the programme is? I do not understand why it came out of court. What did NHS 24 get for coming out of court? It does not have a system, the cost is £117 million-plus and it is no better off.

Fraser McKinlay: Those are all great questions, but I do not think that we are in a position to answer them today. It is more appropriate for questions about the decisions on such judgments to be directed to the board.

What we can say is that significant risk remains, both financial risk and risk in relation to the performance of the system. As Nick Bennett said, lots of discussions will be going on with the suppliers and with the Government. Exhibit 2 shows the brokerage repayment schedule. I expect that what that looks like in future will be part of the discussions—it might be necessary to rephase some of it. We need to continue to keep a close eye on the situation, because it is a very fast-changing picture.

Tavish Scott: I totally accept that.

It would have helped us—and it might also have helped to address your frustration—if the report had included as clear a line of responsibility as it was possible to achieve, because I find it very hard to work out who is responsible for what. You helpfully said to the convener that the accountable officer is the accountable officer, but there are many other people involved. What responsibility did the people who did the three reviews that Mr Don rightly referred to have? Did they just do a review and then go away? Did they have no responsibility for the terms of those reviews and what they did? I do not have the answer to any of those questions, but when it comes to learning from has happened, what is the point of carrying out three reviews if they do not take us any further forward? I wonder whether Audit Scotland might want to reflect on that for future reference.

Fraser McKinlay: That is a helpful bit of feedback. With the benefit of hindsight, it is clear that the review processes have not delivered a successful project but, as Nick Bennett mentioned, that does not necessarily mean that nothing useful came out of them.

Stuart McMillan: I would like to highlight one positive point that the report makes, which Colin Beattie touched on. As paragraph 13 says, while the project has been under way there has been no risk to patient safety. That is a very important point to highlight for anyone who reads the *Official Report* or watches these proceedings online later.

Paragraph 7 highlights the flaws in the contract documentation, and paragraph 10 highlights the failings of Capgemini and BT in looking at the project. That highlights, once again, that the public sector can get things wrong but so, too, can the private sector. We are looking at NHS 24—that is the responsibility of this committee—but the two private sector organisations had a role to play as well, particularly in looking at the contract at the outset. There are failings on all sides; it is not just NHS 24 that is at fault.

Paragraph 17 of the report touches on the external appointment. Did the individual come from within the NHS or from elsewhere in the public sector, or were they from outside the public sector?

11:15

Nick Bennett: The appointment was of someone from within the NHS.

Stuart McMillan: Did they have experience of IT projects or of any projects that were relevant to their taking on this particular project?

Nick Bennett: I am not aware of her specific experience, but she held a very senior position within the NHS.

Stuart McMillan: There are clearly challenges for every organisation that undertakes an IT project of scale. Every organisation is different and has its own internal workings and culture. I understand that, when an organisation—whether it is NHS 24 or any other—is trying to introduce a new IT system, it can be difficult to get IT experts who have experience of the organisation's culture so that, when the initial contract or proposals are being set out, the two can be married up at the very beginning. The private sector gets IT contracts wrong, but it has the benefit of being able to charge its customers more money to cover the cost of overruns; it is a different scenario in the public sector, as we all know.

After reading the report, and given the committee's discussions of previous reports, I wonder whether NHS 24 is too small an organisation to undertake a piece of work of this magnitude on its own.

The Convener: I ask the member to get to his question.

Stuart McMillan: Do you have a view on that, or is it a policy question that you are not able to answer?

Fraser McKinlay: It is a policy question. Thank you for giving me a way out.

As Nick Bennett said, in looking at the scale of the project compared to the size of NHS 24, you need to bear in mind that NHS 24 does a very specific thing and its requirements for the project were, therefore, very specific. It is not just a boilerplate solution that can be rolled out and plugged in again—it is not at all straightforward. I go back to the point that, when any organisation starts out on such an exercise, its capacity—in terms of people, skills and expertise—must be part of the process of deciding how it is going to do it. The argument is not necessarily about size; it is about undertaking a more robust risk assessment at the outset to see whether the organisation has all the things that are required to deliver a very big and complex IT project such as this one.

Stuart McMillan: Do you think that NHS 24 had those things?

Fraser McKinlay: No—it clearly did not. That is the conclusion that one comes to.

Colin Beattie: Mr Bennett, I want to go back to the question of the contract, which is at the core of whatever has gone wrong. You said that it had not been read; you also talked about a page-turning exercise at the time of its signing, but those are two different things. Do you know whether the board members actually read and understood the contract before they signed it off?

Nick Bennett: I will outline what actually happened. The procurement strategy that NHS 24 followed had an output-based specification. Obviously, the key performance measures that relate to that contract are quite critical—

Colin Beattie: Can you define that?

Nick Bennett: It is a specification that is based on the output that is to be delivered. The performance measures are important.

There were two errors in the procurement process. When the output-based specification was loaded on to the NHS 24 procurement software, some of the performance measures were omitted.

Colin Beattie: Was that a clerical error?

Nick Bennett: It was a copying error that happened during an upload to an IT platform.

Colin Beattie: Is there no check on the system?

Nick Bennett: No check was done, no.

The procurement software forms the basis of the tender that is bid for. The problem was further compounded by the fact that there were also omissions in the final contract. Again, some of the performance measures had not been copied across to the final contract that was signed by NHS 24 and Capgemini.

Colin Beattie: I find that quite incredible. Was nobody responsible for checking the contract and verifying that it said what NHS 24 wanted it to say?

Nick Bennett: The accountable officer is ultimately responsible but, as I said, the problem was that there was no complete read-through of the various documents to make sure that the copying and uploading had been done accurately.

Colin Beattie: Would the external lawyer have been responsible for that? Would it have been delegated to them?

Nick Bennett: It could have been the responsibility of a number of individuals, including members of NHS 24 staff.

Colin Beattie: So we do not know who was responsible.

Fraser McKinlay: We are not absolutely clear, Mr Beattie, but the point that we are making is that neither is NHS 24. If someone had been responsible for the error, that would have been clear. If I understand Nick Bennett properly, the read-through should be a final check and balance, so that is not the only thing that went wrong; it just compounded a whole bunch of other stuff that happened up to that point. We should bear it in mind that this is a big, complex process, and the fact that it is output based means that there are no long lists of tasks for people to do; it is about delivering. In some ways, that is a good thing because it focuses everyone on what they are trying to deliver, but it means that performance measures and the expectations of all parties have to be crystal clear. That did not happen here, as became clear when NHS 24 tried to implement the process in 2013.

The Convener: The auditors are not responsible for the actions that should have been taken. We will have the opportunity to decide whether to take further evidence on that.

Nigel Don: Convener, could I—

The Convener: I will just take a very brief question from Dr Simpson first.

Dr Simpson: NHS 24's annual report said that it was committed to a 25 per cent reduction in senior managers. Does your audit demonstrate whether the senior managers who were got rid of had anything to do with the catastrophe? Catastrophe might be too strong a word, but did any of them have anything to do with the problems that we are now facing? It is all very well to say that you will cut a swathe through senior managers but what if you get rid of the people who are responsible for significant programmes, finance or whatever? Did getting rid of those people have any adverse effect?

Nick Bennett: That is probably a question for NHS 24.

Dr Simpson: Right, but the audit did not find anything that points to problems arising from the restructuring.

Fraser McKinlay: We have not seen any causal link, and lots of other organisations are experiencing the same kind of reductions.

Dr Simpson: That is what worries me.

Fraser McKinlay: The work that we have done has not identified any causal link.

Nigel Don: We have talked about the read-through and an output-based specification. How many pages would an output-based specification run to? Surely it is not that many words.

Nick Bennett: I cannot remember the number of pages. It is a large document, though.

Nigel Don: But the output-based specification cannot be that large. I have seen huge documents sitting on the table—I recognise that contracts are often very large—but the output-based specification would be one side of a piece of paper, would it not?

Nick Bennett: I believe that it is an appendix to the contract.

Nigel Don: Perhaps we need to ask to see it.

The Convener: Thank you, colleagues.

"The 2014/15 audit of NHS Tayside: Financial management"

The Convener: The next section 22 report on the agenda is on the audit of NHS Tayside. We will have a brief opening statement from Audit Scotland.

Fraser McKinlay: The second report in front of the committee is on NHS Tayside. This is the first time that the committee has seen a section 22 report on the Tayside board. The Auditor General has made the report for a few reasons. In 2014, NHS Tayside received £14.2 million in brokerage, in two instalments. It received an initial payment of £8 million to cover retrospective holiday pay enhancements and some overspends in workforce costs and primary-care prescribing. The board later required an additional £6.2 million following an accounting adjustment identified by our colleagues, as auditors of the board, in recognition of the sale of land—formerly Ashludie hospital—in the 2014-15 accounts. This is the third year in succession that the board has required brokerage.

The report says that the board's reliance on brokerage stems from overspends and an on-going difficulty in selling a number of surplus properties, which means that the board has been unable to generate income from planned sales. The board has agreed with the Scottish Government that it will repay the brokerage from the proceeds of the sale of those properties. The board is currently engaging with the Scottish Futures Trust to develop plans for the main sites for disposal in an attempt to sell those properties more quickly and reduce the risks associated with planning permission applications.

Having said all that, the timing of the disposals remains uncertain. The Scottish Government has indicated that it will discuss repayment options with NHS Tayside should disposal not happen as planned.

In addition to the brokerage repayments, in 2015-16 the board is required to find £27 million of efficiency savings in order to break even. As at 31 July this year, the board had yet to identify £11.2 million of those savings. In the first six months, the board overspent by just over £5 million. As the board continues to rely on the sale of property to address the issues, there continues to be a risk that it will not break even in financial year 2015-16.

I am happy to take questions on the report.

The Convener: The first question is about the inclusion of the land disposal in the accounts. How unusual is it for a board to include a proposed land sale in its accounts when final sign-off on the sale has not taken place?

Fraser McKinlay: I will ask Kenny Wilson to talk to the detail of that. It is unusual, and it was the auditors that required it to be changed. Kenny, would you give more detail on exactly what happened there?

Kenny Wilson (PricewaterhouseCoopers): NHS Tayside signed an agreement with Miller Homes in December 2014, in which it agreed in principle to sell the property, depending on a number of conditions. The main condition was achieving planning permission. I think that the board felt that the likelihood of getting planning permission was extremely high and that the risk of not getting it was very small. However, from an accounting standpoint, it is quite right that we should not recognise a disposal until all conditions are met. While the risk of not meeting such an important condition was deemed to be small, we know that these things often take longer than expected to resolve. However, on 23 October, the board concluded the transaction, with planning permission.

The Convener: Are you saying that, at the annual general meeting, the accounts were proposed to and accepted by the board on the basis that the transaction had taken place? Were any caveats attached to the board's papers? I take it that you uncovered the issue, rather than it being presented to the board.

Kenny Wilson: Yes, that is correct.

11:30

The Convener: We have had that with other boards. The committee has made inquiries about information that has been provided by managers to board members to ensure that they can take decisions. For example, we have had an inquiry on brokerage in relation to NHS Highland. Is it acceptable that board members were not made aware that the disposal had not taken place?

Kenny Wilson: Why that was the case is possibly a question for the board, but it was certainly unhelpful that the board members were not totally aware of or did not recognise the real position.

The Convener: Is there an argument to be made that the issue is one of poor governance? Board members were presented with a set of accounts that included a disposal that had not taken place.

Kenny Wilson: I think that it was possibly more a case of the wrong judgment being made by the finance team in recognising the disposal at that time, rather than any attempt to mislead the board.

The Convener: I appreciate that, but the matter would have had ramifications for other decisions that the board might have had to take. Is there any record that the board was kept up to date on whether the transaction had taken place and what progress had been made? It is quite a significant omission to say, "These accounts include the disposal" and to make them available for the public record, only for the auditors to come in following that and say, "Actually, this disposal has not taken place."

Kenny Wilson: You are probably best asking the board why that happened.

Fraser McKinlay: Convener, you drew a couple of comparisons, but we see some important differences from the likes of the NHS Highland case that you mentioned. I should also say that adjustments to the accounts after they are signed are not in themselves unusual—that happens all the time. The issue at NHS Tayside is significant due to its scale. There is always judgment and debate between a finance director and an organisation and the auditors, because they come from a position of managing the finances, whereas we come from a perspective of accounting standards and other matters. As I say, there is always a bit of adjustment, which is why there is a period between, in this case, the board signing its accounts and the auditor signing the opinion three or four months later. That is what happens in the process.

I do not think that the issue was necessarily about the board being kept in the dark. You mentioned brokerage. In fact, the evidence that we have, which is set out on page 5 of the section 22 report, demonstrated that a good process was in place. The finance officers kept the board up to date about the financial position and the potential requirement for brokerage, which happened way back in November 2014. That was much earlier than, for example—

The Convener: To be fair, I am not raising the issue of brokerage in relation to the NHS Tayside issue. The board was told that the accounts included the disposal—the disposal was clearly in the balances that were made available to it. The main issue is whether it was made aware of the fact that the disposal had not taken place before the auditor found that out. I appreciate that that question should be raised with the board directly, but there must be governance issues if board members were not kept aware. I think that the standard practice with disposals is that the money is not put in the bank until the developer gets planning permission. Is that not quite a common arrangement?

Kenny Wilson: I am not aware that the board was aware of that fact until we raised it at the audit committee.

The Convener: Therefore, decisions that the board took once the accounts had been presented to it may have been impacted. If I were a board member and I was not made aware that the land disposal may not take place or had not taken place, would that not have an impact on my decisions and that of the board? Is that not a governance issue?

Fraser McKinlay: Yes, and the—

The Convener: That is the comparison that I am making.

Fraser McKinlay: Sure—

The Convener: I appreciate that there are brokerage issues in NHS Highland, but the concern relating to NHS Highland is primarily about how the board was provided with information to allow it to take the decisions that it needed to take.

If I were a board member and the set of accounts put before me made it clear that the disposal had taken place and there were no caveats—I appreciate what can happen afterwards—that would be a significant omission. If I had seen those accounts, I would be pretty relieved to be able to say at the board meeting, "Yes, that looks very good now, because the land disposal that we're expecting has actually taken place"—but that would only be because nobody had made me aware of the caveats. I appreciate that that is a discussion that must take place directly with the board.

Mary Scanlon: How do you expect any health board to make £27 million of cuts in one year? Paragraph 13 of the NHS Tayside section 22 report has the nitty-gritty bit—on top of brokerage, the NHS Tayside board is required to make £27 million of cuts. Is that possible and who decided that that would be done in one year?

Kenny Wilson: The board is required to meet the 3 per cent efficiency savings target annually. Last year, NHS Tayside made £22 million of efficiency savings. The key point to draw out is that 60 per cent of those efficiency savings came from non-recurring items, so it will become increasingly hard for the board to make further efficiency savings. There is no doubt that making £27 million of savings will be difficult.

Mary Scanlon: I have definitely been here too long because I have to correct Fraser McKinlay. It is not the first time that NHS Tayside has come to the attention of the Parliament in this regard. I do not know whether there was a section 22 report, but I remember that back in 2001-02, NHS Tayside had a £16.5 million deficit. The matter came to the Audit Committee and believe it or not, the chief executive resigned, something that does not happen now. He was a chap called Tim Brett, but that is all history.

I want to get into the details of the property disposal. I was brought up in Hillside and went to Hillside primary school, so I am very familiar with Sunnyside. Sunnyside royal hospital has lain derelict for decades. My concern is in relation to the various property disposals that are on the accounts in Tayside, such as Sunnyside. Is it possible that they appear in the accounts at an inflated value that makes the accounts look quite good, but when they come to be sold, the sum realised is much lower than that shown in the accounts? Does that not create an immediate deficit?

We all know that relying on non-recurring savings is bad, but this is a huge amount of land and property. Surely if the land and property was put on the accounts at a certain time in recent decades, given the state that it is in now and the current state of the property market, it cannot possibly be worth the original estimate? Is there not an inherent problem going back to 2001-02 in relation to overpriced properties on the board's accounts?

Kenny Wilson: Every year, a full valuation is done by valuers on the properties right across NHS Tayside and we review that valuation.

Mary Scanlon: And it is changed over time.

Kenny Wilson: Sorry?

Mary Scanlon: The valuation is regularly changed to reflect the state of dereliction and so on.

Kenny Wilson: That is right. The valuations held in the accounts will reflect the state that the property is in, the original cost and exactly what the valuers think might be realised from selling it, so I believe that the property values carried in the accounts are appropriate.

Mary Scanlon: I appreciate that the Ashludie hospital sale went through in April and was not included in these accounts, but was the amount that it was disposed for pretty well equal to the valuation in the accounts?

Kenny Wilson: The profit for Ashludie was £4 million on final disposal proceeds of £5 million. The net book value was just over £1 million, so a profit was made on the Ashludie sale.

Mary Scanlon: Right. Would you expect the same from Sunnyside? I believe that it is finally on the market after many decades.

Kenny Wilson: It went on the market in August this year and we hope that it will realise at least the carrying value but, of course, the amount will clearly vary depending on each property. That is one of the challenges that the board is facing—it is trying to realise its surplus estate in a difficult market.

Mary Scanlon: I have just one other question on Tayside—because I come from that area, I get a lot of anecdotes. I understand that there is quite an inflated team of directors in NHS Tayside. Did you look at the management team of executives, directors and senior managers? Is the number of people higher than in other health board areas? Are they paid more than in other board areas? Have they been given superior performance-related pay that differs from other board areas? Is that something that you looked at in your audit?

Kenny Wilson: I am sorry, but that is not something that we specifically looked at, and I have not done a benchmark exercise to find out how that compares with other boards.

Mary Scanlon: But you might look at doing that in NHS Tayside in future.

Kenny Wilson: We can certainly take on board and look at that suggestion.

Colin Beattie: I see some mention of changes to how the public pension schemes are valued. If I am not incorrect, it appears that the additional costs to the pension are £5.5 million.

Kenny Wilson: That is correct.

Colin Beattie: Is that the deficit?

Kenny Wilson: That is in effect the increase in costs that the board will be paying. It is similar to what is happening in all other boards as a result of the recent revaluation of the national pension scheme.

Colin Beattie: Okay. That, combined with the national insurance charges makes things quite challenging.

Paragraph 24 of the NHS Tayside report says that

"NHS Tayside recognises that traditional approaches"

to making savings are resulting in a decline in those savings. What are the implications of that? Does that mean that all the soft options have been used and that things are going to get a bit tougher?

Kenny Wilson: I think that that is right. As we have heard, the challenges that face the NHS as a whole go right across Scotland, but we need to be

more strategic and look at having a longer-term plan in order to make savings that can be sustained for the long term. Perhaps, as you have suggested, the low-hanging fruit has been picked.

Colin Beattie: I assume that the overspend of £4.549 million in the first four months that is mentioned in paragraph 27 includes staff payments.

Kenny Wilson: That is right. The additional staff payments in respect of the—

Dr Simpson: Enhancements during leave.

Kenny Wilson: Yes, the EDL. As those payments were accrued at the end of last year and have been taken care of in the 2014-15 accounts, they should have no impact on 2015-16.

Colin Beattie: So the £4.5 million is separate from that.

Kenny Wilson: Yes.

Colin Beattie: And it is not part of the additional staff costs that were accrued as a result of EDL.

Kenny Wilson: That is right.

Colin Beattie: Okay.

Obviously NHS Tayside is in quite a difficult position. Given the sheer size of the deficit that has to be covered, will its approach be practical on an on-going basis? After all, whether it sells Ashludie or not, that is a one-off, non-recurring asset sale.

Kenny Wilson: It certainly faces challenges and it needs to move away from its reliance on non-recurring items and the dependence on disposals of surplus properties. I know that the board is looking at that situation and is coming up with a detailed plan for addressing it, but it will certainly be challenging.

Fraser McKinlay: The report is interesting, not only with regard to the specifics of what is happening in NHS Tayside but because it presents in microcosm the issues raised in our earlier discussion on the overview report. It shows us all the pressures in one board and, as Mr Beattie said, it looks for sure as if it will be very difficult for that board to break even this year.

Dr Simpson: I have two questions, the first of which is about the sale that was put on and then taken off the accounts. Was that sale declared as part of the board's efficiency savings for that year?

Kenny Wilson: I think that it was declared as one of its non-recurring savings.

Dr Simpson: That is what I am talking about. The sale was included in not only the board's accounts but the report that we received on efficiency savings.

Kenny Wilson: That is right.

Dr Simpson: It is a fairly significant amount and I presume that it will not appear again as an efficiency saving for this year, even though the sale itself went through this year.

Kenny Wilson: Yes.

Dr Simpson: Right. I hope that someone has taken a note of that and that we do not get it again.

The issue of the enhancements during leave payments is very interesting. They total four point something million pounds and go back over four or five years, but the staff themselves have said that the situation is inadequate. Is either Mr McKinlay or Ms Gardner comfortable that this is a one-board event? Are we fairly certain that it is not occurring in other boards?

11:45

Caroline Gardner: As you would expect, Dr Simpson, that is exactly the question that I asked when I received the auditor's annual report. We have done checks with all the auditors that I appoint to NHS boards and we are confident that it was simply one board where an error took place in the treatment historically.

Dr Simpson: That is probably the one piece of good news that we have had today. I have only just joined the Public Audit Committee, but one of the elements that came up when I was a member of the Health and Sport Committee and we were looking at the future finances of the health service was ensuring that equality of pay was implemented. I think that you qualified accounts in previous years on that issue. I do not see anything in the report before us referring to equal pay issues. Previously, it could not be quantified what equal pay would cost. Has the equal pay issue been dealt with in Tayside?

Caroline Gardner: There is a provision for liabilities relating to equal pay in just about every health board's accounts. The situation in the NHS is now very different from that in local government. At the end of 2014-15, it was possible to quantify the liabilities for the first time. In its accounting treatment equal pay has moved from being an unquantified contingent liability to being a quantified provision, and the amounts involved are coming down quite markedly. That is why I did not draw attention to them in the "NHS in Scotland 2015" report that the committee took evidence on earlier or in the three section 22 reports that the committee is looking at just now.

Dr Simpson: Good. That is very helpful. Thank you.

The Convener: There are no further questions from colleagues on the Tayside report.

"The 2014/15 audit of NHS Highland: Update on 2013/14 financial management issues"

The Convener: We move to "The 2014/15 audit of NHS Highland". Stephen Boyle, the assistant director of Audit Scotland, has joined the Auditor General and the assistant auditor general. I understand that Mr McKinlay will make an opening statement on this report.

Fraser McKinlay: I will try to be brief, convener. The issues around NHS Highland probably need no introduction, but for consistency I will provide one for the committee.

The committee will be well aware that the 2013-14 audit report on NHS Highland by Stephen Boyle highlighted weaknesses in financial management that were a major factor in the board requiring brokerage of £2.5 million from the Scottish Government to break even. As you will know, the need for that brokerage was mainly due to an overspend on operating costs at Raigmore hospital. The auditor, and this committee subsequently in its inquiry, identified significant concerns about governance in the board and the decision making around the decision to go for brokerage.

The Auditor General decided to bring a section 22 report back to the committee this year as an update. After we did our work on the board and the committee had its inquiry, NHS Highland developed an in-year financial recovery plan that detailed how the board expected to address projected shortfalls against its budget and achieve its planned break-even position at the year end. The committee will also be aware that the Scottish Government brought forward £3 million of NRAC money in January 2015 to help the board reach a break-even position in 2014-15.

Based on a review of the work undertaken by the board in 2014, the auditor, Stephen Boyle, concluded that NHS Highland has strengthened its financial management arrangements and scrutiny of financial performance. In 2014-15, NHS Highland achieved its two key financial targets and broke even against its revenue and capital budgets, and 40 per cent of savings made in year were on a recurring basis. Raigmore hospital reduced its budget overspend to £6.9 million, but that fell short of the £6 million target, which adds to the continuing pressure that the board is experiencing this year.

I am very happy to take questions on the section 22 report.

Colin Beattie: Clearly, there has been tremendous improvement here. It is clear from the Auditor General's report that a great deal of work has been done. Obviously, it is still a worry that there is such a high level of non-recurring savings, which we also commented on when the previous report was issued. The big problem still appears to be Raigmore hospital. It has reduced its budget overspend, but are you satisfied that adequate steps are being taken to bring the hospital, which contributes such a large proportion of the deficit, back into financial equilibrium?

Fraser McKinlay: As you say, Raigmore has responded well to the audit work and to the committee's inquiry in the past 12 months. As we mention at paragraph 17, an important part of that is the hospital's three-year recovery plan, which takes it through to 2016-17. I will ask Stephen Boyle to give you a little of the flavour of what is in that plan, but it looks to us as if it covers all the right things.

The issues that the committee raised with the board during its inquiry to do with the way in which clinicians and others at Raigmore were spending money without any real control or reference to their budgets have provided a particular focus for getting the situation under control.

Stephen Boyle (Audit Scotland): We have certainly seen an improvement in the control environment in Raigmore hospital. We note at paragraph 22 some of the practical steps that the hospital is taking. For example, the director is overseeing and taking control of the authorisation for locum doctors and temporary staff. That oversight is factored into the financial projections for the hospital.

All that said, the financial environment for Raigmore remains challenging. The board's most recent set of in-year financial projections for period 7 suggests that it is still looking at a potential overspend of £6 million for the year. Given that the hospital, which dominates the board's overall spend, is not quite making its savings target, and given that the financial environment remains challenging, it will remain challenging for the board to continue to deliver on the financial recovery plan.

Colin Beattie: Can you remind me of the overall budget, or the overall financial spend, at Raigmore? I am just wondering what proportion of that £6.9 million amounts to.

Stephen Boyle: As exhibit 5 sets out, the hospital's budget for the current financial year is £145.8 million.

Colin Beattie: Paragraph 64 of the Auditor General's report on "NHS in Scotland 2015" states:

"NHS Highland reported that its policy is to hold corporate services vacancies open for at least six months ... to allow it to generate non-recurring savings."

Those almost become recurring savings if the board does that all the time. How significant a contributor is that element to reducing the deficit? Is it desirable? If a post is empty for six months, does the board need that post?

Fraser McKinlay: Stephen Boyle might know what proportion of the total such savings represent.

Stephen Boyle: I am sorry, but I do not have that figure to hand. Flipping a non-recurring saving into a recurring saving has been part of the process that NHS Highland has used over a number of years. If a post is vacant for such a long period of time, the board will—exactly as you suggest, Mr Beattie—take a judgment on whether it is still required.

Colin Beattie: It would be interesting to know how much that contributes as a proportion of the savings that the board is trying to achieve.

I have one last question. Paragraph 22 of the NHS Highland report highlights an increase in temporary staffing and overtime, and there seem to be additional controls around that. Does the figure of £9.859 million seem disproportionate, or is it a reasonable spend?

Fraser McKinlay: We can double-check that. The Auditor General is helpfully seeing whether she can find a number in the overview report just now. We do not have a figure in the NHS Highland report, but we can certainly check and come back to you on how that stacks up in comparison with other boards.

Colin Beattie: Thank you.

Mary Scanlon: As I have been quite critical of NHS Highland, it is only right for me to be fair where it has done some corrective work. It is also fair to say that Raigmore overspent its budget in the past five years, and that it is really only since Audit Scotland produced its section 22 report that the overspend has gone down from £9.9 million to approximately £5 million. As a Highlands MSP, it is quite annoying to me that, for many years, NHS Highland has not received from the Government the recommended amount of funding in accordance with the NRAC funding formula. Although it got some last year to help it to break even, it has been underfunded for many years.

As you know, NHS Highland and Highland Council were the first organisations in Scotland to integrate health and social care. They really are pioneers, and all credit to them for making that work. My concern is that, although NHS Highland has addressed its issues and the future is looking good—it has corrected a lot of things that were addressed in the section 22 report—it now relies on Highland Council doing its share. This week, Highland Council has learned that it is facing £40 million-worth of cuts. I appreciate that this is new to you but, even though the NHS budget is protected and NHS Highland is doing everything right in order to meet your recommendations, council budgets are not protected—I do not want to go into that—and, because of health and social care integration, NHS Highland has to take some responsibility for the £40 million-worth of cuts that Highland Council has to make. How difficult is the situation going to be in other areas, given the integration of health and social care services? Are you considering the situation, given that many councils have followed in the footsteps of NHS Highland and Highland Council?

Fraser McKinlay: We are indeed. In fact, we are publishing our first report on health and social care integration tomorrow. It is due to come to the committee in two weeks' time, I think.

Mary Scanlon: That is timely.

Fraser McKinlay: That will give you plenty of opportunity to consider the issues.

The other interesting thing about NHS Highland is that, as well as being the first health board to participate in the integration of health and social care, it is the only board to have gone for what is known as the lead agency model; all other areas have gone for the integration joint board model.

Mary Scanlon: So the responsibility for children is with the council. That is worrying, in light of the £40 million-worth of cuts.

Fraser McKinlay: Indeed, and that is why they have swapped those things over.

Without giving too much away about the report that we are publishing tomorrow, I can say that the way in which the money is working in all of this is one of the biggest issues that are proving difficult for NHS boards and councils to bottom out. Tomorrow's report is really a position statement, given that it is quite early days in the new integration landscape. We are just trying to set out the facts and describe the shape of what is happening. However, we also identify some issues for the future. Certainly, Highland Council and NHS Highland have had a lot of experience of figuring out how the money works, because the model that they developed at the start of the process two or three years ago has had to be adapted as the service has levelled out.

That is the long answer to your question. The short answer is that, yes, health and social care integration will feature heavily in our work programme in the next three to five years.

Nigel Don: I am concerned about budgets and how they are set. Exhibit 4 concerns the situation

at Raigmore hospital. With the benefit of hindsight, what justification might there have been for the budget, given that it has always been overspent and that it continues to be overspent by a significant amount? It rather looks as though it costs about £145 million to run Raigmore hospital but that the budget has never said as much. Am I being too cynical?

Fraser McKinlay: I would not say that you were being cynical; your observation is a perfectly fair one. Stephen Boyle can keep me right, but I believe that, between 2011-12 and 2012-13, there was a process of rebasing the budget, which is why it jumped from £130 million to £135 million. However, that still was not enough money. I absolutely agree that, along with the longer-term financial planning and thinking about budgets, the budget for Raigmore will have to be considered. Of course, the challenge is that, if the budget for Raigmore is simply raised by £5 million or £6 million, that money must be found from somewhere else. As well as considering rebasing the budget, there is a challenge to continually try to push down the costs at Raigmore.

12:00

Nigel Don: Which brings me to the bigger question of how on earth these budgets are set. Again, you must forgive me, but when I look at the non-recurring savings column in exhibit 3, I see non-recurring savings of £3 million for every foreseeable year. The board has no idea where those savings are going to come from, so a figure of £3 million goes in and the incredibly accurate figures to the left of that column are, of course, just the difference between the non-recurring savings and the total savings to be found. That is the way that numbers come out, but can the board do any better, or is that just the nature of this kind of budgeting? Is it simply a case of having to work one's way through this every year and hoping that it can be made to work?

Fraser McKinlay: As auditors, we would always say that these things could be done better; in a sense, that is what we are all about. However, there is a point at which you have to make some assumptions and put some numbers into the budget. As we said earlier, the situation can be helped with better longer-term financial planning, better understanding of the demographics, the pressures and all of those things and, as difficult as it might be, some assumptions about the money that the board is going to get. That has to be the right thing to do, which is why—and this was one of the criticisms made in last year's report—in-year financial management and monitoring are so important. They ensure that the savings that the board says that it is going to make in year are being delivered.

Nigel Don: Does the budget come from a build-up of known costs or from the slice that the board gets of the total budget?

Stephen Boyle: Organisations take different approaches such as priority-based budgeting and activity-based costing but, broadly speaking, the budget is put together on an incremental basis. The organisation's budget and the costs that it is incurring will be inflated for known and anticipated costs, known additional activity, such as work through the treatment time guarantee and so forth, and that broadly leads it to be able to strike a budget in advance of the new financial year.

Nigel Don: The incremental approach itself makes it very difficult for a board to make any substantial change, but if your historic costs have never been right and you have never hit your budget, there will be only marginal changes from something that was and which continues to be wrong.

Fraser McKinlay: That is exactly the reason why in the earlier report we make a recommendation about the need for greater flexibility and better longer-term planning. If you continue to add bits on to what you have always done, the significant change that we think is needed in the system is simply not going to come about.

Dr Simpson: Paragraph 22 of the report highlights a staggering reduction of 31 per cent in the first 10 months in locums at Raigmore hospital. What effect has that had on the running of the hospital? People employ locums not because it is fun to do so or because someone needs a job but, I would think, to meet the treatment time guarantee. Such a reduction means that either Highland is going to find it difficult to meet the treatment time guarantee or the difficult question will arise of whether staffing levels are totally safe. I have experienced this situation myself. You have to make an application for a temporary member of staff almost up to chief executive level, and by the time it comes back down, your situation with temporary sickness, maternity leave or whatever is over. In the meantime, your staff sickness rate has gone up because you have put so much blooming stress on the rest of your workforce. It is all very well producing this lovely figure, but do you look at things such as sickness rates, target effects, whether staffing levels are safe or the number of staff complaints about feeling unsafe?

Fraser McKinlay: The short answer is yes, but we did not necessarily do it as part of this piece of work, because our focus was on financial management issues.

However, you are absolutely right. One has to be careful here and realise that a reduction in the use of locums is not necessarily a good thing in

itself. That said, the last time round, the use of locums at Raigmore was very clearly identified as one of the significant cost pressures, and tightening controls in the hospital was, we think, a good thing to do. We would absolutely expect the board and the hospital to assure themselves that such a move was having no knock-on impact. The exhibit in the overview report shows that there is no doubt that NHS Highland is experiencing pressures on some of the targets. Whether we can draw a direct link between the two things is a different question.

The exhibit in the overview report shows that there is no doubt that NHS Highland is experiencing pressures on some of the targets. Whether we can draw a direct link between the two things is a different question.

Dr Simpson: We might see it in future years.

What really concerns me is the focus on finance. I know that it is critical, but if you look back to the report on the Mid Staffordshire NHS Foundation Trust, that is where it all started. The staffing was cut, which made the hospitals unsafe. I just ask you to look at staff complaints in the system. Health Improvement Scotland or you should be drilling down into that. We might put NHS Highland under such pressure that we create a Mid Staffs situation.

Caroline Gardner: I absolutely share your concern. There have to be risks, given the pressures that are on the health system just now.

In the report on the management of waiting times that I produced back in 2012 on the back of the problems in NHS Lothian, one of our broader findings was that some boards were focusing on financial performance and quality of performance as though they were different things. We recommend that boards should have information that pulls that together in a dashboard or some other way so that they can see the interaction between financial performance and what is happening to patients. The one cannot be divorced from the other; they are two sides of the same coin.

Dr Simpson: Are you satisfied that that is now happening as a result of your recommendation?

Caroline Gardner: It is happening to different degrees in different parts of Scotland. The annual audit reports that are produced by the auditors that I appoint to the 14 health boards give that overview of financial performance and the other key targets to which boards are working. Part of our review process in deciding what to bring to the Public Audit Committee's attention is to look for disturbing patterns.

The Convener: The issue of vacancy rates came up in the original report and we had quite a substantial exchange when we took evidence on that. It was related to staff morale and sickness levels. Are the vacancy rates still the same as they were previously?

Fraser McKinlay: I do not think that we have any information to add, to be honest.

The Convener: Perhaps you could provide us with that information. The impact of vacancy rates and sickness levels was highlighted in the report and it would help us to see the current position if you provided us with before and after figures.

Fraser McKinlay: I remember the discussion well, convener. It was about keeping vacancies open and whether that was having a knock-on impact on morale and absence. I will see what we can dig out on that.

The Convener: I thank you for your evidence.

Section 23 Report

"Accident and Emergency: Performance update"

12:07

The Convener: Item 4 is the Scottish Government's response to the Auditor General's report "Accident and Emergency: Performance update". Do members have any comments on the correspondence that we have received?

Colin Beattie: The correspondence from Paul Gray is quite interesting. We are beating ourselves up over not meeting our targets and yet what we are achieving is better than what is being achieved in the other nations of the UK and in some other countries overseas. I liked the bit that highlights the fact that the Canadian report, "Time to Close the Gap"

"singles out performance in Scotland as the benchmark to which Canada should aspire."

That is quite commendable. It does not mean that we should not strive to meet our targets, of course. The targets are there for good reason, but it is encouraging to know that we are leading the pack, so to speak.

Mary Scanlon: I take a slightly different tack. I found that I got halfway through Paul Gray's response and I knew the state of affairs in Germany, the Netherlands, Australia, New Zealand, Canada and England, but I had to read further down before I came to Scotland. Quite honestly, I am not that interested in accident and emergency response times in Australia; I am more interested in the response times in Scotland.

There is no point in setting a target and saying that we cannot reach it but that we are still better than Australia. I do not think that it is acceptable for a director general to do that. For that reason, I refer colleagues to paragraph 22 of the Audit Scotland submission, "Accident and Emergency: Briefing paper to the Public Audit Committee". It highlights that

"The number of people who waited longer than 12 hours in A&E ... has increased by 55 per cent"

and that

"it ... increased by 292 per cent over the last year."

Paragraph 22 goes on to highlight that, in the same period, the number of patients who waited for more than eight hours went up from approximately 8,700 to 14,000.

I am sorry, convener, but I do not find Mr Gray's response acceptable in the context of a Scottish national health service with Scottish targets, a Scottish Government and a Scottish Parliament with a Scottish Public Audit Committee. We are here to audit what happens in Scotland. A response that tells us about Germany, the Netherlands, New Zealand and Australia is irrelevant. It is not our job to consider those countries. I ask Mr Gray to focus on Scotland, please, because we are not responsible for the health service in New Zealand. I would like to hear more about what he is doing to address problems in Scotland than about what is happening on the other side of the world.

Dr Simpson: There are nine targets. Two targets have been met, as we have just heard from the Auditor General, and seven have not, and the performance against all of them is deteriorating. It is the trend, rather than the actual figure, that is interesting. That is a real worry.

However, there is a difference between the accident and emergency target and the other targets. We are told that the A and E target is evidence based—in other words, the consequences of not meeting a four-hour target mean poorer outcomes for the patient. The other targets are nice, but they are not clinical, and they do not have the same degree of clinical relevance. They are concerned with patients' rights. For example, the 12-hour target—which we are not meeting despite it being a legal guarantee; heaven knows I have said that often enough—is quite different from the A and E target.

The trouble with setting targets is that it results in conscious or unconscious gaming. We saw that happening with the waiting times issue, to which the Auditor General has just referred. We now know that there are 13 units in our acute hospitals that are not governed by the accident and emergency waiting times targets. They are variously called clinical decision units, acute assessment units and immediate assessment units; I cannot remember the name of the unit at the Queen Elizabeth hospital, which is where all that came to light.

The question—I cannot answer it, and I am not saying that this is happening—is whether there is gaming going on, in which referrals are being made to those non-governed units in order to try to meet targets that are proving to be very difficult. Even though the targets are no longer set at 98 per cent—such targets were being met at one time—and there are now interim targets set at 95 per cent, those are not being met in specific areas, mainly in the west of Scotland and in Glasgow.

The report is unsatisfactory. We need to go back to Mr Gray and say that the Cabinet Secretary for Health, Wellbeing and Sport's announcement on looking into those 13 units must be brought forward rapidly so that we understand the true position. We can then have a rational discussion, in either this committee or the Health

and Sport Committee, or in Parliament, about the whole business of targets.

Mary Scanlon and I are leaving the Parliament, so we do not have an axe to grind in that respect. I have said, and my party is saying, that we really need to look at the target issue. It is not just about not meeting targets—the effect is causing the stress of not shifting things into preventive care and community care, and mental health and general practice are suffering as a result. Health services are deteriorating as a result of targets that no longer have the purpose of making the health service, and patient outcomes, better.

The Convener: I should clarify that we actually asked Mr Gray to provide comparisons with various countries.

Dr Simpson: Yes, and they are very interesting, but—

The Convener: I just want to clarify that Mr Gray included that information in his correspondence because we asked for information on benchmarking with various other parts of the world. We need to be careful in that regard. We are not here to defend Mr Gray, but we should be clear about the information that we asked for, and we asked for that information.

Tavish Scott: I support Richard Simpson's point about the need for proper assessment of targets. I am told that Audit Scotland could assist us in that. It is probably a job for a future committee in a future session of Parliament, but all I hear at a local level in my part of the world are comments about the pressure that targets put on clinicians and staff. There needs to be a proper, rational, non-political discussion about the most appropriate targets.

It was not that long ago that Alex Neil, as the Cabinet Secretary for Health and Wellbeing, turned up at this committee to tell us why the Government was taking the target down to 95 per cent from its previous level. The discussion about the target is relative, as the target is now lower than the one that was originally set.

12:15

Colin Beattie: I have two points to make. One point—which the convener made—is that we asked Paul Gray for those comparative figures for the other nations in the UK and for countries overseas where he had those available.

My second point relates to targets. It is interesting to note that, in 2007, there were 200 reportable targets in the NHS and that figure has been taken down to 20. I agree that there should be a discussion on the appropriateness of those 20 targets. Are we getting information that will allow us to drive the national health service forward in the future? Will it give us the vision that we need to be able to allocate resources? In terms of resources, what is coming down the road is changing all the time and we need to be flexible in that regard. Will the targets that we are looking at give us the indicators that we need to enable us to be flexible and to adapt? That is a valid question that we need to discuss.

The Convener: Okay, colleagues—we have here the response from the Scottish Government and there are a number of different options for how we take things forward. The first option is to note the correspondence, but having listened to members' comments, I do not think that that is the direction of travel from the committee.

Perhaps we could highlight to the Government the various points that colleagues have made on the targets, including the point that Colin Beattie has just made. Is that helpful? Are we agreed on that?

Members *indicated agreement.*

Mary Scanlon: On Richard Simpson's point, can we get some information about the units that are not included in the waiting times targets?

The Convener: On the centres that are not included? Yes, that would be helpful. It would also be helpful for the legacy committee's work and the Auditor General's future work to look at how that information could be provided at some point in the future.

Thank you, colleagues. As previously agreed, we move into private session.

12:17

Meeting continued in private until 12:54.

Published in Edinburgh by the Scottish Parliamentary Corporate Body

All documents are available on
the Scottish Parliament website at:

www.scottish.parliament.uk

Information on non-endorsed print suppliers
Is available here:

www.scottish.parliament.uk/documents

For information on the Scottish Parliament contact
Public Information on:

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