OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit and Post-legislative Scrutiny Committee

Thursday 3 November 2016

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 3 November 2016

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PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE
7th Meeting 2016, Session 5

CONVENER

*Jenny Marra (North East Scotland) (Lab)

DEPUTY CONVENER

*Alison Harris (Central Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Liam Kerr (North East Scotland) (Con)
*Monica Lennon (Central Scotland) (Lab)
*Alex Neil (Airdrie and Shotts) (SNP)
*Gail Ross (Caithness, Sutherland and Ross) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Nick Bennett (Scott-Moncrieff)
Carol Calder (Audit Scotland)
Caroline Gardner (Auditor General for Scotland)
Jillian Matthew (Audit Scotland)
Kenny Wilson (PricewaterhouseCoopers)

CLERK TO THE COMMITTEE

Terry Shevlin

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit and Post-legislative Scrutiny Committee

Thursday 3 November 2016

[The Convener opened the meeting at 09:02]

Decision on Taking Business in Private

The Convener (Jenny Marra): Good morning and welcome to the seventh meeting of the Public Audit and Post-legislative Scrutiny Committee in session 5. I ask everyone present to switch off their electronic devices or put them into silent mode so that they do not affect the committee's work.

Under item 1, the committee is invited to agree to take items 5, 6 and 7 in private. Item 5 is consideration of evidence received under item 2 on the report "NHS in Scotland 2016"; item 6 is consideration of evidence received under item 3 on the report "The 2015/16 audit of NHS 24: Update on management of an IT contract"; and item 7 is consideration of evidence received under item 4 on the report "The 2015/16 audit of NHS Tayside: Financial sustainability". Do members agree to take those items in private?

Members *indicated agreement.*

Section 23 Report

"NHS in Scotland 2016"

09:02

The Convener: Item 2 is an evidence-taking session on the Auditor General for Scotland's report "NHS in Scotland 2016". I welcome to the meeting Caroline Gardner, the Auditor General for Scotland; Angela Canning, assistant director at Audit Scotland; Carol Calder, senior manager at Audit Scotland; and Jillian Matthew, audit manager at Audit Scotland. I invite the Auditor General to make her opening statement.

Caroline Gardner (Auditor General for Scotland): Today, I bring to the committee my annual overview report on the national health service in Scotland. It examines the performance of NHS boards during 2015-16 and comments on the challenges and pressures that face the NHS. It also looks ahead to assess what progress the Government is making towards delivering public service reform, including its ambition for everyone to live longer, healthier lives at home or in a homely setting by 2020.

Over the past decade, there have been real improvements in the way that health services are delivered: the time that patients wait for hospital treatment has reduced; treatment is safer; and hospital-related infections have dropped. Overall, people are living longer and are now more likely to survive conditions such as heart disease. Those improvements are testament to the hard-working staff of the NHS, who provide a vital service for all of us in Scotland. However, the health of Scotland's population is relatively poor compared to that of other developed countries, and significant health inequalities still exist.

I have highlighted in previous reports the challenges that NHS boards face. They find it increasingly difficult to achieve financial balance and many used short-term measures to break even in 2015-16. The percentage of non-recurring savings has increased and, for the current year, boards are setting higher savings targets—the average is 4.8 per cent. The total planned savings are £492 million in 2016-17, which is 65 per cent higher than in 2015-16. That will put considerable pressure on the NHS this year, and there is a significant risk that some boards will not be able to remain within their budgets.

Overall, NHS spending is not keeping pace with the growing and ageing population, increasing demand and rising costs. NHS funding has increased each year since 2008-09, but the small real-terms increases of less than 1 per cent over that period have been below the general inflation

rate and well below the higher health inflation rate, which was estimated at 3 per cent in 2016-17.

The committee might remember that we analysed the increasing demand for health and social care services in our report "Changing models of health and social care". In the report that is before us, we highlight a range of cost pressures, including in relation to rising drug and staff costs, the achievement of national waiting times and new technologies. It is clear that the NHS cannot continue to provide services in the same way within the resources available. The Government has had a policy on shifting the balance of care for more than a decade and has published several strategies for reducing the use of hospitals and supporting more people at home, but most spending is still on hospitals and other institution-based care. Some progress is being made in shifting to new models of care, but it is not happening fast enough to meet the growing need.

My report sets out a number of recommendations to increase the pace of change, including having a clear plan with measures or milestones to allow progress to be assessed. There also needs to be financial modelling and a funding plan for the implementation of the strategy; a clear workforce plan to ensure that there are the right staff with the right skills for new ways of working; and continuing engagement with the public about the future of health services. The Cabinet Secretary for Health and Sport has accepted our recommendations and has committed to publishing by the end of the year a delivery plan that will bring together the various strands of reform that are under way, and I welcome that commitment.

Convener, my colleagues and I are happy to answer the committee's questions.

The Convener: Thank you. The first question is from Alison Harris.

Alison Harris (Central Scotland) (Con): Good morning. I have questions in relation to the recruitment and training of staff. My major concern is that without trainees going into specialist trainee posts, there are unfilled vacancies, as the report states, in old-age psychiatry and clinical oncology, which will be a major problem going forward—for example, as the population gets older. Most junior doctors seem to do their two years to become registered with the General Medical Council but are not taking the next step of going into specialties. Has Audit Scotland done any work to see why that they are not taking up those posts? What is causing that drop-off?

Caroline Gardner: Those are very timely questions. The 2016 report pulls together evidence from the audit of each of the health boards, particularly the 14 territorial health boards, during 2015-16. The previous couple of reports have highlighted pressures on the NHS workforce. We are about to start a new performance audit that will look specifically at those questions and drill down into the high-level findings in the 2016 report.

Alison Harris: Right. That is certainly something that needs to be drilled down into. We need to know why junior doctors are not going on to take up specialist training posts. I look forward to seeing that report.

Page 12 of the report refers to balancing budgets. Paragraph 18 shows that boards seem to have done a wee bit of creative accounting in order to balance their budgets, which concerns me. It seems that the more creative boards are in that respect, the better they can balance their budgets, and so they think that they are okay. Do you have any thoughts on that?

Caroline Gardner: You are right. As accountants, we look for the areas where there is a risk that people are, to a greater or lesser extent, flexing the figures to hit a target this year, which very often means simply pushing a problem into next year. We refer in the report to the specific example of NHS Ayrshire and Arran making a pre-payment for public holidays, which the auditor concluded was simply not acceptable. Ayrshire and Arran restated its figures and increased the pressure on achieving its break-even position. We absolutely rely on the auditors whom I appoint to each of the health boards to ensure that proper accounting practice is being used. Given the attention that is focused on both the revenue limit and the capital resource limit, the actions and transactions that boards undertake to hit those measures are areas that the auditors pay particular attention to, as you would expect.

Alison Harris: Thank you.

Colin Beattie (Midlothian North and Musselburgh) (SNP): As is often the case with Audit Scotland reports, this one gives mixed information. It highlights the challenging financial situation that the whole public sector is facing, but I am pleased to see that it also contains a lot of positive stuff about improvements in overall health, life expectancy, patient safety and survival rates for certain conditions, and a reduction in delayed discharges. Those are all positive things, although that does not take away from the fact that there is a great deal of pressure in the sector.

I want to focus on one or two points. At paragraph 28 on page 15, the report states:

> "The ... conclusion was that adequate accounting records had not been kept in relation to elements of property, plant and equipment assets."

That is pretty basic stuff. Has that situation been rectified?

Caroline Gardner: I will ask Jillian Matthew to come in on the detail, but it is fair to say that the issue that we described is now relatively unusual. Most NHS boards have decent records of their assets and manage them well, although—as you highlighted—there was a particular instance in Shetland this year.

Jillian Matthew (Audit Scotland): The issue in Shetland was that the board had recorded assets that had been purchased but had not kept adequate records on disposal or sale of assets. The assets that were examined were quite old, and the board had assumed that they had been sold or disposed of, but it did not have the records, and the information had not been kept up to date on the asset register. The auditors have worked closely with the board on that and improvements have been made, and they have been assured that it will not be a problem in the future.

Colin Beattie: I am looking at paragraphs 29, 30 and 31 on page 17. Would it be correct to say that there has been a small improvement in the NHS estate in the period that the report covers?

Caroline Gardner: It is probably fair to say that, but—as you will see from reading those paragraphs—the situation is slightly more nuanced. The changes in each of the categories from "good condition" through to "unsatisfactory" move in different directions, so although there is a small improvement, a significant amount of the estate still requires significant investment to bring it up to an appropriate standard.

Colin Beattie: At paragraph 39 on page 19, the report states:

"Scotland, along with the rest of the UK, has one of the highest generic prescribing rates in the world."

The prescription of generic drugs generally reduces costs, and yet—if I remember correctly—prescriptions make up approximately 12 per cent of NHS costs, which seems an awful lot. We are seeing year-on-year inflation-busting increases in the cost of drugs. Is the switch to generic prescribing actually having the impact that one would hope that it would have?

Caroline Gardner: Over the long term, it has had a very significant impact. We have reported on general practitioner prescribing in its own right on at least two occasions over the past decade or so, and we have seen both significant increases in the generic prescribing rate and real savings as a result, to the extent that it looks as though the remaining savings that are available to be achieved are pretty small.

What has changed has been the conditions in the market. The supply of some of the unbranded generic drugs has been restricted for different reasons and the price has risen. Jillian Matthew might want to add a bit of detail to that.

Jillian Matthew: To echo what Caroline Gardner said, a lot of savings have been made through the switch to generic prescribing, but a lot of issues have arisen over the past few years around the prescribing of drugs. The number of items that are prescribed is going up, which is linked to the ageing population; more drugs have been approved; and new and very expensive drugs for rare conditions have been developed, so boards are having to finance those.

There are many pressures from various sources that are causing the overall increase, and the Scottish Government predicts that that will continue for the foreseeable future, with an approximate increase of 5 to 10 per cent each year. That is a big pressure for boards at present.

Colin Beattie: The report also states in paragraph 39:

"Our 2013 report on GP prescribing found that most of the potential savings ... have already been made."

I assume, therefore, that there is not a great deal to be got out of that now.

Caroline Gardner: As I said, Scotland has made real advances in generic prescribing over the past decade, and we think that most of the savings have been achieved.

The challenge lies in the new drugs that are coming through; increasing levels of prescription, such as the prescription of statins, for some conditions; and very significant increases in the price of some drugs where the supply is restricted to one or two manufacturers, or a new supplier has bought the rights to manufacture them and has significantly increased the price. We have tried to set some of that out in the following couple of pages, which contain examples of drugs to which that challenge applies.

09:15

Colin Beattie: I also noticed that a fairly high proportion of prescriptions are for over-the-counter drugs, which seems odd.

Caroline Gardner: That is a policy matter that you should ask the Government about. There might be good clinical reasons for prescribing to a particular patient things such as ibuprofen, which is one of the drugs that we identify in the report, but the fact is that most of us can simply purchase over-the-counter drugs when we need them. There might be a particular preparation of the drug or, for some patients, it might be appropriate for the health service to fund that instead of the individual. However, the area seems to be worth looking at, particularly given that, as we have highlighted, last year the cost to the health service

of paracetamol, ibuprofen and antihistamines was around £17 million. That is a significant amount of money.

Colin Beattie: On the use of agency staff, which seems disproportionately high, the report states that there is a difficulty for the NHS in recruiting staff at what seems to be almost all levels. Is that correct?

Caroline Gardner: We highlight in the report that the NHS is facing problems in recruiting and retaining its staff. The situation affects different parts of the country differently, and it affects different specialisms and types of staff differently as well. I think that the challenge for the NHS is that, in most circumstances, it must have a member of staff present for quality and patient safety reasons, and if there is a gap in the rota, one cannot avoid bringing in a temporary member of staff.

As we say in the report—and as we have reported in more detail previously—the way in which that is done really matters if it is a short-term fix. On the whole, having your own bank is cheaper and provides higher-quality care than using an agency. Obviously, the longer-term solution is to draw back and look at workforce planning in the way that Ms Harris was suggesting earlier.

Colin Beattie: You might not have an answer to this question, but is it more profitable or better paid to be employed as agency staff than it is to be a permanent employee of the NHS?

Caroline Gardner: We have not looked at that in depth recently, but when we last looked at the issue it appeared that the drivers were more about flexibility for staff and their ability to choose their own working hours and location in ways that would have been less available to them had they been on the permanent establishment of a hospital or other healthcare setting. It costs the health service more to use an agency because it involves VAT and commission, but that does not necessarily mean that the member of staff is being paid more directly. It appeared that the attraction was the flexibility.

Monica Lennon (Central Scotland) (Lab): Good morning, Auditor General. Exhibit 6 on page 29 illustrates perfectly the challenges that we are facing in our NHS. It does not paint a great picture. I know that Colin Beattie has touched on some of the positives in the report—and they are welcome—but we also see that over the past four years national performance has declined in six of the eight key waiting standards. At the moment, only one of the eight indicators is being achieved.

You said in your opening statement that NHS funding is not keeping pace with increasing demand and the needs of an ageing population. If nothing changed, what could the table look like next year?

Caroline Gardner: As you will understand, auditors are uncomfortable with speculating about what might happen, but we have highlighted very clearly in the report that the service pressures and financial pressures on boards are increasing and that the solution to that is to make faster progress with the Government's vision of reducing reliance on acute hospital services.

For example, the accident and emergency four-hour standard can be a real measure of people who simply cannot receive the care that they need anywhere else, such as through an urgent GP appointment or by receiving social care, which could help keep a frail older person safely at home. As a result, we believe that the long-term solution is to invest in services that might allow people to avoid the need for acute hospital care. However, as we say in the report, that is not happening fast enough to relieve the pressures that you will have seen on standard performance and on the financial performance that we have also reported on.

Monica Lennon: One of the statistics that concerns me most relates to child and adolescent mental health services. I note that five of the 14 territorial boards have failed to meet the 18-week child and adolescent mental health services target. Why are health boards failing to keep up with demand? We know that demand is increasing and we know that the Scottish Government has made mental health a priority, with an extra £150 million committed to it over the next five years. However, the statistic that I gave, which has been raised by members across the chamber, is really worrying. Why are we not getting that right in our NHS?

Caroline Gardner: I completely agree with you that it is a very important service standard. I will ask Jillian Matthew to give you a bit more detail in a moment, but it is worth noting that we are also planning to do some detailed work to drill down specifically into those services.

Jillian Matthew: As Monica Lennon said, we have figures in the report that show that the number of patients has increased. Historically, the target has been challenging for boards to meet, although the position has improved slightly over the past year. It is one of the specialties where there are great difficulties in recruiting staff, and there is a shortage of consultants and other staff to work in CAMHS. As Caroline Gardner says, we will look at the area in more detail next year.

Monica Lennon: That report will be very welcome. Another aspect of this report—this is obvious to all of us—is that significant health inequalities still persist. In all the reports that I have seen, I do not see any real improvement on

that front. Why is that the case? It is a very thorough report looking across the NHS, but why are we still failing to tackle health inequalities?

Caroline Gardner: I am sure that you know better than I do that that is a very complex area—there is no single reason why we are not tackling it faster and there is no single thing that would make a difference. Again, it is one of the really important reasons to break out of the cycle of focusing on the acute health services meeting targets for treating people in hospital, without having a picture of the whole health and social care system and a plan for shifting more care and more provision closer to people's homes.

Very often, healthcare inequality has multiple causes. It starts very early in someone's life or even during their mother's pregnancy. It is one of the reasons why we have highlighted in our recommendations the need for a public health strategy and more emphasis on the preventative healthcare agenda, as well as the need to make sure that the acute hospitals are playing their part in the overall system.

There is no one thing that would fix health inequalities but there is a real risk that if we keep on focusing primarily on the acute hospitals, we will make that gap even more difficult to close over time.

Gail Ross (Caithness, Sutherland and Ross) (SNP): Good morning. I want to touch on part 2 of the report, on service reform. We know locally and from the Government targets for service reform—and it is brought into sharp focus by your report—that change is necessary and that how we provide health services has to keep evolving.

The other part of the report mentions difficulties in the recruitment and retention of staff, especially in rural areas; in NHS Highland, we are having to look at different models of staffing.

Members of the public can be suspicious of change if they are not consulted and not kept fully informed about what is happening in their area. Do you have any comments on how the public are being consulted by different NHS boards? Is it working? Are the public happy? I do not want to pre-empt anything, but I already know the answer to that question for my area. Also, are staff being taken along with the service reform?

Caroline Gardner: You are absolutely right about the concern that there can be about changing services; that is particularly the case when finances are tight, because changing services can very easily look like cuts rather than change.

There is a particular difficulty with this sort of reform because we all recognise a hospital; we know what it looks like. Our parents may have died in a hospital; our children may have been born in one. To feel that we are losing such a visible bit of the health service often feels like a loss. As managers in the health service, as politicians and as people with a stake in this, we are often not good enough at painting a picture of what would replace it and how it would be better in many ways. I think that more could be done there.

I know that a lot of effort goes into this area in health boards across Scotland. I was interested to hear colleagues from NHS Highland giving evidence to the committee last week about not just consulting on plans but involving people in developing plans and taking stock of what is working now and what would work for the future.

However, given the scale and the pace of change that we need, we almost cannot do too much of that. That is really where the attention needs to go and it needs leadership at all levels, from the cabinet secretary to the nurse on the ward whose job will be affected. Staff clearly need to feel that they have a stake in it, rather than that they are being dragged along by changes that they cannot influence.

Gail Ross: Page 24 of the report says:

"The NHS is facing problems recruiting and retaining staff".

We have had different levels of staffing in NHS Highland from anaesthetists through nurses, junior doctors and consultants in hospitals such as Caithness general. We have looked for general surgeons and consultants but there seems to be fewer of those as more of them specialise. That is obviously good for the major hospitals and centres but not so handy for us. We now have consultants and surgeons on rotation from Raigmore, which seems to be working at the moment.

Reading through pages 24 and 25, it is clear that it is not only NHS Highland that faces such a challenge. A lot of health boards have problems with recruitment and retention. Why is that? It seems to have happened all at once and I do not know that we have had a satisfactory explanation.

Caroline Gardner: The answer is similar to the one that I gave to Ms Harris at the start of the meeting. We do not know the answers. There are different stories and views of what is happening and that is why we are planning to do a detailed piece of work on the situation.

In a moment, I will ask Carol Calder to give you a bit more insight because she is planning that work.

It is worth noting that, for the future, areas such as the Highlands will need different types of jobs. A GP there will need to play a role that is different from that which they would play in the deep-end practices in Glasgow. That will affect the other

members of the primary care team and people who work in hospitals. That is why we think that we need a workforce plan that is not just about how many and what type of staff we need, but about how we get those skills in place.

Carol Calder (Audit Scotland): As Caroline Gardner said, the issue is about changing roles and responsibilities to deliver different models of health and social care. At this stage, we do not have a national work plan that we can use to identify what the skills capacity will be to deliver a changed health service.

We have started a piece of work to unpick some of the issues around the retention and recruitment of staff, but it will be about looking at what we need the health service to deliver and then working backwards to the lead-in times to train GPs and nurses. That means that we cannot change very quickly, so we need to look forward to identify what we need and then work backwards to change what trainees are coming through and so on.

Gail Ross: I have one more question. We talk about shifting the balance of care from acute services to more community-based services. You might not be able to answer this but I want to get it on the record. Are our care at home and community care services ready for such a huge shift? If not, what do we have to do to ensure that they will be?

Caroline Gardner: The short answer is that, as we found in our work, there are some great examples of new types of care that are not just providing traditional care in people's homes but are working upstream to identify older people and others who need particular support to keep them safe and living full lives at home. We reported on that in our March report "Changing models of health and social care". However, there are not enough of those examples and they are not developing fast enough to make a difference across Scotland.

One of the things that is slowing down the growth of those services is the need to keep on meeting the demand that turns up at the doors of the acute hospitals because the new services are not yet there. There is a risk that that will turn into a vicious circle, so there needs to be a plan that will help us to break out of it and identify how we can invest enough in community-based and home-based services that will break the cycle of rising demand on the acute hospitals and build the services that are needed across Scotland.

There are some real beacons of light out there, but they are too isolated to make a difference to the acute hospitals so far.

09:30

Liam Kerr (North East Scotland) (Con): I have a couple of questions. The first relates to page 15 of your report; there is something that I want to check. In paragraph 28, you say:

> "NHS Shetland was unable to locate over four per cent of its assets included in its fixed asset register."

I find that rather concerning. Is that unique to NHS Shetland or is it a problem across the estate?

Caroline Gardner: That was a particular problem in NHS Shetland. The auditor concluded that the assets had been recorded properly when they were first acquired but that, as they were disposed of or taken out of service, they were not written off appropriately. NHS Shetland has undertaken to make sure that its asset register is up to date and is kept up to date for the future. The problem is quite an unusual one for us to find in the health service.

Liam Kerr: So you can be confident that it is unique to NHS Shetland.

I have a wrap-up question. On pages 6 and 7, you make a number of recommendations. You mentioned earlier that you are uncomfortable about speculating—I understand why—but you make some very important recommendations. Let us assume that all those recommendations are taken on board and implemented. Is that a solution?

Caroline Gardner: There is a great deal of consensus not just in Scotland but more widely that the Scottish Government's vision to provide more care in homely settings or in people's homes is the right one and is the solution not just to the financial pressures but to the need to provide all of us with better care as the population ages.

A plan for implementing that vision is needed because, first, it is not happening fast enough and, secondly, nobody is clear about how much investment is needed, and where, to bring it about. In yesterday's statement to Parliament, the cabinet secretary committed to producing a plan by the end of this year. We will look at it closely to determine to what extent it picks up the funding implications, the staffing implications and the public engagement questions that Ms Ross raised to make sure that it can have the desired effect. Nobody has a better plan for the overall vision; the question is about turning it into reality.

Liam Kerr: On page 36 of your report, you mention that although the idea of a shift in the balance of care has been in play for some considerable time, it is clear that it has not happened yet. Can you say why that is the case? If all the stakeholders are saying that that needs to happen and that that is a solution, why has it not happened for the best part of 11 years?

Caroline Gardner: It probably comes down to a couple of things, one of which is that the acute services have no option but to respond to demand when it appears—for example, when someone who attends an A and E department needs an emergency medical admission that means that they cannot stay at home any more. We have been in a position—it is almost a vicious circle—in which, because there has been an insufficient number of the right services in the community near people's homes, more people have been admitted to hospital. We have done the analysis that shows the trends in that, particularly with an ageing population. In turn, that reduces the resource that is available to invest in the services that would avoid that happening in the first place.

We think that what is needed is a plan to break out of that cycle. We need to make sure that we know where the investment is needed in the buildings and services and the staff—GPs and community nurses—that are required and that there is much closer working between community services and the hospitals. The integration authorities should play a significant role in that. They came into effect on 1 April this year, so it is still early days. We know that some of them are still struggling with agreeing their budgets and their strategic plans.

In our report, we recommend that a boost be provided to make sure that the aspirations that are in place become a reality quickly enough to make a difference to the pressures that are being experienced across Scotland's health boards.

Alex Neil (Airdrie and Shotts) (SNP): I will start with staffing, which is an immediate issue in some of the areas of pressure, both geographically and in terms of specialism, that you have referred to. There is also the big strategic issue of how we solve the problem. It is estimated that, across the world, we an additional 70,000 doctors will need to be recruited in the next 15 years, so we are talking about an international labour market.

When Paul Gray, the chief executive of NHS Scotland, was here, he said that an additional 100 training places were to be made available for entrants into medical school. That is a welcome development, but given the projected demand for services and taking into account the fact that we are operating in a competitive international labour market, is 100 extra places anywhere near enough?

Caroline Gardner: It is not possible to answer that question in isolation. The question of how many staff we need, of what sort and with what skills, is something that the Government needs to set out as part of the plan for how we achieve this. Staffing is one of the big challenges. With an ageing population, there will be fewer people of working age available not just to be doctors, but to work in nursing, social care and all the things that are needed to make the policy work. It is possible that our exit from the European Union will make that more difficult, depending on what happens with migration across borders.

On the other side of the equation, new technology makes some things possible that were not possible in the past—holding consultations by Skype is an interesting innovation in some parts of the Highlands. There is also the community empowerment agenda: we can think again about how communities take more responsibility for looking after their members, and how all of us individually can take more responsibility for that.

We would like to see all that detail in the workforce plan, which would help us to say whether 100 doctors is a useful contribution or is what is needed to deliver the vision.

Alex Neil: We hope to get that plan fairly soon.

Caroline Gardner: The cabinet secretary committed yesterday to producing it by the end of the year.

Alex Neil: Ever since the national health service was created, the British Medical Association has been resistant to significantly increasing the number of trainees being recruited to medical school, saying, "We don't want any unemployed doctors." That is just one of the restrictions that the BMA has imposed for the last 60 years. Is it not time that we looked at such restrictive practices and at the productivity of our specialisms?

Let me give you an example: in NHS Lanarkshire, one of the reasons for redesigning orthopaedic services has been that for an orthopaedic surgeon to operate safely, they should carry out a minimum of 35 procedures a year, but apparently some surgeons have been carrying out as few as five procedures a year. Now, those people may well be doing other things, but is it not time to examine the productivity of those consultants to see whether we are getting value for money? If they are not performing during the week, they are then employed over the weekend on triple time, which is a financial bonanza for them, but is very costly for the health service. If that does not happen, we end up with patients having to go to the private sector in order for the waiting time requirement to be met. Is it not time that we drilled into that to see whether we are getting value for money?

Caroline Gardner: Mr Neil will know better than I that the Scottish Government has produced a couple of reviews over the past 15 years, looking at the way in which acute hospital services should be provided for the future. The first report goes back to about 2005 and there was a review and then a refresh of that a bit later on.

It is clear that the evidence is that we need to reconsider having more regional centres for some specialist procedures, thinking about the role of acute hospitals to ensure that they are both safe and efficient. Productivity is a key part of that. That is part of the answer to ensuring that hospital services are as high quality and efficient as they can be for patients, and that they are dealing only with the patients who need that type of care, so that we have resources that we can reinvest in services for people who could stay very happily and safely at home with more support from a good community team. The groundwork is there, but what is needed is the planning to turn it into a reality. That is not to say that it is easy, but it is increasingly important.

Alex Neil: I understand that an internal review of productivity in the NHS in Scotland was carried out. Have you seen that report?

Caroline Gardner: I have not. That would be a question for the Government.

Alex Neil: I think that you should see it—we should ask for a copy. Productivity is an extremely important element in all this and there are many restrictive practices that inhibit our ability to rise to some of the challenges, particularly in the short term.

I want to return to the drugs issue. One of the exercises that we carried out when I was Cabinet Secretary for Health and Wellbeing was to compare the use of drugs in each health board. Comparing like with like, we reckoned that if every one of the 14 territorial health boards was as efficient at managing its drugs bill as the best health board was, at that time, we could have saved more than £100 million a year. Given those figures, is it not about time that we revisited that exercise and took the necessary action to ensure that we get a far better return on our money for the drugs?

Caroline Gardner: Given the amount of money that we spend on drugs and the rate at which it is increasing, making best use of the drugs bill is a really important part of helping the health service to meet the pressures that it faces. The figure that you have touched on is very much in line with the figures that came out of our reviews of prescribing in previous years. Our report says that the Scottish Government has established, with health boards, a task force that is looking at four areas of efficiency—I think that drug costs is one of them. You may like to explore that further with civil servants in order to understand more about their approach and what they expect the benefits to be.

Alex Neil: If we can save anything like £100 million a year, that is a significant saving that can be redirected to other front-line services.

Finally, as Auditor General for Scotland, what do you expect to see in the delivery framework that we are, apparently, getting by Christmas? Are you looking for a business plan, or an operating plan? Are you looking for a five or a 10-year framework? Are you looking to bring the whole thing together, including the staffing, technology and funding? What are you looking for that delivery framework to do?

Caroline Gardner: We try to be as clear as we can in the report about what we think is needed. There are three areas to that. The first one is a financial plan that contains the sort of financial modelling that we have been talking about, and a funding plan, in case there are gaps in how we get from here to where we need to be. The second area is a clear workforce plan for the numbers of staff that we need and their skills, and how, in the long term, we will train those people and, in the short term, manage any gaps that exist. The third area is the plan for engagement with people across Scotland about why this matters and how they will be involved in shaping services for their local area. Those are the three key things that need to be covered for the plan to have the effect that we think is needed.

Alison Harris: Alex Neil talked about the BMA and restrictive practices. There is more involved, though. If we go back to doctors' training 30 years ago, there was fierce competition to go from trainee level, when one became General Medical Council registered, into specialist training. That situation is acknowledged among the generation of doctors who are now near retirement age. Something must have happened to change that. Those doctors could recount to you the competition in their day—it was horrifically difficult to get into specialist training—whereas now we are scouting around begging for doctors to train as specialists. There is something more than just the restrictive side of the BMA—although I am not condemning the BMA in any shape or form. As I was discussing earlier, we need to look at what has gone wrong—at that little chink. Something has happened in 30 years. I do not understand it, at all.

Caroline Gardner: Those sorts of questions are very much why we are planning our new audit on workforce planning. I will say, though, that it is very clear that we cannot do that without doctors and nurses being part of it. There may be some historical anomalies that need to be ironed out of the system. Equally, there are more opportunities, particularly for GPs, to work as partners in the health service rather than as contractors with it. I know that the Scottish Government is thinking hard about negotiation of the new GP contract and about making GPs very much a central part of the transformation that we all want to see.

The Convener: I would like to understand a little bit more about non-recurring savings. If you do not mind I will use NHS Tayside as an example—I know that we are coming to the report on it later. If I understand it correctly, exhibit 2 says that 60 per cent of NHS Tayside's planned savings are non-recurring. My understanding of non-recurring savings is that they include, for example, the one-off sale of an asset. NHS Tayside is selling off property. Those are non-recurring savings—one-off savings—but why are recurring savings not happening at the same time as non-recurring savings? Why is that percentage so high?

09:45

Caroline Gardner: I will try to keep my response general in this case, because I know that you will want to explore the section 22 report on NHS Tayside in more detail later this morning. You are right—non-recurring savings include sales of property and other assets. Another saving might come from short-term delays in filling vacancies. For example, if a member of staff leaves, rather than filling the post immediately, a board might keep it vacant for a while and take the saving that comes from that period, if it feels that it can do that without affecting the quality and safety of the service that is provided to patients. Those are all things that can help in the short term to close a funding gap, but clearly they do not do much to make a board's financial position more sustainable for the longer term.

You will see in both exhibits in the report quite significant variation among boards on how much they rely on recurring and non-recurring savings. In this and previous years, we have found that boards often plan a higher level of recurring savings than they are able to achieve. They expect to be able to redesign a service in order to provide the same service at lower cost, but it either takes them longer to do that or the savings do not reach the expected level so they fill the gap in their budget with a non-recurring saving. We have a concern about that: it is not sustainable and it focuses a lot of effort on short-term financial management rather than on the long-term planning that is needed to deal with the issue.

The Convener: What are the reasons for the disparities in recurring savings and in the 14 boards' success at making those recurring savings?

Caroline Gardner: The reasons vary in boards, as you would expect. I will leap ahead slightly to the section 22 report on NHS Tayside. We have reported that analysis suggests that its operating model is more expensive than that of many other boards and that, so far, it has not been as successful as it had planned to be in producing efficiencies that would bring down costs and, at the same time, close the funding gap. Other boards have made more progress in redesigning services and at taking approaches that help them to bring the revenue that they receive from the Scottish Government into line with their expenditure in each financial year. The reasons are different in every health board.

Jillian, do you want to add to that?

Jillian Matthew: I do not think that there is anything else to add.

The Convener: Is it an issue of management, planning and strategy?

Caroline Gardner: There are elements of all those. In many cases, the disparities also reflect the starting point—the position that each board is in. Some boards have historically had more generous funding than others and have therefore found it easier to make recurring savings. Others' models of service had recently been reviewed, so there was not as much space or headroom for them to generate savings. There is a wide range of reasons across the different boards.

You are right, however, that the approach that boards take, how effectively they involve staff in thinking about better ways of providing services, and the scrutiny and support that they provide in making sure that plans are realistic and are being carried out as planned all play a part.

The Convener: As an auditor, how comfortable are you with 60 per cent of savings being made through non-recurring savings?

Caroline Gardner: In broad terms, that figure is too high. We are looking for not just an annual budget, but a medium-term financial plan covering five years or so that is very clear about the likely levels of revenue from the Government and expenditure, and which has detailed plans for closing the gap sustainably.

The Convener: I have a general question about agency costs. We have already touched on recruitment and retention problems. What else could health boards do to prevent spending on agencies?

Caroline Gardner: It is very important, for cost and quality reasons, to minimise use of agency staff in favour of a staff bank that is managed and owned by the health board itself. In response to Colin Beattie's question, I said that it is often the flexibility that is attractive to staff, rather than the fact that they are being paid more. Most health boards have a bank where nursing staff—also medical staff in small numbers—can register as being available for temporary work for ad hoc shifts and to fill gaps as they occur. They are generally paid on standard NHS terms and conditions, so the cost is lower. They know the

system, they can be trained and inducted, and they know how things work. A staff bank is better in every respect, than having to turn to an agency.

Because of the health service's nature, most boards will on occasion have to turn to agencies. The challenge for the boards is to minimise reliance on agency staff, to invest in their own bank and, of course, to do the work to make sure that their workforce is fully up to capacity and planned for the longer term.

The Convener: To come back to what you said about prevention, I sympathise with that agenda. Last night in Parliament, we launched a cross-party group on the preventative agenda for non-communicable diseases. I know that you have tackled the issue before, but is there a way to audit prevention and its impact on the health service?

Caroline Gardner: That is a great question, but there is no easy answer. It is not just about the health service: many of the problems that the health service ends up having to deal with come from children's early years and from problems including poverty and poor-quality housing, rather than relating simply to health or even to health and social care services.

In many ways, that is why we focus on what the Government is trying to achieve in its outcomes in the national performance framework, in all the money that it spends and the budget process, and through the services that it provides. We try to look back upstream and see how far things are joined up, but it is very difficult to audit everything all at once. That is why we tend to take slices in the way that we do.

The Convener: You perhaps cannot answer this, but is that one of the reasons why we have not seen much of a resource shift to prevention—not just in the health service but across other services? It is very difficult to audit and create results on prevention.

Caroline Gardner: It is not just because prevention is difficult to audit—it is also difficult to do, for two reasons. First, it is genuinely difficult because we say that we want to make Scotland a country in which everyone has the chance to flourish. We therefore need to think holistically about healthcare, education, early years, justice and housing, and about how all those areas develop. The new social security powers provide another dimension that needs some thought.

More generally, we have reported in a number of instances on what we see as a gap between the outcome that the Government wants to achieve and the detailed plans that it has for its services; it is not clear how one relates to the other. We think that filling that gap would make the national performance framework and the outcomes approach more productive in changing people's life chances over time and in tackling some of the problems that we see in health and social care, justice and education.

The Convener: I thank you all very much for your evidence on the report.

Section 22 Reports

"The 2015/16 audit of NHS 24: Update on management of an IT contract"

09:52

The Convener: Item 3 is evidence on the Auditor General's report, "The 2015/16 audit of NHS 24: Update on management of an IT contract." The Auditor General is now joined by Carol Calder, senior manager for Audit Scotland, and Nick Bennett, a partner at Scott-Moncrieff. The Auditor General will make an opening statement before I open the meeting out for questions.

Caroline Gardner: Thank you, convener. I bring two further reports to the committee this morning that highlight matters of public interest in NHS 24 and NHS Tayside. I have prepared the reports under section 22 of the Public Finance and Accountability (Scotland) Act 2000. I highlight at the outset that, in both cases, the external auditors gave unqualified opinions on the accounts of the organisations, which means that they are satisfied that the accounts provide a true and fair view of the bodies' financial position.

I have prepared reports on the boards because I believe that there are issues of public interest that should be brought to the attention of Parliament through this committee. I will start with NHS 24. The report on NHS 24 provides an update on implementation of a new information technology system called the future programme. I reported to your predecessor committee in October 2014 and again in November 2015 on how weaknesses in contract management had led to delays and escalating costs in the programme.

In October 2015, NHS 24 attempted its planned launch of the new system. Following a serious deterioration in call-handling times as NHS 24 staff struggled to use the new system, NHS 24 reverted to its previous system in order to protect patient safety. NHS 24 now plans full implementation by December 2017—four and a half years after the original intended implementation date of June 2013.

Last year I reported that the total cost of the programme had risen by 55 per cent to £117.4 million, in comparison with an outline business case cost of £75.8 million. NHS 24 now estimates that the total cost of the programme will be £131.2 million, which is 73 per cent more than the cost in the original business case, mainly as a result of additional double-running costs. The Scottish Government provided additional loan funding of £20.75 million to NHS 24 over the period 2012-13 to 2014-15 to help it to manage the additional costs. Of that brokerage, £20.35 million is still outstanding.

Over the past nine months, under the leadership of its new chief executive, NHS 24 has undertaken a fundamental look at what needs to be done to implement fully the new system. Although significant challenges remain, I believe that the board is now taking reasonable steps to reduce the risk of further delay.

I am joined today, as the convener said, by Nick Bennett from Scott-Moncrieff, whom I appointed auditor of NHS 24. Between us, we will do our best to answer the committee's questions.

The Convener: Thank you. Colin Beattie has the first question.

Colin Beattie: Auditor General, I accept what you have said about patients not being impacted. However, what you have outlined about the NHS 24 information technology contract is part of an on-going story with information technology projects. The committee has repeatedly heard evidence about their being mismanaged—the NHS 24 IT contract has clearly been mismanaged.

Do the measures that are outlined in paragraphs 22 and 23 on page 7 of the report not seem like overkill? It seems that, immediately following the realisation that there was a problem with the contract, umpteen management groups were formed to oversee it and—I presume—trip over each other. At one time when I worked in the private sector, I had an IT division reporting to me—I could not imagine having to work through the sort of complexity that is outlined in paragraphs 22 and 23. What is your take on that?

Caroline Gardner: I will ask Nick Bennett to comment in a moment, but my view is that most of what is outlined in those paragraphs was almost certainly required. The review that the new chief executive undertook when she took up her post highlighted—as we note in the report—that some problems came from failure to engage with people in health boards who need to join up services with what NHS 24 does. A great deal of the new architecture that is highlighted in paragraph 22 is about ensuring that those relationships are in place and are working effectively. Nick Bennett is closer to that and might have a perspective that you will find useful.

Nick Bennett (Scott-Moncrieff): I agree with the Auditor General's point. The groups that have been set up provide the scrutiny and challenge that are required for the project. There are highly experienced senior individuals in the groups who will be involved in a sign-off process for any subsequent phased development of the project. The groups are certainly a useful development in governance.

Colin Beattie: Are they not compensation for the fact that we do not appear to have people with the right skills to manage the contract, with the response therefore being to form a committee?

Nick Bennett: In the past, we have commented on the lack of appropriate skills in NHS 24. In response, the board has brought in outside experts to scrutinise and challenge.

Colin Beattie: Are we paying money for people from outside the NHS to sit on the groups?

Nick Bennett: The people are all internal to the NHS or are from wider public sector bodies. They are highly experienced senior individuals and are all from the public sector.

Colin Beattie: Okay. One of the big concerns is the financial obligations in the IT project. On "Financial implications", the report says that it is unlikely that any of the additional costs can be recovered. Do we have a feel for what the total additional costs will be over the period?

Caroline Gardner: I think that NHS 24 is confident that it can deliver what is required within the figure that is included in my report. A significant amount relates to the double running costs of implementing the new system while keeping the old one up and running. Clearly, there might be change over time, but what is in the report is the latest estimate from NHS 24 regarding its projection of what the project will cost. In my view, it is based on a more thorough understanding of what is required than was the case in my previous reports.

10:00

Colin Beattie: The reference to additional costs is purely about the double running.

Caroline Gardner: We have tried to break that down in exhibit 1, where we compare the original business case, the projected costs last October and the projected costs in June from NHS 24. You will see that most of the increase has been in the implementation costs, including the double-running costs, which have gone up by £39.1 million to 132 per cent of the original estimate. The on-going support costs for the contract itself have gone up by a relatively much smaller amount.

Colin Beattie: You seem to be confident that, now that NHS 24 has a grip of the project, it will be delivered within the timescale and budget indicated—is that correct?

Caroline Gardner: I am now much more confident that the board understands the scale of what needs to be done and has put in place appropriate mechanisms for doing it. It is for the board to provide assurance and deliver that. However, I now feel more comfortable about the project's prospects than I was a year ago.

Colin Beattie: Clearly, there is a bigger issue that I hope the committee will address in due course.

Liam Kerr: I appreciate that you have looked at the matter a couple of times previously, but I was not about then and I want to explore the contractual arrangements. In the report, you state that the contractual arrangements were "flawed" and you provide a useful chronology on page 12, in appendix B. The omissions in the tender document were discovered in August 2011 and a contract was awarded two months later. Six months later, NHS 24 staff identified that things were missing and, two years later, the matter was reported to those in charge. To me, that was an enormous failure. Who was found to be responsible and what were the consequences?

Caroline Gardner: You are right—it was a very significant failure, and it was of serious concern to your predecessor committee. None of us likes to see an IT system getting out of control. However, what the audit work and the inquiries uncovered, which was that a member of staff was aware of omissions in the contract documentation that were not brought to the attention of the chief executive until much later, was a serious failure of governance and accountability.

Nick Bennett will keep me straight on this. There have been significant departures of staff, from the chief executive down, among those people who were originally responsible for the project. NHS 24 is now in the final stages of appointing a new permanent chief executive, who has been involved in turning the project around and will be accountable for taking it forward from here.

Nick Bennett: That is correct. A new chief executive has been appointed. Most of the senior management who were involved in the original procurement of the future programme have now left the organisation, and most of the non-executive directors have changed as well.

Liam Kerr: That is encouraging, but we are now running under various letters of intent, and contractual documents are not due to be signed until December despite the fact that the contractual review has been running since January 2015. What is your view on that? Is it good business to be running the whole project and changing the senior management when there are not even any contracts in place?

Nick Bennett: It is an area of risk, for sure. The board is trying to finalise the contracts. The new contracts have been sent to Cap Gemini and BT, and negotiations are going on to finalise those direct contracts. It is an important area that needs to be finalised pretty quickly.

Liam Kerr: You mentioned that a final cost will be available only at launch. In paragraph 27, the report states:

"A final, definitive cost for implementing the system will only be available once it has been launched and is operating successfully."

As auditors, are you comfortable with that?

Nick Bennett: Because the whole project has been beset by problems and delays, we are not going to know whether the final implementation is in accordance with the timetable that is laid out until it happens. Also, given that a lot of the costs are costs of double running the existing system, the final cost is not going to be known until the new system goes live successfully.

Liam Kerr: That is extraordinary. You have said that the total projected cost is £131 million. I appreciate that we are talking about a complex system, but it cannot be unique. Fundamentally, things look like each other. Do you have any idea, or is there any way to establish, what an equivalent cost would be in the private sector? If the private sector commissioned a system to do something similar to what the NHS 24 system is supposed to do, what would be the cost of that? Has that comparison been done?

Nick Bennett: Not as far as I know. The outline business case was originally for £75 million but, to be fair, the new system has progressed significantly since that. One of our recommendations is that a business case be prepared on what the new system delivers—not only what it costs but the benefits. Once the business case has been prepared, the board will be in a better position to answer that question.

Liam Kerr: To prepare the business case must be a good recommendation but, meanwhile, the contracts are still being negotiated and the systems are still being progressed in the absence of that business case. At what point does it become a good idea for NHS 24 to step back, hit pause and say that, because the system has not worked, it needs to review what is going on and what it needs the system to look like rather than trying to negotiate in the background and run the system?

Nick Bennett: We reported to your predecessor committee that there had been a detailed review of whether NHS 24 should progress with the system. The last time the system failed to go live, there was a deep-dive review of whether the board should abandon it, which concluded that it should continue to develop the system on which it was working.

Liam Kerr: Right. This is not the first time that the committee has considered the matter or that it has considered IT projects. Do you have any idea who is taking the macro learning from it? Various IT projects are in significant trouble; do you see any evidence that that is being acknowledged and that the process for future IT projects is being future proofed?

Caroline Gardner: You are absolutely right that, sadly, it is not an isolated incident. I have reported a couple of times on the bigger picture for developing major IT systems in the public sector. The Government has made some changes: it has appointed a chief information officer and has plans in place to develop capacity within Government that can support smaller bodies such as NHS 24 when they make large investments in IT. We have also made some recommendations about the importance of focusing effort at the beginning of a project to be clear what the body intends to achieve, what the right contract structure is and how we will know that good progress is being made.

The committee has taken evidence on that overall strategy a couple of times. It is too soon to be clear that it is having the desired effect, but it must be the right approach to invest in a central core of expertise at the right level to undertake IT projects and to ensure that bodies do not start off such projects without the right expertise, understanding, IT skills and legal skills to make them work.

I hope that we will not see a situation similar to that in NHS 24 again. It is too soon to say that the changes that the Government has made will deliver that.

Alex Neil: I have two questions. The first concerns the outstanding loan of more than £20 million that NHS 24 has to repay to the Government. That is on top of the normal requirements for efficiency savings. I appreciate that the repayment period has been extended, but £20 million is not an insignificant amount to take out of such an organisation. What other services will be cut back to enable NHS 24 to pay the £20 million to the Government? Something has to give.

The project has now been running for four or five years and the point was to introduce new, leading-edge technology. Given the pace at which technology changes, is the technology still leading edge? Is it up to date? What will be the life-cycle of the technology, given that the system is five years beyond the date when it should have gone live?

Caroline Gardner: I will start off by saying that repaying £20 million to the Government would obviously be very significant for a board of this size. It is also worth noting that the revised repayment plan has been agreed between the board and the Government. Nick Bennett might be able to add more detail on where the board intends to make savings in order to deliver that, or

it might well be a question that should be directed to NHS 24.

Nick Bennett: Inevitably, savings will have to be made to repay the brokerage and the additional costs that will be required to be met. A number of the initiatives that had been planned have had to be put back, but it is probably best to address the question of the other savings that the board will have to make to the health board itself.

Alex Neil: We should write to the board and ask those questions.

Nick Bennett: On the issue of technology, one of the reasons for asking for a full business case is to identify the changes that have been made to the original future programme and any benefits that have been brought that were not envisaged when the original business case was drafted. After all, significant changes have been made to the technology over this period.

Alex Neil: Will this technology be fit for purpose and, if so, for how long?

Nick Bennett: I think that that is another question for the board.

Alex Neil: Well, you are the auditor, so you should surely have a view on the matter.

Nick Bennett: We would like to see the full business case prepared, because that will identify the benefits that will come to the board over the next 10 years.

Alex Neil: I think that we should take that up with the board, too.

The Convener: Has the total cost of the future programme changed since the AGS's report was published?

Caroline Gardner: No. The board is projecting £132 million as of June this year, I think, and there has been no change to that of which we are aware.

The Convener: The estimated total cost is now £55.4 million higher than that envisaged in the business case, and the Scottish Government has loaned the £20 million as discussed. Does that mean that there is a deficit of £34.7 million, and have the auditors discussed how that might be met?

Caroline Gardner: The difference in the cost between the £20.35 million that has been provided in brokerage and the £55 million total has been and will be met by the board itself from its overall budget during the period. As Nick Bennett has said, that has meant delaying some projects that the board had planned to undertake and making efficiency savings elsewhere, but the board has not run a deficit with the brokerage available from Government. It has hit its tight financial targets.

Nick Bennett: It is also worth pointing out that the £132 million includes £62.5 million for on-going support costs, which are, in effect, the support costs over the 10-year period hence. In other words, those costs have not yet been but will be incurred.

The Convener: Thank you very much. I suspend the meeting for a five-minute comfort break before the next item.

10:12

Meeting suspended.

10:19

On resuming—

"The 2015/16 audit of NHS Tayside: Financial sustainability"

The Convener: Item 4 is our evidence session on the Auditor General for Scotland's report "The 2015/16 audit of NHS Tayside: Financial sustainability". The Auditor General is joined by Carol Calder, senior manager in Audit Scotland, and Kenny Wilson, a partner at PricewaterhouseCoopers.

The Auditor General will make an opening statement before we move to questions.

Caroline Gardner: As we discussed earlier, the NHS is under increasing financial pressure for a range of reasons. I prepared a report on NHS Tayside for the committee last year that highlighted the board's reliance on brokerage from the Scottish Government to meet overspends, difficulties in achieving its planned savings and delays in selling surplus property.

This year's report highlights my continuing concerns about the board's financial sustainability. In 2015-16, NHS Tayside received a total of £5 million in brokerage from the Scottish Government to enable it to break even. The board has now received a total of £24.3 million in brokerage over the past four years, of which it has been able to repay £4.3 million. NHS Tayside did not repay any brokerage during 2015-16, and it does not anticipate that it will be able to repay any of the outstanding £20 million in 2016-17. It is currently discussing a revised repayment plan with the Government.

In addition to the commitment to repay brokerage, the board is projecting a potential deficit of £11.65 million for 2016-17, and it needs to make efficiency savings of £58.4 million in the same year. Overall, I have concluded that there is a significant risk that the board will not achieve its financial plan for 2016-17 and future years.

I am joined by Kenny Wilson from PricewaterhouseCoopers, whom I appointed as the external auditor for NHS Tayside. Again, we will do our best to answer the committee's questions.

The Convener: Thank you, Auditor General. Alex Neil will open the questioning.

Alex Neil: Am I right in saying that NHS Tayside owes the Scottish Government £20 million, has £58 million of savings to make and is projected to make a deficit of £11 million this year? How on earth is it going to achieve any of that?

Caroline Gardner: It is in discussion with the Scottish Government about its financial position. Our expectation is that it will agree a revised repayment plan for the outstanding brokerage and likely additional support for the current year. We have done the report because I am concerned about financial sustainability with that widening gap.

Alex Neil: NHS Tayside has to repay the existing £20 million-plus, and this year's deficit of £11 million presumably has to be funded by the Scottish Government through brokerage or a loan. That is more than £30 million. Where is the board going to find £30 million to repay the Scottish Government while making £58 million of savings at the same time? That is a huge reduction in service provision. Surely that is totally unachievable and unsustainable.

Caroline Gardner: I will ask Kenny Wilson to comment in a moment but that is really a question for the board. The reason for Audit Scotland reporting to the committee is that I am concerned that the board's financial position looks to be increasingly unsustainable.

Kenny Wilson (PricewaterhouseCoopers): The board has put in place a five-year transformation plan and it hopes to make savings of £175 million in that five-year period. There is no doubt that, in 2016-17, £58 million of savings is required to achieve financial balance, which is significantly more than the board has saved in previous years. That will be a challenge, but it is worth saying that the board has a number of good opportunities to make those savings through a redesign of the whole service. The board has certainly embraced that.

The board's average patient cost and prescribing cost are higher than those of other boards. With more than 26 hospital estates, it has one of the largest property footprints in comparison with other boards. More than 60 per cent of the board's property is more than 30 years old, which is older than that of other boards.

There are therefore a number of things that the board can do. Those will take time, but it is planning to make those savings in its five-year transformation plan. The board has an ambitious plan but is working to try to achieve it.

Alex Neil: As you know, a redesign of services takes a long time. I do not know the detail of NHS Tayside's proposals for redesign, but I presume a significant redesign will be required to facilitate the repayment of such a large amount of money and will take years.

We have already seen that one of the board's failures is its failure so far to dispose of assets on anything like the required scale. Surely it is very optimistic to assume that it will suddenly be able to dispose of assets on the scale required in order not to make very deep cuts in service provision? As auditors, you must recognise that. We cannot just say to patients in Tayside, "Because of the incompetence of your board, we are going to hammer you with service cuts." That is just not sustainable. If this were the private sector, the board would be a basket case.

Caroline Gardner: We are not saying that services must be cut to fund the gap that I have highlighted. The reason for bringing the report to the committee's attention is so that the committee and the Parliament are aware of the challenges and have the opportunity to explore with the board and the Government how they plan to address the problem.

Alex Neil: We need to talk to both the Government and the board about the situation. The potential impact on service provision in Tayside worries me. What is being proposed sounds unacceptable to me in terms of the service cuts that would need to be made in order to pay for the board's incompetence.

In your report you talk about the payment of enhancements during leave. Paragraphs 12 to 16 clearly tell a story of management incompetence. I am not suggesting that that is the only factor because we all know about the pressures on the national health service, but it is clear that things have not been managed very well in Tayside. Have any heads rolled? Has anyone been hauled over the coals for that? It shows rank bad management by people who are paid extremely well.

Kenny Wilson: No. I am not aware of anyone being held to account for that or having lost their job as a result.

Alex Neil: So no one has been held to account for this mess.

Kenny Wilson: The board recognised the challenges that it has and is regularly discussing with Scottish Government how it can address those. However, as far as I am aware, no one has

been held to account for anything that has happened in the past.

Alex Neil: Do you not think that that sends out the wrong message to everyone in the health service? If people are in very well paid senior positions—we are talking not about medics, but about managers—but are delivering that kind of performance, surely something has to happen.

Kenny Wilson: Yes. Something should happen. Action is being taken to address some of the concerns and challenges that the board is facing, and that is encouraging.

Alex Neil: Does the current management team have the competence to take the necessary action, given that it got the board into the mess that it is currently in?

Kenny Wilson: The current management team was put in place relatively recently. The chief executive has been in post for only the past couple of years, along with the director of finance. Those are the two key executives who are making changes in the transformation plan. With the new management in place, progress will be made.

Alex Neil: I wish I were as confident as you are about that.

We need to invite in both the board and Paul Gray from the Government. I do not see how the board is going to be able to get anywhere near the savings that are required to repay the money without making very deep cuts in service provision, which I think would be unacceptable to patients in Tayside.

Caroline Gardner: I completely agree that the situation is very serious. The powers that we have are to report to the Public Audit and Post-legislative Scrutiny Committee so that the committee is aware of the issue and can explore with the Government and NHS Tayside the action that they are taking.

The Convener: Mr Wilson, how appropriate are pay enhancements for senior managers, given the state of NHS Tayside's finances?

Kenny Wilson: Pay enhancements are in place not just in Tayside, but across other boards; they are in line with other boards. The practice has been in place for a number of years and the question whether those pay terms should be amended would be a matter for discussion with the Scottish Government.

The Convener: Is whether to award pay enhancements in the hands of the Scottish Government?

Kenny Wilson: Enhancements are certainly part of the packages that are given to reward staff and therefore I guess that they are just like any other aspects of rewards—they can be adjusted through negotiation with staff.

The Convener: In your audit, did you reach a figure for what the pay enhancements totalled over the past year?

10:30

Kenny Wilson: Yes. I will just double check in my papers for the annual cost of pay enhancements. There are two elements to pay enhancements in Tayside. There is the one-off catch-up for the error that was made in previous years. That totalled a provision of close to £10 million—

The Convener: Sorry—to clarify, I am talking about senior managers rather than the enhancements programme.

Kenny Wilson: Are you asking about enhancements for senior management?

The Convener: Senior managers, yes. Awards were made very recently that were significantly above 1 per cent. I wondered whether you had totalled those during your audit.

Kenny Wilson: I do not have that number to hand but I can certainly provide it to the committee after the meeting.

The Convener: Okay, thank you.

You talked about the five-year transformation programme, which I am familiar with and which was discussed at NHS Tayside's annual review just a few weeks ago. You also talked about a redesign of the whole service being appropriate—I think that the Auditor General said that as well—but what exactly does that mean?

Kenny Wilson: The executive team has set up work streams to look at all aspects of the health board. As I said, the board has a number of areas where the operating cost model is higher in comparison with other boards. The work streams include workforce planning, property planning, realistic medicine, better buying and procurement, and facilities and estates, so the board is looking right across a number of areas at how best it can make the service more efficient and more effective.

The Convener: Could that mean a reduction in the number of jobs?

Kenny Wilson: In a number of areas, such as clerical and administrative staff, there is a higher proportion of staff in comparison with other boards. That indicates that savings could be made if the number of jobs were reduced, hopefully without any impact on the service.

The Convener: The report talks about brokerage, and we know that NHS Tayside has

had to go to the Scottish Government for the past four years for brokerage. Can brokerage be provided indefinitely? Could it be waived by the Scottish Government? If brokerage is required for Tayside possibly into next year, which would mean a total of five years of brokerage, does that suggest that brokerage is not really about unexpected change to planned expenditure?

Caroline Gardner: Brokerage is certainly intended to be a short-term loan that responds to unexpected expenditure. In order to receive brokerage, a board normally has to demonstrate to the Scottish Government that it is able to repay it in future years. A repayment plan is part of the conditions for brokerage.

In this case, it appears that the repayment plan was not realistic. The health board has not been able to repay very much at all of the brokerage that it has received. It has no plans to repay it this year and discussions are under way about future years.

There is no reason why the Scottish Government could not waive brokerage if it chose to do so. My concern for the health service as a whole, as well as for NHS Tayside, is that a more strategic, longer-term financial plan is needed—one that provides a realistic balance between the funding that is available and the costs of providing services. Tayside is the health board where the gap is most apparent.

The Convener: So if the Scottish Government decided to do so, it could waive the debt that NHS Tayside has incurred over the past four years.

Caroline Gardner: As far as I am aware, there is no reason why the Government could not do that if it so decided. It would have to think about the impact on NHS Tayside and on the wider health service, but I think that waiving it would be at the Government's discretion.

The Convener: The brokerage model is about unexpected change. NHS Tayside has had to go for brokerage for the past four years, but clearly the future debt, the planned savings and so on are not unexpected, as you have identified. It is very much expected that it will be very difficult for NHS Tayside to meet its savings targets—I hope that it will not do so through a cuts agenda. Does the Scottish Government require a model that is different from the brokerage model to meet NHS Tayside's very difficult situation?

Caroline Gardner: Again, I put this in the context of the NHS as a whole. I think that two things are needed. First, committee members might recall that this year and in previous years we have reported on the need for a more flexible regime that does not require each health board to balance its revenue and capital spending to the penny every year. Such an approach focuses a lot of attention on that particular year's targets instead of long-term sustainability. Secondly, as we have been discussing in relation to the overview report, part of the solution is to put in place a longer-term financial plan for the NHS as a whole to ensure that its finances are sustainable and that change is happening. I completely agree that the way in which brokerage is being used here is not helping to address the underlying questions about the board's financial sustainability.

The Convener: Given the very difficult situation, would you recommend to the Scottish Government that it come up with a different model to help out NHS Tayside?

Caroline Gardner: Our understanding is that NHS Tayside and the Government are already in discussion about the future. I do not know what those discussions are covering, and that might well be an issue that the committee will want to explore with both parties.

The Convener: Your report says that reliance on agency staff has risen by 39 per cent just over the past year. Why is that figure so high?

Kenny Wilson: One of the key issues that the board is looking to address is the use of agency workers and increasing its nurse bank. In 2016-17, the aim is to reduce the costs of non-contract agency workers by 30 per cent, which is encouraging. Part of the reason for that approach is to ensure that the board has a good nurse bank on which it can draw instead of having to use agency workers, and that is certainly one of the issues that it has been trying to work at. That said, I am unclear as to the reasons for the high reliance on agency staff. You will have to ask the board about that.

The Convener: Okay. When we spoke about jobs, you said that because of NHS Tayside's expensive operating model, clerical or administrative posts might be part of service redesign. I am very concerned about that, given that we obviously do not want staff to bear the brunt of financial mismanagement at NHS Tayside. Why is its operating model so expensive?

Kenny Wilson: As I think I mentioned earlier, a number of factors have probably had an impact. It is unclear to me why, say, agency and prescribing costs are higher, but those are two things that drive a big cost difference.

I should also point out that NHS Tayside has 26 hospital sites, which is a large number, and there is a need to look at consolidating some of them in order to make some savings. Again, the five-year transformation plan is looking at all such options. Moreover, the board has an older property estate, which tends to be more inefficient; because of its age, it takes more effort and costs more to look after it. Some of the estate has a very low

occupancy, so there is an opportunity to consolidate things.

As I have said, a number of factors have contributed to the position, and that is what the board is looking to address.

The Convener: That brings me to the issue of non-recurring savings, which we touched on in our discussion of the overview report. How concerned are you about the high percentage of non-recurring savings, given the huge amount of savings—£60 million—that NHS Tayside has to make this year?

Kenny Wilson: It is of grave concern that the proportion of recurring savings is so low. That is partly because achieving such savings requires some more structural change, which tends to take longer to put in place. However, there is no doubt that the board would be in a far better position if it had a lower percentage of non-recurring savings.

The Convener: Prescribing has been identified as one of the costs. Was prescribing identified as a factor in your report on NHS Tayside last year, too?

Caroline Gardner: I have to confess that I cannot confirm that from here. We can do it immediately after the meeting.

The Convener: Mr Wilson talks about redesign of the service and much more structural change. One of my concerns, though, is that the initiative on prescribing was launched only about three weeks, or at most a month, ago. Why has NHS Tayside not managed to deal with those issues a lot sooner? It has been aware for a long time that prescribing has been an issue.

Kenny Wilson: That is true. It is probably best to ask NHS Tayside that question. I cannot answer it.

The Convener: I come to my last question, which is on a minor point of clarification. Paragraph 21 refers to an

"efficiency savings target for 2016/17 ... set at an unprecedented level of £58.4 million".

Is that unprecedented for Tayside or for Scotland? The general report, "NHS in Scotland 2016", suggests that Shetland's target may be slightly higher, but that might be as a percentage rather than in terms of total cost.

Kenny Wilson: It is certainly unprecedented for Tayside. The Shetland savings target is more like 7 per cent.

Caroline Gardner: Our report shows it as 8.7 per cent, but that is obviously a percentage of a much smaller overall spend for the board. It is still significant for Shetland, but it involves a much smaller sum of money.

The Convener: So, in terms of efficiency saving targets in pure numbers—in hard cash—this efficiency saving target for NHS Tayside is unprecedented across Scotland.

Caroline Gardner: From the information that is available here today, yes—it is higher than anything across Scotland in cash terms. More important, as Kenny Wilson said, it is unprecedented for this board in terms of its ability to deliver savings in recent years. It is a significant increase which, as you and other members have highlighted, is very challenging for the board.

The Convener: Alison Harris?

Alison Harris: I think that you have asked everything that I was thinking about.

The Convener: Liam Kerr?

Liam Kerr: Likewise.

Colin Beattie: I associate myself with Alex Neil's comments. Looking at the report and all the financial indicators, I think that it is unfortunate that the management team did not handle this better. There are clear deficiencies here. The board has higher staffing and higher costs than other NHS boards and cannot even meet more than five out of 15 national targets. It would be bad enough to have the extra costs and so on, but not to meet the targets as well is pretty shameful.

This bears a great deal more investigation. In paragraph 29, you highlight a series of workstreams that the board is putting in place to try to sort the thing out, which are all basic management activities that should already have been dealt with. They are not new—they represent day-to-day management that does not seem to have been taking place.

I pick up on something that Kenny Wilson said. We are talking about awards to senior staff. We should be clear that the Government may set the policy on those awards but it is the local board that makes the awards. The Government is not directly involved in giving awards.

I come back to the property side, which is obviously a great concern. These are one-off sales, which are not sustainable. In a previous report, Auditor General, you talked about Ashludie hospital. There was a particular issue in respect of the accounting for the sale of that hospital. Has that gone away? Has it been adjusted through the accounts? Is Ashludie one of the properties that are still awaiting sale?

Caroline Gardner: I will ask Kenny Wilson to give you the up-to-date position. You are absolutely right that one of my previous reports raised concerns about the accounting treatment, whereby proceeds were being recognised in

advance of a sale being agreed, which is clearly contrary to proper practice.

Kenny Wilson: In 2014-15, we reported that we made the board adjust for that. It had recognised the sale of Ashludie in its accounts in 2014-15. That was reversed out and was not recognised in that year.

Colin Beattie: You say "reversed out". What impact did that have on the accounts?

Kenny Wilson: The impact was a requirement for additional brokerage—the figure was about £5 million—in 2014-15. The sale was finalised in 2015-16 and correctly recognised in the accounts as a profit.

Colin Beattie: The same sum?

Kenny Wilson: Yes—the same sum was recognised correctly in 2015-16. The sale was concluded in October 2015.

10:45

Colin Beattie: So that one-off sale has reduced the brokerage.

Kenny Wilson: Yes—in discussion with the Scottish Government, the board was allowed to take it into the revenue numbers for 2015-16.

Colin Beattie: With regard to the outstanding properties, the report notes that the board anticipates receipts of £7.6 million from the sale of 24 properties and sites. That seems to be an awful lot of properties and sites. What do they consist of? I have no feel for it. That is not very much money for such a number of sites.

Kenny Wilson: One of the challenges that the board faces in the current environment, given where the sites are, is to find buyers that want to convert them to a different use. The board has had a lot of challenges in finding appropriate buyers, and it has outlined that it hopes to sell the sites for £7.4 million. It will take the board some time to achieve the maximum value that it can get.

Colin Beattie: There are a fair number of properties. Presumably, a substantial number of them must be empty and awaiting sale.

Kenny Wilson: Yes.

Colin Beattie: So there is a cost for maintaining them, providing security and so on. Although there is a one-off benefit from selling them, how much benefit would there be on the revenue side in reducing those costs?

Kenny Wilson: There will certainly be on-going savings from disposing of the properties, through reducing maintenance.

Colin Beattie: Anything significant?

Kenny Wilson: I do not have a number for those particular sites, but I can try to find out what the potential savings would be. The majority of the sites are unoccupied and not in use.

Colin Beattie: As we well know, providing security for some of these sites and keeping them safe can be quite expensive.

Kenny Wilson: Yes, it can be—you are right.

Colin Beattie: It would be interesting to know what the potential impact on revenue would be. That would be a recurring saving as opposed to a one-off saving.

Kenny Wilson: Yes, it would be.

Colin Beattie: My suspicion is that it will not swing the board round.

Kenny Wilson: No, but it will certainly help. I can find that number and provide the committee with it after the meeting.

Colin Beattie: Okay—thank you.

The Convener: Are there any other questions from members?

Monica Lennon: I had a question, although Colin Beattie has picked up some of it. It is on the issue of assets held for sale. From reading the report and hearing the evidence today, my sense is that there is quite a strong reliance on those 24 properties. The report highlights that the vast majority of them have been held for sale for quite a long time—13 for over a year and three for more than four years. I assume that the figure of £7.6 million is based on projected market value.

What advice is the board receiving? Does it have internal expertise? What is the plan for marketing those properties? Is it being kept under review? From reading the report and hearing what you have said, I am not convinced that the £7.6 million is achievable any time soon, and there does not seem to be any fallback. What can you say about the professional advice that has been made available to the board?

Kenny Wilson: I am aware that the board is working closely with skilled people and experts in the Scottish Government, and the Scottish Futures Trust has been advising it on the disposal of properties. You are absolutely right—it is taking the board longer than it would like to sell the properties. I think that it will take longer than the board anticipates. The values that it has put on the properties are estimates that it has been given by professionals—those are the prices that the board thinks that it can get—but unfortunately only time will tell whether it can receive the amount that it highlights.

It is fair to say that the values that the board has achieved to date in selling properties have not

been as high as people thought might have been achieved or as high as the board would have liked. The management team has done a lot of work to understand what the properties are and to try to ensure that the estimates are realistic. The timeframe for selling the properties is difficult to measure, and there is a trade-off between maximising the value and trying to dispose of them quickly.

Monica Lennon: Have offers been made but rejected on the basis that they are not achieving good value?

Kenny Wilson: Offers have been made on a couple of properties and the management has taken steps to accept them, because the board recognises, as Mr Beattie says, that it is better in some respects to dispose of the properties and move forward on them. The board is working on that, and it is taking advice from the right people, I believe.

Monica Lennon: Are those offers below market value?

Kenny Wilson: The offers are around market value for some of the properties and below for others. You are probably best asking the board for an update on exactly where it is with that.

Monica Lennon: If properties were being sold on the cheap, how would that be reported at the board? As far as transparency is concerned, how would we find out whether there was good value, with properties not being sold off too cheaply?

Kenny Wilson: That is certainly part of every audit. We would see the value coming through the accounts as a loss on the disposal of the properties. We would be able to see from the annual accounts what the impact of that was.

I do not believe that there is a plan to sell off the properties at levels that are any lower than the market value. Fortunately, the value at which they are being sold is very much what the market is willing to pay. It is difficult, because the property market in Dundee and Tayside is challenging.

The Convener: I will return to a couple of points. I go back to the 39 per cent rise in the spending on agency staff. I am not clear about why there has been such a huge rise just over the past year. I know that I have asked this question before, but can you shed any light on it?

Kenny Wilson: The challenge that the board has had is that it has not been in a position to have sufficient bank nursing and the right staffing. It is a question that you would be best asking the executive team. It is an area that the board is focused on trying to address. As I indicated, it is looking to reduce agency costs by 30 per cent by the end of 2016-17. It is increasing the nurse bank quite significantly in order to reduce them.

I am unclear as to the reasons why the increase that happened in the previous year got to that level.

Caroline Gardner: I have just been checking with Carol Calder what information we have here now. It is a question that you would need to explore with the board. Looking at the summary information that we have in the overview report, I think that it is clear that the nursing and midwifery agency spending has gone up a lot, but the nursing and midwifery vacancy rate is not particularly high compared with that in other boards in Scotland. The question would be well worth exploring with the board to see what has led to that jump in agency spending. In the submission that it has made to you, the board targets that as one of the key areas where it wishes to reduce spending in order to bring its finances back into balance, although it does not explain what led to the increase in the first place.

The Convener: I know that you considered the matter in your general report, which we studied earlier. Judging from best practice in other boards that have less reliance on agency staff, how do you think that they achieve that, and what lessons do you think NHS Tayside could learn from that?

Caroline Gardner: Three things play into the use of agency staff. One is having vacancies on the establishment. It appears from the figures before us that the vacancy rate is not particularly high in NHS Tayside. The second is having high levels of sickness absence, which create a need to fill the gap across the piece because services need to continue to be delivered and members of staff need to come in. The third is how those short-term gaps are filled—whether by agencies or by the board's own nursing bank.

Any of those three is possible. The figures that we have here today—the figures in the overview report—suggest that it is not down to either the vacancy rate or the sickness rate. I think that that is an entirely appropriate area to explore with the health board.

The Convener: So it is a matter of managing the balance between bank nursing and contracted nurses.

Caroline Gardner: I would expect that that is one of the areas to explore. There may be other factors that are unique to Tayside that are not coming through in the submission that the board has made to you. It highlights that it forecasts a 30 per cent reduction this year, which is equivalent to £1.5 million, but it does not focus on why the spend is as high as it is in the first place.

The Convener: Do you think that that reduction is achievable?

Caroline Gardner: As Kenny Wilson and I have said throughout this session, it is challenging. Whether that specific reduction is achievable will depend on the reasons for the high level of spend in the first place.

The Convener: Given that you all think that the situation is challenging, could we be looking at the cuts to services in NHS Tayside that Mr Neil mentioned?

Caroline Gardner: That very much depends on, first, the success with which NHS Tayside is able to deliver on its transformation plan, which it summarises in its submission to you, and secondly on the support that the Scottish Government is able to give it while it is implementing the plan. The reason why I have reported to you today is that I am concerned that the board's finances are currently not sustainable and services cannot carry on being delivered against that financial background.

The Convener: Do you think that the transformation plan is good enough at this stage?

Caroline Gardner: Kenny Wilson might want to add to this, but I think that our sense is that it focuses on the right areas and that the board has struggled to deliver its efficiency savings in the past.

Kenny Wilson: I agree with Caroline Gardner. It will be a challenging five years. I think that the five-year plan is focusing on the correct areas—the areas that the board needs to focus on. It is clear that there are circumstances unique to NHS Tayside that provide an opportunity for us to make some significant improvements to both its efficiency and its effectiveness. That is good, but there is no doubt that it will still be quite a challenge to implement and make savings of £175 million over the five-year period and to repay the brokerage.

As we said, a deficit is forecast for the current year—2016-17—and the board still has to make just under £46 million of savings. That will be challenging. The amount is more than double the savings that it has made in previous years. There is no doubt that there is risk around the transformation plan, but the positive thing is that the board is totally engaged with that. It is talking closely with the Scottish Government on a regular basis and, from what I have seen, it is certainly doing the right things.

The Convener: But you fear that that could result in some clerical and administrative posts going.

Kenny Wilson: I think that the board would say that it has higher staffing in certain areas compared with other boards. That indicates that there may be opportunities over a period of time to reduce those numbers without impacting on things. However, that is something that the board will consider, and I am sure that it will be able to talk to you about it.

The Convener: Finally, has any NHS board in Scotland been in a similar financial predicament before?

Caroline Gardner: In my time as Auditor General, this is the most challenging position that I have seen. In the slightly more dim and distant past, we had real challenges in the Western Isles and Argyll and Clyde health boards, but they occurred before I had my current responsibility, so I cannot compare them in that sense.

The Convener: Thank you for your evidence today. We now move into private session.

10:58

Meeting continued in private until 11:09.

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