OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit and Post-legislative Scrutiny Committee

Thursday 16 November 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 16 November 2017

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PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE
27th Meeting 2017, Session 5

CONVENER

*Jackie Baillie (Dumbarton) (Lab) (Acting Convener)
Jenny Marra (North East Scotland) (Lab)

DEPUTY CONVENER

*Liam Kerr (North East Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Bill Bowman (North East Scotland) (Con)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Monica Lennon (Central Scotland) (Lab)
*Alex Neil (Airdrie and Shotts) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Bruce Crosby (Audit Scotland)
Caroline Gardner (Auditor General for Scotland)
Fiona Mitchell-Knight (Audit Scotland)
Claire Sweeney (Audit Scotland)
Kirsty Whyte (Audit Scotland)

CLERK TO THE COMMITTEE

Terry Shevlin

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Public Audit and Post-legislative Scrutiny Committee

Thursday 16 November 2017

[The Acting Convener opened the meeting at 09:01]

Decision on Taking Business in Private

The Acting Convener (Jackie Baillie): Good morning and welcome to the 27th meeting in 2017 of the Public Audit and Post-legislative Scrutiny Committee. I ask everybody in the public gallery to switch off any electronic devices so that they do not interfere with the committee's work.

Agenda item 1 is a decision on taking business in private. Do we agree to take items 4 and 5 in private?

Members *indicated agreement.*

"NHS in Scotland 2017"

09:01

The Acting Convener: We will now take evidence on the Auditor General's report, "NHS in Scotland 2017". I welcome Caroline Gardner, Auditor General for Scotland and, from Audit Scotland, Claire Sweeney, associate director, and Kirsty Whyte, audit manager. I invite Caroline Gardner to make an opening statement.

Caroline Gardner (Auditor General for Scotland): Thank you. Today's report is our annual overview of the national health service in Scotland. It looks at how the NHS performed in 2016-17, both financially and against national standards, and examines the progress made towards moving more healthcare into the community. It highlights the key issues facing the NHS and a number of areas that need to be addressed urgently to achieve sustainable change.

Since the NHS was set up in 1948, both Scotland and its health service have changed significantly. Scotland's population has grown to its highest level ever, life expectancy has improved markedly and the number of people with complex care needs is increasing. In terms of the NHS, staff numbers have increased, along with the range of services provided, as technology has improved and demand has grown.

There is broad consensus that healthcare cannot continue to be provided in the same way, but there is no simple solution to the challenges facing the NHS and previous approaches are no longer sufficient. There is a lot of activity under way to achieve the Government's vision that everyone should be able to live longer, healthier lives at home, but some crucial building blocks still need to be put in place if healthcare is to be transformed.

NHS staff remain committed to providing high-quality care, and patient satisfaction is at an all-time high. However, there are warning signs that the NHS's ability to maintain high-quality care is under pressure: patients are waiting longer to be seen—there was a 99 per cent increase in the number of people waiting more than 12 weeks for their first out-patient appointment—patient complaints have increased by 41 per cent over the past five years and a number of surveys have found that staff are worried about the quality of care that they can provide.

The challenges facing the NHS continue to intensify. In 2016-17, NHS boards had to make unprecedented savings of almost £390 million to break even and they are finding it harder to make those savings. Cost pressures are continuing:

spending on drugs rose by 7 per cent, backlog maintenance remains high at £887 million and spending on agency locums increased by 6 per cent. Demand for services also continues to increase and significant health inequalities remain: people living in the most deprived communities are still likely to spend longer in ill health and die younger than people living in the least deprived areas.

We found that urgent action is needed in several key areas. The Scottish Government needs to set out how existing and future funding will be used differently to move more healthcare into the community; workforce planning needs to improve urgently; and staff and the public need to be properly engaged in developing new ways of providing health and social care.

As always, we will do our best to answer the committee's questions.

The Acting Convener: Thank you, Auditor General. I turn first to Colin Beattie.

Colin Beattie (Midlothian North and Musselburgh) (SNP): Audit Scotland probably has the best independent view of the overall NHS of any organisation. NHS chiefs and the Government have recently started to talk about the issue not being a case of more money and more people any more, because that is an unsustainable model. The share of the Scottish budget spent on the core health service has gone up from 38 to 43 per cent of the national budget. Clearly, that is unsustainable. Are we at a point at which we need a complete re-engineering of the NHS?

Caroline Gardner: First, you are absolutely right that we cannot spend our way out of the challenges facing the NHS. We are seeing the difficulties of continuing to try to meet targets—for example the targets for access to acute care are getting harder to meet, with costs rising and demand increasing. We also say in the report that there is a broad consensus, which I share, that the vision for delivering healthcare differently, in the way that you are hinting at, is the right one. We need to make sure that services in the community, particularly around primary care, are able to look after the needs of many more people with complex care conditions, avoid more admissions to hospital and help people get home more quickly. We have got the vision but we need those building blocks: a financial framework, what workforce is needed and making sure that the capital investment decisions are supporting the vision rather than investing most of our capital resources in acute hospitals.

Colin Beattie: You mentioned a lack of detail in areas such as those concerning general practitioners. That has come up before. I understand that under the new GP contract that came out in the past few days there is provision for getting information from GP surgeries. Do you have any more detail on that?

Caroline Gardner: You are right that that is covered in the proposals for the new GP contract that were published this week. Claire Sweeney or Kirsty Whyte may be able to give you more detail.

Claire Sweeney (Audit Scotland): Previous issues have included the lack of information about those parts of the system that are not in the acute hospitals and getting better access to patient information. We have seen improvements in those areas over the past few years, but clearly more needs to happen on access to information through general practice and community services to get a much more rounded feel for how patients are accessing the system and what needs to change. There are provisions in the new contract that should help.

Colin Beattie: We have talked on a number of occasions about a lack of data from the national health service. It has always been a bit of a juggling act, because although a lot of data has been collected, it has perhaps not been in the right place or in consistent form. Are there indications that we are starting to get better data now?

Caroline Gardner: There are two areas where that is the case. As Claire Sweeney said, one is in the new GP contract in which there are some specific proposals about GP practices providing data on their staffing and activity—the demand and the number of patients seen—that will help to fill that gap. Beyond that, the overall information about services that are provided in the community is not nearly as strong as the information about hospital activity. The review published this week by Sir Harry Burns makes the very good point that healthcare information needs to look at the whole system, not just one part of it, or else you risk skewing attention and resources towards the part that you are looking at and cannot manage or balance the system as a whole.

Colin Beattie: The NHS is coping at the moment but showing some strains. We certainly do not want to be in the situation that exists south of the border; we want to maintain our NHS. Are there any quick fixes that can be put in place now?

Caroline Gardner: There are never quick fixes for a system as important and complex as health and social care. As we say in the report, there is a lot of activity already going on. The three things that we have highlighted are the things that will make the difference: a financial framework that makes it clear how current and potential future funding is used; better workforce planning—the committee has heard over the past couple of weeks about the problems of knowing the way in which NHS staffing needs to change in future to

make that shift into community settings; and making sure that the capital money that is available is being invested to support that vision rather than investing in more acute care where that is not needed.

Colin Beattie: Clearly, indicators are key to redesigning the NHS or effectively making the changes that are needed. In paragraphs 34 and 35 of your report you seem to indicate that the NHS itself is producing better indicators, but on the community side and in primary care the indicators are less good and efficient—perhaps they are not even there.

Caroline Gardner: I will ask Claire Sweeney to pick up the details of the community indicators. First, I will make a broad point. It is useful to distinguish between indicators and targets. There are lots of parts of health and social care where we need good information and that we need to monitor as auditors, as a committee and as people with an interest in healthcare right across Scotland. The danger of turning that into targets is that you run the risk of skewing priorities towards those targets. The review published by Sir Harry Burns helps to move that debate on to asking what it is that we want to know and what the relatively few things are that we should be setting targets for.

Colin Beattie: Presumably the indicators drive the targets.

Caroline Gardner: I see indicators as things that you measure and monitor, seeing how things change and where there are indications of pressure points in the system. For example, we know that the number of people waiting more than 12 weeks for an out-patient appointment has doubled, so that is a good indicator that pressure is building up all the way through the system. Focusing just on that number as a target runs the risk that you do not think about what is happening in primary care and in the community, which would have a longer-term effect on the number of people waiting to be seen in hospital. I draw that distinction.

Claire Sweeney: We know a lot about what is happening in our acute hospital system, particularly how long people wait for certain individual parts of the system. We are much less good at understanding how things are interrelated—what the connections are between different parts of the system. That is why the report says that there is no simple solution to some of the challenges facing the NHS. It is a very complicated system. It is interrelated with social care services, for example, and the work of GPs increasingly involves thinking about things that are not necessarily related to only the health system, such as social prescribing, access to green space and exercise. Those are things that can make a difference in improving people's wellbeing and long-term mental health. We are very well sighted on the acute system and waiting times, but less so in terms of the rest of the system.

We are also interested in the extent to which the Harry Burns review will lead to a review to help us focus more on outcomes and the impact that the services have on people. In the report, we make the point that we know far less about quality. Lots of what we are talking about are throughput measures; it is not about the quality of the care that is provided to people. We would like to see more work on that too.

Colin Beattie: Paragraph 33 of the report says that the increase in people attending as out-patients has gone up 12 per cent between the first quarter of 2013 and the first quarter of 2017. That is a very big increase. Is there any indication that it is levelling out?

Caroline Gardner: If we carry on as we are, all the indications are that it will not level out. Exhibit 6 is headed "Indicators of demand for NHS services" and goes back to 2012-13—a five or six-year period. All of the indicators are going up by different amounts: emergency admissions, numbers of procedures, out-patients, people waiting for in-patient and day case treatment and GP consultations. We know that to a large extent that is driven by an ageing population, where more people have complex care needs, and that for many of those people—although they could be cared for, often better, in their own homes if we had a good primary care system around them—at the moment of need there is often no alternative to admission or a referral to hospital. That is absolutely what the vision for healthcare is founded on. It is what the GP contract proposals that were published this week are trying to build capacity for. Our message is that the urgency of building that capacity and being able to see what effect it is having is the only realistic way of dealing with those continuing increases.

Colin Beattie: There must be a projection that shows that at some point the demographics turn. We have this bulge of older people who need more services, but that will reduce in the future. We should start to see a downwards curve.

Caroline Gardner: At some point, yes. However, I was looking at statistics yesterday for a speech that I am giving tomorrow and the latest projections are that, by 2030, the number of people over 65 will increase by 50 per cent.

If we plug those numbers into what we have seen over the past five years, it starts to look unsustainable. That is why there is general consensus about the vision for the future that is required to deal with that. As we get older, we have a wider range of needs, beyond things that

are easily fixed, such as needing a knee replacement. Although we would much prefer to be in our own homes, we can do that only if we build strength and depth of capacity in primary care.

09:15

Alex Neil (Airdrie and Shotts) (SNP): I begin by asking about waiting times. Harry Burns's report, which seems very good, raises a whole host of issues. One of the issues that I do not think that we have ever properly addressed is the cost of trying to reach some targets, particularly on waiting times, and the extent to which that might distort decisions on other clinical matters. Supposing we suspended the statutory waiting times targets for a year, what impact would that have on performance, finance and a better allocation of resources within the health service?

Caroline Gardner: We have not attempted to estimate the impact in exactly those terms. However, 18 months ago we published a report, "Changing models of health and social care", that aimed to get under the skin of what is happening with demand and what successful responses to it look like. The main message that came out of that was that there is a real risk in looking at one part of the health and social care system. If you have got people working to not just a four-hour accident and emergency time but a 12-week target for in-patient or hospital care and a reducing target for discharging people safely from hospital after their treatment, and you do not look at what is happening in the community, you run the risk of building up pressures elsewhere that cannot be dealt with. For example, the number of people waiting more than 12 weeks for their out-patient treatment has doubled in the past year, which is a sign of pressure building up elsewhere. We do not know how many people are having to wait longer for a GP appointment, because we do not collect that information routinely, but there is a real risk that, by focusing on this bit of the system, you have got pressures building up elsewhere that you are not aware of and that are potentially having a more significant impact on people's health and wellbeing than getting right the treatment time guarantee or whatever other indicator of the acute system you are focusing on.

Alex Neil: The four-hour target in A and E was driven by the clinicians; it was not a political invention. Even today, if you asked emergency consultants, they would say that the four-hour target is absolutely the right thing to do. The problem was that when that policy was introduced 20 years ago, nobody looked at the impact and how it related to the flow of patients through the hospital sector. A lot of the problems in achieving the target have been related to the lack of a flow of patients through hospital wards. What Harry Burns seems to be suggesting is that we need a new performance and impact measurement framework that looks at the totality of the patient pathway and the relationship between the sectors—primary, acute and so on. Correct me if I am wrong, but does that equate to what you are suggesting?

Caroline Gardner: That is what we say in this report and have been saying for a while. I need to be careful, because I am precluded from commenting on the merits of policies, so I cannot talk specifically about targets, but we have been saying that there is a risk in looking simply at the acute sector. You need to pull that focus back to understand all of the things around health and social care that are leading to somebody arriving at A and E.

Alex Neil: But at the moment we are not doing that. First, we tend to look at silos, or chunks, rather than at the relationship between the different parts. Secondly, we tend to look entirely at performance against stated targets, rather than at impacts. I think that the point that Claire Sweeney was making was that impacts are at least as important as performance. Also, if you look at impacts, it differentiates between what the health service can do and external factors over which the health service has no control. What we want to know is the added value of the health service and whether it is maximising added value, and we do not have a performance and impact monitoring framework that does that. Is that a fair comment?

Caroline Gardner: I think that that is right.

Alex Neil: Inevitably, our focus is very much on the work of the territorial boards and, within that, the GP and acute sectors as well as, for the purposes of this discussion, the Golden Jubilee. However, the Jubilee is also a special board, and the seven other special boards, which include the Scottish Ambulance Service, NHS 24 and NHS National Services Scotland, play important roles to different extents. If we look at the financials, are we, in your view, getting value for money out of those seven boards?

Caroline Gardner: You are absolutely right—potentially, they play a significant role in addressing some of these challenges. I will ask Claire Sweeney to pick that up in a moment.

Because of the overall financial pressure on the NHS, the territorial boards have had their funding protected in real terms, but that has not been the case with the special boards, which, for understandable reasons, have seen significant real-terms decreases in their budgets over a period. That suggests that they are playing their part in getting value for money, but for me the question is probably more about their ability to fulfil

their potential and really start to change some of this. For example, we have seen NHS 24 gradually moving to the point at which it is helping to redirect to other forms of service patients who do not need to go to A and E, and we have seen NHS Education for Scotland thinking about new professional roles. Those are the areas where they probably have much more potential to play their part in making the whole system more effective.

Claire Sweeney: Appendix 2 in the report lists all the territorial and national boards and sets out the very wide range of different services and supports that the national boards offer. Examples that we have pulled out in previous reports range from the role played by the Scottish Ambulance Service in responding to patient need in very urgent situations—and we have seen some excellent examples of how that has helped to reduce pressure on other bits of the health and care system—to the role played by NSS and Healthcare Improvement Scotland in helping to drive the improvement agenda across health and social care services. They are providing really important services that can help to achieve the goal of making care better for people in Scotland.

However, as Caroline Gardner has said, the question is the extent to which they are realising the full potential of that, given the context in which they are working. As we have said in the report, a longer-term planning horizon, longer-term financial planning and a move away from a short-term focus and a focus on individual bits of the system will help those boards make the maximum impact.

Alex Neil: Given the new regional structure, has the time come to devolve at least some of those functions to the regions instead of running them at a national level?

Claire Sweeney: There is absolutely a conversation to be had about that as part of regional planning. We are very interested in the extent to which the planning arrangements for health and social care across Scotland will work, and in exhibits that we have set out at the beginning of the report, we start to draw out how we think that will work in practice. There is a need for more thinking and more work on how to connect up the regional focus on planning, what the territorial boards are focusing on and the role of integration authorities and general practice in localities to ensure the most effective use of resources. We have tried to be as clear as we can at the start of the report in pointing out the need for more thinking in that respect.

Alex Neil: You have rightly indicated in previous evidence that one of the problems with looking at the primary care sector is the absence of data, particularly from GPs and GP surgeries. Having looked at the draft of the GP contract, which is currently out to consultation with GPs, are you satisfied that that black hole is going to be filled?

Caroline Gardner: Kirsty Whyte will answer that.

Kirsty Whyte (Audit Scotland): With regard to the Scottish primary care information resource—SPIRE—which is the new primary care data system for GPs that is being developed, we raise in our report an issue about the potential for GPs not to have to provide that information to integration joint boards because they are independent contractors. I understand that they will, under the new GP contract, have to provide the data, either through SPIRE or through their own system, which will certainly help IJBs to plan because it will fill in data gaps so that they can work out local needs and what services need to look like.

Alex Neil: That information will fill some of the data gaps, but should not we be trying to fill all of them? The opportunity to do so will not arise for at least another five years.

Claire Sweeney: We have seen progress in the past few years. Following the introduction of integration authorities, there was certainly a lot more targeted support from some boards to focus attention at local level on what the data say. For example, there was a focus on things such as the number of people who make very intensive use of health and social care services, and who access lots of services across the system, from acute services right through to general practice. It is important that there is a focus on how such people use the services so that we can ensure that they get the care that they need as early as possible in the right place, and are not bounced around the system.

We have seen improvements in the data. Among our consistent messages over the past few years have been messages about gaps in understanding, provision in communities and primary care services. We do not really understand enough about numbers of GPs, how they work and the services that they provide. The new GP contract certainly starts to make progress towards a better understanding of those things.

Alex Neil: From my experience as a health secretary, I can say that the Improvement Service does a fine job of identifying improvements in best practice. However, that is often where it stops. For example, about eight or 10 years ago, it picked up on a bit of best practice in the Western Isles, where community nurses were using a digital pen that had been developed locally on their own initiative, but it has still not been rolled out elsewhere. Best practice is not being spread and there is a lack of drive from the centre to ensure that best practice is adopted reasonably quickly

across the board. I know that that is frustrating for many people who work in the health service.

Last week, we got a lot of anecdotal evidence from the NHS chief executive about what might happen in Cowdenbeath. That is fine, but, if it is good practice, why is it not happening across the whole of Scotland?

Caroline Gardner: We say in the report, in pulling together the action that we think is needed, that a tightening of the governance arrangements is needed for the change that is required, given its scale and complexity. We all accept that, in a system that is as complex and people-centred as the NHS is, top-down direction is not likely to be successful. The approach has been very much about letting people develop good practice locally and hoping that it will spread. We now know, as Alex Neil said, that it is not spreading as quickly as it needs to spread. I have recommended in the report that we look again at governance and think again about approaches that have been used in the patient safety programme and the early years collaborative, so that we can build up understanding at local level across Scotland of why change is needed, what change might look like in the locality and how we will know that it is happening.

Claire Sweeney: There is another dimension of which we have made much at the end of the report. Staff across the NHS system need to buy into the values and truly to live them in order to make the changes, but there is also an issue about the involvement of patients and the public. We therefore say a lot in the report about the need for more transparency and clarity about services and their quality, and about the need for true engagement with the public about how services will be delivered in the future, because difficult decisions will need to be made. We see some examples in which that has been done well, but we think that there is scope to improve.

09:30

Liam Kerr (North East Scotland) (Con): You give some key messages early in the report, on page 11. You say:

> "The majority of key national performance targets were not met in 2016/17 and wider indicators of quality suggest that the NHS is beginning to struggle to maintain quality of care."

That is then drilled down into at paragraph 40, where you give examples of how the various pressures that you have isolated might impact on the quality of care. Is it clear to anyone exactly why those pressures have arisen? Assuming that that is the case, how do the health boards intend to respond to those pressures?

Caroline Gardner: The circumstances will be different in different parts of Scotland, but across the country we have an increasing ageing population. Many of us are living longer, which is a good thing, but age tends to bring with it complex health conditions and care needs that are not easily fixed by one admission to hospital, as is often the case when we are lucky enough to be younger.

Healthcare costs also tend to rise more quickly than general inflation. Although the Government has committed to maintaining the health budget in real terms, drug costs rose last year by 7 per cent against a general inflation rate of 2 or 3 per cent. Drugs are one example: costs also rise more widely because of innovations in health technology. Those aspects are behind the recognition in our report, and which is shared more widely, that we cannot just spend our way out of the problem: it is not just a matter of being more efficient.

During the past few years, health policy that is visible in the public domain has tended to be about the targets to which attention has been drawn—for example, how long people wait for acute care or for admission to hospital for treatment. However, the only way to speed up that part of the system is to take away some of the pressures that come from people who could be treated better if there was a good primary care team that could prevent their being admitted in an emergency. For example, a person's chronic obstructive pulmonary disorder being treated better, or the patient being helped to recognise when their health is deteriorating and they should take action, are better than their ending up in an accident and emergency department on a Saturday evening because they missed the signs.

The point of our report is to focus attention on that end of the system and to capitalise on things like the proposals for the new GP contract and the review of targets. We need to see the system as a whole rather than to look just at one dimension of it.

Liam Kerr: That makes sense, of course. You say that there is a macro picture, but also that there is a more micro picture in which each individual board has its own pressures. Did you get any sense that the individual boards understand the individual pressures that pertain to them, and that they have bespoke plans to deal with them?

Caroline Gardner: The situation varies. Claire Sweeney will pick that question up.

Claire Sweeney: The situation does vary. In the report, we say that a number of the big issues that are affecting the NHS in Scotland are common across boards. Included in that list are difficulties

in recruiting and retaining in certain specialties, which is widely recognised as a national issue. There are similar issues in the social care sector, which has a knock-on effect on healthcare. Many things that are affecting the system are common across Scotland. We would go further than that and say that many of the issues are affecting health systems across the world. This is not unique to Scotland.

Particular issues affect individual boards: they are aware of them. They include difficulty in recruiting and retaining staff in health and social care in the central belt, where there are many other employment opportunities. There are also particular pressures in the island boards—for example, around recruiting and retaining GPs.

Generally speaking, there are issues across Scotland that need to be addressed. Some are specific to local areas, but broad issues affect the system across the nation.

Liam Kerr: This is not where I intended my questioning to go, but you have made the point that the problems are not unique to the NHS in Scotland or the NHS in the UK, but are coming up across the world. Has anyone successfully solved those problems elsewhere and—if they have—what are we learning from them?

Claire Sweeney: I have opened a can of worms. Very good examples from around the world of individual practice, such as for access to primary community care services, are starting to change how health systems operate. Those examples fit with the general shift in Scotland to the focus on providing care closer to people's homes, on supporting and enabling practitioners to make more independent decisions about care, and on putting the person at the heart of the treatment that they receive. Scotland is trying to learn from those examples.

Pockets of innovative practice being taken on board is fine, but our report highlights that what is needed in the financial picture is a plan and financial framework—as we call it in the report—to give a sense of how to get from the here and now to that ambitious view of how the world will look in a few years. We need to bridge the gap between the two. There are some examples of how systems have started to overcome the challenges, but they are incredibly complex and difficult.

Liam Kerr: I will focus on that financial aspect. Colin Beattie was quite right to raise the issue of savings. It is obviously difficult for the boards to make particular savings. In your report, you comment that NHS boards' use of non-recurring savings is "unsustainable". In delving into that, you explain that

"Non-recurring savings accounted for 30 per cent of all savings planned in 2016/17, more than double the level of five years ago".

First, it cannot be sustainable continually to pare a service. How concerned are the boards about the current approach to savings? Secondly, have the boards proactively suggested alternatives to the current programme of non-recurring savings?

Caroline Gardner: Kirsty Whyte will pick that one up.

Kirsty Whyte: That is a good point. We have said for a number of years that the level of non-recurring savings is unsustainable. Every year, the boards generally manage to make their savings, but this year they did not meet the target that they had set for themselves. The actual non-recurring savings in 2016-17 were just over a third—at 35 per cent—of all the savings that were made.

It is interesting that the level of unidentified savings has also increased over the past few years. In 2016-17, the range was from NHS Shetland, which knew where all its savings would come from, to NHS Fife, which did not know where 33 per cent of its savings would come from at the start of the year.

Alongside those savings issues, we have seen an increase in the level of risk that is attached to the savings. Boards have known that a number of their savings were high risk; some of that risk would have been related to—

Liam Kerr: Forgive me for interrupting, but I did not follow that point. Are you suggesting that, at the start of the year, an NHS board would have said, "We intend to save £X by this time next year, but we don't know where one third of it will come from; we're just going to save it." That refers to what I think you called the unidentified savings. Is that correct? Do I read you aright?

Kirsty Whyte: Yes, that is correct. The 33 per cent example was particular to NHS Fife; in 2016-17, the national percentage was 17 per cent. In their local delivery plans, health boards set out that they agree with the Government that they will make £X of savings. They then try to identify where they will make the savings. We have seen an increasing tendency over the past few years for boards not to know from where savings will come.

When boards know where the savings will come from, those savings are, increasingly, high-risk savings: many are attached to such things as closures of facilities. A board may identify at the start of the year that it would like to close a facility, but as the year goes on, public and political pressures mean that it becomes difficult for it to do so.

Liam Kerr: The final question that arises from that is this: do boards project the impact of those

savings on patient care? If so, do they assess retrospectively the impact of the savings on patient care and, indeed, the staff, especially if, at the start of the year, they did not know what savings were going to be made?

Kirsty Whyte: Savings should be assessed for their clinical impact. That should be done before the information goes to the boards and decisions are made about the savings. The boards should identify exactly what impact savings will have on the clinical element, and savings' link to patients.

I am not aware that boards retrospectively consider impacts of savings. Some of that will come through as impacts on existing performance indicators: there may be drop-offs or improvements in some areas. I would be happy to come back to the committee with more information on that.

Liam Kerr: That would be useful.

A board might intend to do X, which its members think will save £Y, and will then assess the impact of the proposed savings. Have you seen any evidence of boards finding out that the impact could be considerable and therefore not doing what they had intended, but instead finding another way to make the savings?

Claire Sweeney: You will note the point about differences in savings in how we describe the savings picture on pages 15 and 16. We can see something of the trends in recurring and non-recurring savings over the past year. You will note that, at paragraph 26, we have drawn out the point that there are differences in how savings are reported. That message changes throughout the year. We are interested in whether there is scope to make things much clearer—not just in planning services and understanding how resources have been used, which are important, but in what is said to the public. Is there clarity about how the savings agenda is being planned for throughout the year? Is that being done in a meaningful way in order to improve efficiencies and to reach the aspiration of how services will operate? We have made a recommendation that there is scope for getting much sharper in respect of how the savings issue is dealt with.

Although that does not speak to the detailed point that Liam Kerr asked about, it shows the context that we are working in, and suggests that there is scope to be sharper in reporting of savings.

Liam Kerr: That is very useful. Thank you.

Caroline Gardner: We know that boards take savings very seriously, which is why some of them fail to meet the level of savings that they planned—they are not prepared to put patient care and patient safety at risk. One of the things that drives the approach to planning that Kirsty Whyte has been describing is the need for boards to break even every year. One of our recommendations in our report has been to give boards a longer-term financial planning framework, so that they can think about how they invest to save and how they make changes in a way that is not just about cutting at the margins. As we have seen, that approach is reaching the end of its usefulness.

Colin Beattie: Liam Kerr referred to paragraph 40 and the overall pressures on the health service and so on. Why is there all this doom and gloom about things that have built up and pressures on the health service when, in paragraph 39, you say that

"Inpatient satisfaction is at an all-time high ... Patient safety indicators continued to improve"

and that

"The Nuffield Trust's 2017 report ... found there was a strong culture of continuous improvement in the NHS in Scotland"?

There seems to be a bit of a conflict there.

Caroline Gardner: In part, that reflects the great efforts to which staff go in order to continue delivering high-quality care for patients, and the fact that patients recognise the concerns that we are all exposed to every day about the effects of austerity on public services. Patients know that staff are working very hard to maintain care. The Government has made significant commitments and investment in the patient safety programme, and there have been real positive results in terms of rates of healthcare-acquired infection.

Across the page, however, we also highlight evidence of things going the other way, with patient complaints increasing and staff responding to surveys with concerns about the time that they have available for delivering the quality of care that they want to provide. I absolutely recognise the huge commitment of staff in continuing to provide the best care that they can provide. We need to put that in the context of signs that it is getting more difficult for them to do that.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): I will pick up on the earlier point about meeting targets. There is a series of tables in appendix 3 showing the extent to which boards have met the various performance targets. I am looking, in particular, at the 12-week treatment target, which only one board met. Our impression of that is that the situation is disastrously bad and there is something far wrong, but what is the impact of demand on those performance figures? If they are simply raw figures on meeting a 12-week target, how do we know about the impact of demand in the various communities, which might be pushing those numbers down?

09:45

Caroline Gardner: That is a really good question, which goes back to the questions that Mr Neil asked earlier about the effect of targets on the system as a whole.

We have said before that there is no evidence that the targets were set with an understanding of the system's capacity to manage flow through it. Our report in March 2016 tried to set out some of the modelling that suggests that it will get harder to meet the targets because of imbalances in the system across the piece.

Hospitals are getting much better at managing the flows through them. The four-hour A and E waiting time target has been a driver for that, because hospitals have had to manage as actively as possible patients going on to the right place quickly. However, they cannot manage things that are outside the hospital system. At the moment, they cannot easily manage the number of patients who arrive in A and E who could, in many cases, be better looked after in primary care if the capacity were available there, and they cannot directly manage the number of patients who are medically fit to be discharged but cannot safely be discharged because social care is not readily available to make that transition safely.

Willie Coffey has pointed to a really good example of why focusing just on the acute service and access to it does not give the whole picture and runs the risk of simply speeding things up to the point at which the system cannot cope because the real drivers are outside.

Willie Coffey: Do we need to do something about that and show the impact of demand on those targets—not to conceal where there might be bad performance, but to give a more accurate reflection of the service's performance? If we look at the table in appendix 3, we see that the figure for poor NHS Forth Valley is 63.5 per cent. We might wonder what on earth was going on there. Perhaps it performed really well, but demand doubled. We do not know that. Should we try to reflect that in the statistics that we produce from year to year?

Claire Sweeney: That is a good point. On pages 20 and 21, we tried to draw out how demand interacts with what is happening with waiting lists. There will be a sense of waiting lists just getting larger but, when we looked, we saw that it is not always the case that more people are getting treatment. There is something about starting to see the effect of the potential difficulty of filling vacancies, and the fact that the system is being driven so fast that it is very hard for it to continue to improve in that way. It is absolutely true that there is a need for more understanding of what is really happening because of the waiting times figures. When we get that we will start to see some differences across the board.

Kirsty Whyte: One of the points that we made in the report was about the need for better and more information in the area. That relates to the length of waiting times for patients and the number of general practitioner referrals, and it goes back to the point about the need for data on the primary care element and what is driving the pressure on the acute system. For example, in the past year, NHS Grampian has started to write to patients to say that they have been referred for treatment and give them the numbers of people who are waiting and the likely length of the waiting time. That has been done just to try to be more transparent about the pressures in the system.

Willie Coffey: Let us stick with the same column in appendix 3 and think beyond the target. Does anyone collect data on when people were seen? If, for example, 63.5 per cent of the Forth Valley patients were seen within 12 weeks, when were 100 per cent seen? Was that a week or months later? Are there clinical impacts on the people who are included in all the targets and who fall outwith the target time? What are the clinical impacts, if any?

Caroline Gardner: Individual health boards and hospitals have data on that and use it actively. That is another example of where having data and indicators is more useful than having targets. If a target is that 100 per cent of people who are referred to out-patient services need to be seen within 12 weeks, people will try to drive everybody through in that 12 weeks, as that is what the target says. We have seen that that is getting harder to do. The number of people who waited more than 12 weeks doubled last year.

If we look at the situation in a more nuanced way, we could say that we are still managing to see everybody within 16 weeks, that that is acceptable for now, while we manage the pressure in GP practices and in in-patient or day-case treatment, and that we will work on the system as a whole. Alternatively, we could say that we have some people who are waiting for 26 weeks or a year, which is not acceptable, so we will focus on those specialties.

Having that information helps us to understand what is going on and to manage the system in a way that is much more likely to lead to better outcomes for patients than having a target that says that 100 per cent of people should be seen within a particular timeframe. That is a more nuanced approach. The difference between measuring what is happening and having a target is really important in being able to manage the system and get the best outcomes for as many patients as possible.

Claire Sweeney: In the past few years, we have looked at the issue in some detail for certain bits of the system. We did some work that involved looking at accident and emergency services. We set the clock when people went into A and E and looked at when they received treatment up to and beyond the four-hour waiting time target. It was interesting to discover that it was quite difficult to do that, and it was illuminating to find out that, in some instances, people were waiting longer because they were being seen just before they went over the four-hour target. Front-line staff face all sorts of issues in being able to treat the right people at the right time not just from the point of view of clinical priority and need, but with an eye to the targets. That is why the use of targets can have a significant effect on the way in which people experience the health system.

Willie Coffey: I turn to the main recommendations that you make in your report. You talk about better financial planning, capital investment, workforce planning, governance and transparency. Those issues are not uncommon—we have heard about many of them before. Having made those recommendations, what is your sense of the extent to which you will be able to follow up on the progress that has been made on implementing them? Do you think that the various departments of the NHS that deliver the various services will be able to structure themselves in such a way as to make positive gains in delivering on those key recommendations? How will we know whether they have been met? Will we say the same things next year, or are you confident that there are structures and management processes in place that will enable the recommendations to be delivered on?

Caroline Gardner: I am more hopeful now than I have been. I looked back at the report that we published in March 2016, in which we talked about the need for stronger national leadership to deliver the vision. Since then, there has been big progress on the proposals for the new GP contract, the review of targets and indicators has come through and some of the workforce planning measures have started to gather pace.

We say in the report that there is a lot of activity happening. I think that the key recommendations that we make on the financial framework, workforce planning and the capital investment strategy can help to bring that activity together, as can the forward look on demand and responses to it that the committee has been exploring over the past few weeks. Many of the building blocks are there. Our recommendations will help to bring them together and to make sure that everyone is moving in the same direction, and that it is possible to measure progress and to respond when progress is not being made as quickly as it needs to be made.

Willie Coffey: I presume that you will follow up on the recommendations that you have made.

Caroline Gardner: Yes—we will be here again next year.

Willie Coffey: In paragraph 45, you say that the health gap is not closing in areas of multiple deprivation and that, in some areas, it is widening. Have you made any specific recommendations to assist the Government and the NHS in closing that gap?

Caroline Gardner: The work in that area operates at two levels: there is what the health service can do, and there is what society and public services as a whole need to do. I know that Claire Sweeney wants to pick up on that.

Claire Sweeney: A few years ago, we produced a report on health inequalities. As part of that work, we asked questions about the universal provision of services and people's expectation that everyone would receive the same level of care. We also wanted to understand what efforts were being made to close the gap and to address the needs of people who had found it extremely hard, for whatever reason, to engage with their GP or to get into, for example, the screening system.

We have made a series of recommendations in the report to try to help the service to focus on addressing the gap, because it is not enough to provide the same to everybody. People in some parts of society need a bit extra support to get the services that they need and which they probably need more than other people in society. It is about that extra work to support people to get into the system. There are good examples of that across Scotland, but we know from our work that there is a need to do more.

Willie Coffey: Do you see an increasing role for telehealth in shaping service delivery for the NHS? Where do you see it making the greatest impact?

Caroline Gardner: Telehealth has huge potential. We see some good examples of that, such as the attend anywhere pilot in Grampian. I echo, though, what the chief medical officer for Scotland said last week in evidence to the committee, which is that we should not underestimate the straightforward technology that everybody has, such as the telephone. The committee has heard examples of GPs using the phone to make early contact with people to understand what their problem is and whether they need to be brought into the practice quickly or need to be pointed towards somebody else, if that is a better response. We can think in much more flexible ways about how the health service as a whole responds. Technology makes that more possible, but we do not need to wait for the magic technology to come along.

Willie Coffey: Is it consistent enough? Alex Neil mentioned that good practice exists in pockets. How do we ensure that good practice in areas such as telehealth is spread across the country?

Caroline Gardner: I am sure that it is not consistent enough at the moment. Again, there are some pointers in the proposals for the new GP contract that can help with that. The recommendation that we made about the need for stronger governance, so that it is clear what is expected of people and whether that is happening, is also an important part.

Monica Lennon (Central Scotland) (Lab): There is a recommendation at the back of the report that has not been mentioned, but it is important because it is about everyone working together. We are still not seeing real evidence of that. It is interesting that paragraph 87 states:

"Although public health has traditionally been seen as the domain of the NHS, as little as ten per cent of a population's health and wellbeing is linked to access to healthcare."

A lot of what we are talking about here today is therefore not just for the NHS to sort out. Paragraph 87 refers to having a shared commitment across the public sector and perhaps beyond. Where is the evidence that there is that shared commitment and that people understand the need to work differently and to work together?

Caroline Gardner: The recommendation is at the end of the report because we think that it is very important, not because we think that it is not. I ask Claire Sweeney to pick up on what we see the state of play being.

Claire Sweeney: We mention in the report the introduction of the integration of health and social care being part of the key here. We are going to carry out more work—we are just starting it now—and will report next year on the progress that has been made with integration and some of the challenges that we are already seeing coming through. However, those challenges represent an opportunity for having an integrated approach beyond just the health and social care system that takes into account the needs of the local population. As I mentioned earlier, those needs might be about access to green space and ensuring that children are eating healthily and that everything is being done to help them succeed in school and find work after they leave education. There is an opportunity through the integration of health and social care to think much more broadly, and we are starting to see some good examples of that happening. However, it is challenging.

One of the other messages in the report is around the long-term nature of a lot of the things that we are talking about here today. There is no quick and easy fix, and some things will take a long time. We need to have in place the right measures and the right workforce, and we need to have an open conversation with the public about what is possible. There is also an onus on the public with regard to their own health, and we are starting to see conversations about that happening across Scotland, which is encouraging. There are therefore some green shoots that show that things are starting to move forward and there is a mechanism through which that should be a bit easier in future, but we are yet to report on that.

Monica Lennon: The integration joint boards in health and social care operate at quite a high level. However there are people working in housing, roads and planning departments, for example, and people who deal with leisure centres. How many of those people do you think have a focus on what we are talking about here today and think that they have a part to play in that? I know that working groups and other things have been set up, but there are thousands of people across the public and other sectors who, day to day, have a role to play in this. Are people sitting back, waiting for some direction from the top? How do we ensure that a bottom-up approach is taken?

10:00

Claire Sweeney: Without predicting what the report in question might say, because we have yet to do the work, I would point out that it has been recognised that housing, which you have just highlighted as an example, is absolutely vital to this. Given our previous work on the role of housing in the broader context of health and wellbeing, I do not think that it would be a surprise to find that more needs to happen out there in Scotland. There are some really good examples of housing being tied into all of this, but I am sure that we will find that there is a need to do more around that.

The integration of health and social care offers the opportunity to have a real and meaningful conversation about local communities' needs, the services that are working very well, where the gaps are and the opportunities to do something different. As far as the voluntary and housing sectors are concerned, it is important that that sort of thing is front and centre in that development, but we are doing more work that will touch on that issue and on which we will report next year.

Monica Lennon: Have you seen any evidence of health impact assessments being carried out on decisions on budgets, policies or strategies? After all, for a joined-up approach to work, people have to understand the consequences of any decisions that are taken. Is that sort of thing happening?

Claire Sweeney: We have not looked in detail at that in this piece of work. In the course of putting this report together, we have seen a number of examples of where that approach has worked, but we have not included them in the report. I am sure that there is scope for improvement, but it is not an issue that we looked at in any great detail as part of this work.

Monica Lennon: I know that there are opportunities coming up with the proposed planning bill and so on to embed that kind of good practice.

In exhibit 5, which relates to the cost pressures on the NHS, you have highlighted the fact that 70 per cent of the NHS estate was rated as being "in good physical condition". It is good that there has been a slight improvement in that respect, but I note that the backlog of maintenance across NHS boards amounts to £887 million, which is quite a significant sum, and that a large element of that has been classed as "significant and high risk". What kinds of decisions are boards having to make in that respect? If things are being put on the back burner, what are the risks and concerns attached to that?

Claire Sweeney: Kirsty Whyte will probably want to give you some more detail on this, but a broad point that should probably be made is that, with the introduction of health and social care integration and a different way of delivering services to meet people's needs, we recognise in the report that there is more work to be done in order to fully understand this particular issue. With regard to backlog maintenance of the existing estate, some of the estate will not be in the right place or offer the right facilities, so there is a need for planning arrangements to catch up with some of that. We have a figure for maintaining the current estate, but there is a general recognition that things need to change, that services will look different and that that is bound to have an impact on current estates and facilities.

Kirsty Whyte: Just to pick up Claire Sweeney's point, I would note that the global sum of £887 million is not the amount that the boards and the Government will have to find and spend in the next few years. As has been said, the needs of the estate will change, and boards and the Government will have to work together to identify how the NHS needs to change to ensure that it is fit for purpose for the future. Therefore, one of our recommendations in the report is the need for a capital investment strategy.

With regard to the high-risk backlog, boards will identify in their asset management strategies the extent to which the backlog maintenance is classed as high risk and then decide the appropriate strategies for dealing with that. For example, the board might say, "We're about to open a new hospital, so the situation's fine for now, but if we look at the picture next year, the condition might well have changed completely." It is the responsibility of boards to prioritise their capital investment and how they manage their estate and to ensure that it is in good condition, is suitable and functions for patients.

Monica Lennon: In the audit that you have carried out, have boards shown that they have the skills and capacity to do that work well? I know that the recommendation in your report is to

"develop a capital investment strategy",

but has that sort of thing been lacking or not been adequate so far?

Kirsty Whyte: Boards have had asset management strategies for a number of years. The data that exists around the NHS estate is much better now than it used to be, but there is a need at national level for a strategy to pull together all the board strategies.

Boards themselves will identify what needs to happen with their estate and the amount of money that needs to go into it, but there is obviously a limited pot of capital money at the national level. The Government therefore needs to pull everything together and work with the IJBs to identify where the estate needs to move—bringing in the new elective centres, too—and what regional working and the facilities around that will look like. In addition, it needs to look at local facilities such as enhanced GP services. All of that can then be pulled together to ensure that the amount of capital money that is available is able to deliver the estate that will be needed in the future.

Monica Lennon: In your report, you state:

"There has been a seven per cent increase in backlog maintenance classed as significant and high risk".

The figure for backlog maintenance is now sitting at 47 per cent, which seems quite high. What kind of circumstances does the term "high risk" cover?

Kirsty Whyte: It can cover a range of things. Some of it relates to the basics such as buildings being wind proof and watertight. A lot of it is to do how well the facilities comply with safety regulations and regulations for patient care.

Monica Lennon: Do you have a sense of the impact that this issue is having on staff morale? I know that there has been an increase in the number of patient complaints—is that connected to this issue in any way? How people feel in an environment can really affect their wellbeing and mood. If they feel that the building is falling down around them, that might have an impact. Are you getting any sense of that at all?

Kirsty Whyte: We did not look at that in any detail in the report, but the "Annual State of NHS

Scotland Assets and Facilities Report for 2016", which was published in the summer, contains an indicator for patient satisfaction with the estate, which has improved slightly over the past few years.

Bill Bowman (North East Scotland) (Con): Colin Beattie covered the issue that I was going to ask a question about, but I will ask my question anyway in a slightly different way. In the report, you say:

"Levels of overall patient satisfaction continue to be high",

but in the same breath, more or less, you say that complaints are up, and we see in the financial statements that there are hundreds of millions of pounds set aside for medical negligence claims. There is something counterintuitive there. How robust is the statement that

"Levels of overall patient satisfaction continue to be high"?

Caroline Gardner: We have taken the statement from the national in-patient experience survey, which is large and robust and is carried out regularly. It is a record of what patients are saying in response to questions, in large enough numbers to give it credence.

In response to a question from Willie Coffey, I said that the picture is not necessarily straightforward. We know that patients rate the NHS very highly anyway and that, if they recognise that staff are working harder than ever to provide their care, that may be reflected in the levels of satisfaction that they report. For completeness, we have shown a range of different indicators of quality in the NHS and highlighted that they are not consistent in that way. Claire Sweeney may want to add to that.

Claire Sweeney: There is not much more to add. What we are saying is that we understand why those things might look counterintuitive but that, actually, they are the facts as we see them. The fact that people are consciously engaging with clinical staff and feel that the care and support that they get is good does not necessarily run counter to all the challenges that we know that the NHS is facing. It speaks to the message that is right at the start of our report about the commitment and hard work of staff. The information is valid, but we say in the report that it is "becoming increasingly difficult" for staff to continue to provide that level of care.

Bill Bowman: I am not familiar with the survey, but I assume that it asks only a limited number of questions and does not look beyond whether someone had a good experience with the person working on the front line.

Caroline Gardner: It asks quite a wide range of questions. We go on to say in the first bullet point of paragraph 40 that a "significant minority" of patients felt that they were less involved in discussions about their care than they would like to be, so there is some nuance there, but nonetheless the overall satisfaction that the headline mentions is what people reported in response to the survey.

Bill Bowman: I think that you said that there is no quick fix. I do not know what analogy is appropriate for the NHS—whether it is a supertanker or a convoy—but, by the time that a slow fix comes in, the NHS will be somewhere else and in different circumstances. How do we fix it if there are no quick fixes?

Caroline Gardner: Because the health service is about people and because we have good demographic information and information about some bits of the health service, we can see what is likely to happen in the next 30 years. The population forecasts give us a good indication of by how much the number of older people will increase in that period. We know what is happening to life expectancy and we have seen significant increases in that, although it has reduced slightly recently. We can play all of that in. As Claire Sweeney described, there is increasingly strong evidence from around the world that moving our focus away from just what is happening in acute hospitals to what happens near people's homes in primary care and in wider public services can address some of the issues.

The point that I try to make in the report is that some of the building blocks are in place. We have the proposals for the new GP contract, the review of the targets and indicators and the general commitment to the vision. We now need certain key things to make it happen. We need a financial framework that ensures that we are investing in the right places; better workforce planning that ensures that we have the people we need doing the new jobs in the new types of services that will be needed in future; and capital investment that is building an NHS for the future and not just running to keep up with what we have right now. A number of small things can be done that will help the service on the way, but I do not think that there is a quick fix.

Bill Bowman: To go back to something that Liam Kerr asked about, you mentioned unidentified savings. Is that just the way that boards make their budgets? Do they just take the difference between what they know and what they do not know to make the budget balance and then sort it out later?

Caroline Gardner: Kirsty Whyte will talk you through that, but the case study on page 19 gives an example of how NHS Grampian goes about that. As you would expect, the board considers the money that it thinks it will have to spend and what

it thinks will happen to the commitments that it has on workforce, drugs and other pay pressures, and that gives it a gap that it needs to close. It then works on planning how to close that gap.

Kirsty Whyte may want to pick up on that.

Kirsty Whyte: There is not much to add, because Caroline Gardner has given a good explanation. As the case study on page 19 shows, the boards will know certain things and will make assumptions about certain things such as funding in future years. They will work through all that, look at the funding and other income that they receive and then identify where they need to make savings.

To identify the savings, they will basically work through where they think savings can be made. As I mentioned, it is becoming increasingly difficult for boards to do that. We have seen the slicing approach over a number of years, but that is not sustainable. The reason why we have fairly high levels of unidentified savings is because we are getting to the point of service redesign. Things really need to change, because there are no more small amounts that can keep coming off.

Bill Bowman: Auditor General, you write carefully crafted reports and we get carefully worded replies from the Government. In recent meetings, we have had three chief executives of health boards say that there are basically no workforce plans and then we had the chief executive of the NHS say that there are workforce plans. From what you have said, there are a lot of changes to come and a lot of thinking and working together need to be done. Looking through the words, is the system fit for that purpose?

Caroline Gardner: We say in the report that the signs of pressure are increasing. The workforce planning issues that you have heard about over the past two weeks are a subset of the bigger problem that we describe in the report. The recommendations that we made in the reports that led to the committee's sessions on workforce planning set out what needs to improve there. I said in response to an earlier question that I think that this can be done, but it first needs concerted effort and it needs our three key recommendations in the report to be addressed urgently. We have the building blocks and there is a huge amount of commitment to making it work; it is about pulling all that together and ensuring that all the effort is pulling in the same direction on the things that will make the biggest difference.

Bill Bowman: I would say that that answer was a carefully crafted way of saying that change needs to come.

Caroline Gardner: Yes.

10:15

Colin Beattie: I want to come back on a point about savings. The non-recurring costs are a worry, and you do not give a breakdown of what they might be. The thing that I am concerned about has come up in previous reports: a proportion of the savings was generated in some boards by delaying filling posts. I know that there is a problem with getting people to fill posts, but is there any indication of deliberate delays?

Kirsty Whyte: That is one of the ways in which boards are trying to make those savings. In previous years, boards have tried a range of ways to make non-recurring savings, including delaying filling posts until a few months or a year on.

Colin Beattie: How significant is that?

Kirsty Whyte: Do you mean for the non-recurring costs?

Colin Beattie: Yes.

Kirsty Whyte: I do not have those details with me. We did not go into that level of detail, but I am happy to have a look at the issue and come back to the committee on it.

Colin Beattie: That would be good.

The Acting Convener: That would be helpful. Alex Neil has a very brief point.

Alex Neil: It is a very brief point about the increase in the number of complaints. To be fair, during the past three or four years, the NHS has introduced the patient opinion system, which was designed to elicit information about where things are going wrong and so on. Could the increase in the number of complaints be partly, if not largely, because of that better system and a deliberate attempt to get that kind of feedback?

Caroline Gardner: We say exactly that in the report. At the top of page 24, we say:

> "NHS boards have worked to raise awareness of the complaints process, and make it easier for patients to make a complaint. This may account for at least some of this increase in complaint levels."

We cannot break the figure down, but we recognise that that might be a factor.

Alex Neil: I just wanted to get that on the record.

The Acting Convener: I make the anecdotal observation that my constituency casework has increased exponentially and is full of NHS complaints. I thank the Auditor General and her two colleagues for giving evidence on the report this morning.

10:17

Meeting suspended.

10:18

On resuming—

Section 22 Report

"The 2016/17 audit of NHS Tayside"

The Acting Convener: We will now take evidence on the Auditor General for Scotland's report on NHS Tayside. I welcome back Caroline Gardner, the Auditor General for Scotland. I also welcome, from Audit Scotland, Fiona Mitchell-Knight, the assistant director of audit; and Bruce Crosby, senior audit manager. I invite Caroline Gardner to make an opening statement.

Caroline Gardner: Convener, for the first time in five and a half years in this job, I cannot find my speaking note for the meeting, so I will make my opening remarks very short and you can then ask your questions.

As you know, for the past two years, I have reported on questions about the financial sustainability of NHS Tayside and the action that the board and the Scottish Government are taking to return it to financial sustainability. The report that you have in front of you is the third such report. The power that I have under section 22 of the Public Finance and Accountability (Scotland) Act 2000 enables me to bring to the attention of Parliament and this committee issues that have arisen from the audit of the board's accounts that I think will be of interest to you.

Fiona Mitchell-Knight, as the appointed auditor, has given the board an unqualified audit opinion again this year, but she has highlighted that the concerns on financial sustainability continue and that a lot of action is going on in the board to return it to financial sustainability. NHS Tayside made a significant amount of efficiency savings in 2016-17, but it still required an additional £4 million in brokerage last year and the savings were below the targets that it had set.

As you know, the Scottish Government has appointed an assurance group to work alongside the board to provide assurance about the quality of the work that it is doing to change how it works and bring itself back into balance. The latest report of the group recognises the extent of the work that is going on and the extent to which it focuses on the right areas. It also highlights that the next period will be critical in moving from developing plans to implementing them. We will continue to work alongside the group as part of our audit work to understand what that means.

Fiona Mitchell-Knight and Bruce Crosby from the audit team are here to help me to answer the committee's questions.

Alex Neil: I want to clear up the debt and brokerage issue, because there still seems to be some confusion about what will happen. We have had a letter from Paul Gray, which indicates that the board will not be required to repay the debt until it is in financial balance. What is your understanding of the phrase "financial balance"? Given the timeframe to reach what I suspect is meant by financial balance, the date for making the repayment will be quite a challenge. Would it not be better, particularly if we want to ensure that services do not decline significantly in Tayside, if everyone recognised that we should just write off the debt and allow the board to make a fresh start?

Caroline Gardner: I understand that the chief executive of the health service has made the commitment that NHS Tayside will not be required to repay the debt until the board is back in financial balance and that a decision will be taken at that point about whether the debt needs to be repaid.

Financial balance means meeting the resource limits—both revenue and capital—that are set for NHS Tayside, as they are for every board. The board itself identifies that, in order to be financially sustainable, it will need to make savings of £205.8 million cumulatively over the next five years. There is little doubt that the outstanding brokerage of £33.2 million will increase further by a small amount. Fiona Mitchell-Knight will be able to give you updated indications on that if it would be useful.

It is a policy matter for the Government to decide whether it wants to write off the debt or, as it has done, to suspend it until the board is back in balance. As my report says, there is no doubt that it will be challenging for the board to return to financial balance.

Alex Neil: How achievable is £200 million of savings over the next five years, particularly if there is to be no reduction in services? Actually, one should be arguing that there should be anything but a reduction in services and that there should instead be an enhancement of service provision. If you look at all the Government strategies and so on, we see that there will be further demands on resource allocation within Tayside to meet national targets, for example. What are the realistic prospects of achieving a further cumulative £200 million of savings?

Caroline Gardner: That is the key question. The committee knows, from previous work from us, NHS Tayside and the assurance group, that, relative to other boards, it costs NHS Tayside more to deliver like-for-like services even when account is taken of its population and so on. The assurance group has said that the areas that the transformation plan is working on are the right

ones to address that higher cost. The plan is looking at the big areas such as the cost of the workforce, realistic medicine and prescribing—all the areas where Tayside is more expensive in providing the same level of service.

There is no doubt that it will be challenging to do that. In some ways, Tayside is facing a more acute version of the problems that the health service as a whole faces, and understanding how the change can be made, what it will cost to make it and what the impacts will be on staff, patients and other public bodies is a key part of what needs to happen in Tayside over the next few years.

Fiona Mitchell-Knight might want to add to that.

Fiona Mitchell-Knight (Audit Scotland): NHS Tayside continues to face an extremely challenging financial position with regard to achieving financial balance.

In 2016-17, the board delivered significant efficiency savings of £45 million, which is double what was achieved in the previous year. However, that was still below the target that it needed to meet and, as has been mentioned, brokerage was received for that year.

On the position for 2017-18, the financial plan for the board showed that it needed nearly £50 million of savings to achieve balance. It was recognised that the board could not achieve that in one year, so the local delivery plan includes a target of £45.8 million savings with around £4 million to be met from brokerage this year, which means that there is further brokerage to be achieved.

The latest outturn position that is being reported by the board suggests that the shortfall in efficiency savings is in the region of £5 million. However, the board is taking extra action to draw that into the £4 million that was included in the local delivery plan.

The board recognises that, in order to achieve financial balance, it is not enough to keep making efficiency savings and that more fundamental service redesign and transformational change is required. That is the objective of the transformation programme that is now under way in the board. However, it is yet to deliver those savings. We hope to see the impact of some of the initiatives that are coming through that programme in the longer term.

There is a high risk that the financial plan for 2017-18 will not be achieved, but we will continue to monitor the situation and will report on it through the audit.

Alex Neil: It would be helpful if we could get a copy of the transformation plan that the board is working to, if that is possible.

Caroline Gardner: I think that it is possible. It might have been provided when the committee was taking evidence from NHS Tayside. We can work with the clerks to confirm that.

Alex Neil: We can pursue that.

Who is making sure that the savings are not being made at the expense of the patients?

Caroline Gardner: That is mainly the responsibility of the board, the chair and the chief executive. I know, from assurances that they have given this committee, that they take that responsibility seriously. The role of the advisory and assurance group is to test that and to ensure that the effect on patients is planned and measured and that any adverse effects are dealt with as quickly as possible. That is one of the reasons why the Government put the group in place.

Alex Neil: Your report shows that, of the eight targets, three, I think, have improved, four have remained the same and a couple have gone down the way—something of that order, anyway. Would you say that, at the moment, there is no indication that there will be a reduction in the quality of service? I presume that you will keep a close eye on that against the performance targets.

Caroline Gardner: Paragraph 18 of the report says that eight of the standards were not met, that eight were met or exceeded—

Alex Neil: Yes, that is right—sorry.

Caroline Gardner: —and that Tayside is by no means an outlier compared to other boards. We take seriously the need to consider its financial performance in the context of its overall performance and the safety of patients, and we will continue to keep an eye on that.

Fiona Mitchell-Knight: If we compare the performance from year to year, there is no clear picture about whether performance is improving or declining. Four areas have improved, eight have declined, three are the same and there are two for which no targets are available. It is a mixed picture, and no clear direction of travel can be seen in those indicators.

10:30

Colin Beattie: I am being a bit nit-picky, but what is the definition of net expenditure for NHS Tayside? You say £892 million. If there is a net expenditure, there must be a gross expenditure. What is that?

Fiona Mitchell-Knight: That is the net expenditure that comes from the annual accounts that are published and audited by us. That is the bottom-line figure, which is the net position of income less expenditure.

Colin Beattie: Does it take into account any income?

Fiona Mitchell-Knight: Yes, it does.

Colin Beattie: How much income?

Fiona Mitchell-Knight: I would need to look at the accounts to check that.

Caroline Gardner: We can trawl the accounts for you and come back to you with that.

Colin Beattie: I am interested because I want to know what the gross expenditure is and what the savings against gross expenditure are. It would be interesting to see how much income the board actually has.

Fiona Mitchell-Knight: It is not so simple to take that out of the accounts. The accounts show income and expenditure over costs of different natures. That is not a figure that we can easily provide.

Colin Beattie: The £205.8 million that has to be saved over the next five years is in addition to the 2016-17 figure of £45.5 million, is it not?

Fiona Mitchell-Knight: Yes.

Colin Beattie: I echo what Alex Neil said. Is such a saving possible on that level of budget?

Caroline Gardner: It is challenging. We do not think that it is impossible, and the advisory and assurance group does not think that it is impossible. It might be worth looking at the savings forecasts for the next five years, which are set out in exhibit 3. They show the percentage of the baseline funding that needs to be made in savings declining over that period. For reference, in 2016-17, the equivalent report showed that the savings that were achieved were 6.5 per cent and they are reducing steadily to about 5 per cent.

As we have said, the costs in NHS Tayside are higher than in other boards for like-for-like services, so there is scope to make savings, but it is a significant amount to be taking out and that can only safely be done by transforming services, which is what the board is trying to do. That is why we highlight the risks to achieving those savings.

Colin Beattie: The report talks about workforce costs, prescribing costs, clinical supplies and so on. Has anyone looked at it and said whether that spend is appropriate for Tayside, especially given its demography and all the other things that have to be taken into account? Is the expenditure not excessive, given what the board is trying to deal with?

Caroline Gardner: No. When I talk about like-for-like spend, it takes account of exactly those sorts of things. It takes account of the population, the demographic make-up, the extent to which there might be particular challenges for delivery because of rurality and so on. As far as it is possible to make like-for-like comparisons, Tayside is still more expensive than other boards, largely for historical reasons including the number of large hospital sites that have been operating during that period and the referral and treatment patterns that have been seen in Tayside. All of that reinforces the point that the savings are possible, if not easy, and that they rely on transforming services.

Colin Beattie: When the matter first came up, a large proportion of the project savings revolved around the disposal of fixed assets. I know that some fixed assets have been disposed of and I see that the board has reduced its anticipation of what it will get from that source. What is the cost to NHS Tayside of maintaining the fixed assets that it is waiting to dispose of?

Fiona Mitchell-Knight: I do not have that information to hand, but there will be a cost to the on-going maintenance while the board is waiting to dispose of those assets. The board recognises that and it is taking action to dispose of surplus assets. It monitors and reports back on progress regularly.

Colin Beattie: Would it be possible for us to know how much those maintenance costs are? They were significant previously.

Fiona Mitchell-Knight: That is not something that we are aware of as part of this work. You would need to ask the board.

Colin Beattie: The history of the issue with NHS Tayside has not been easy. There have been failures with management and the board over the years. Are we satisfied that the current governance and management of NHS Tayside is adequate for the task ahead?

Caroline Gardner: In my introductory remarks, I said that this is the third report that I have produced on NHS Tayside in consecutive years. The real difference this year is not just that there is a recognition of the problem—we saw that last year—but there is a much fuller understanding of it and of what is needed to address it than there was initially.

Colin Beattie may be the only current committee member who was on the committee then. My reports on NHS Tayside were originally triggered by the fact that its annual accounts contained overoptimistic assumptions about the proceeds of the disposal of assets in the following year, which had the effect of appearing to minimise the scale of the financial challenge that it faced. We have moved beyond a focus on how to minimise the problem to a situation in which the problem is now much clearer. The plans to address the problem are developing all the time; as we say in the

report, the challenge now is to turn those plans into action in a way that takes patients and the people of Tayside with the board to reach a situation that is not just sustainable but in which the board provides better healthcare than it has been able to do so far.

Colin Beattie: Has there been much change in the composition of the board and management of NHS Tayside?

Caroline Gardner: Since the initial problems came to light, we have seen a new chief executive appointed and some turnover among board members, which has contributed to the recognition and grasping of the problem that I have described.

Fiona Mitchell-Knight: The director of finance has now been in place for about a year—that was a change in the management team. Our evidence from working with the board is of a clear commitment from the senior executive team to the level of change that is required.

Colin Beattie: Is the chief executive an internal promotion or is it someone from outside?

Caroline Gardner: It was an internal promotion. I think that the committee explored that appointment in its previous evidence sessions with the board.

Colin Beattie: However, is it, in essence, the same board that oversaw the situation of the past few years?

Caroline Gardner: I do not want to mislead the committee by focusing on specific appointments. There has been turnover and I think that there has been a new chair since the problems built up, which happened before my first report. Bruce, can you shine any light on that?

Bruce Crosby (Audit Scotland): We only took on the audit for this year, so I am not sure about the composition of the board before then. I do not think that I can add anything.

Colin Beattie: My concern is that we need to ensure that those people who failed previously are not building us up for failure in the future, and that there are people in there who understand the issue, have their hands around it and are managing it efficiently and successfully.

Caroline Gardner: I recognise that concern, which I was aware of when I was reaching my audit conclusions for the report that you have before you. The board and senior management team now have a full understanding of the issue and a commitment to resolve it. The challenge of doing so is the next step.

Bruce Crosby: I think that we state in the report that it is being done by the transformation support team. You can take some comfort from the commitment of the executive team at NHS Tayside, and the advice and support of the transformation support team will be crucial in making sure that NHS Tayside gets to a balanced position in the coming years.

The Acting Convener: We have a brief supplementary question from Liam Kerr.

Liam Kerr: In response to Colin Beattie, Fiona Mitchell-Knight said that the director of finance had only been there for about a year. I had it in my mind that he had been there for about 33 years. What have I missed?

Fiona Mitchell-Knight: He has worked at the board for a longer period, but he has been in the post as director for just over a year.

Liam Kerr: It is the same chap who has been there for 33 years, is it not?

Fiona Mitchell-Knight: Yes, it is. He has been there for some time, but I do not know the exact term.

Bruce Crosby: Colin Beattie asked about the level of income earlier, and I have now had an opportunity to look at the accounts. The income is of the order of about £600 million, which brought the net expenditure down to just over £800 million.

The Acting Convener: I will resist the temptation to ask a follow-up question on that point.

Willie Coffey: I did not take part in the previous discussion on NHS Tayside. Will you elaborate a wee bit about the differences that might be giving rise to some of those cost pressures? What is different or special about Tayside?

Caroline Gardner: The costs are higher in three key areas. Its level of staffing costs is higher than the average for boards across Scotland, relative to the population that it serves and its activity; its prescribing costs—in hospitals and, I think, primary care—are higher, due to higher numbers and higher costs of prescriptions; and estates and property costs are higher than the average for NHS boards in Scotland. NHS Tayside has a lot of analysis as to why that is and where the costs arise. Would Bruce Crosby like to add to that?

Bruce Crosby: No. I think that the point has been covered.

Willie Coffey: I am interested in why the costs are higher. Paragraph 14 of your report notes:

> "prescribing costs - overspent by £6.7 million, compared to an overspend of £4.7 million"

in the previous year. So, in one year, prescribing costs went up by another £2 million. What on earth could the reason for that be?

Caroline Gardner: The board is not alone in that. Its overall prescribing costs are higher than those for Scotland as a whole, but, as we were saying in the earlier evidence session, drug costs are rising faster than inflation UK-wide. Part of that is straightforward inflation in the cost of drugs; part of it is new drugs becoming available, as they tend to be very expensive; and part of it is to do with the ageing population and more people getting prescriptions. The board is not alone with things moving in that way, but it is unusual in that the baseline is higher for NHS Tayside than it is for other boards, and that is having an impact on its overall financial position.

The board has commissioned some detailed exploration of where the higher costs are arising—how much of that is volume, how much is price, whether it is hospital prescribing or GP prescribing and in which specialties it is happening—so that it can drill down and address the matter. The board has a much better understanding now and is getting its arms around the problem, but its starting point is higher than that of other health boards.

Willie Coffey: So there is good evidence that it is taking that on board and is tackling the matter directly now.

Caroline Gardner: Absolutely, yes.

Monica Lennon: I have been looking at the performance figures at the back of the report, and something from the previous evidence session has been stuck in my mind. I note from the section on psychological therapy that there have been a number of vacancies, and there have been career breaks, maternity leave and so on. Is it possible that posts are deliberately not being filled? That is quite concerning, given the drop in standard.

Caroline Gardner: I do not think that we can answer that specific question. We know that psychiatry is one of the specialties that can be hard to recruit to across Scotland. NHS Tayside is not alone in that, however.

Fiona Mitchell-Knight might wish to add to that, based on her local knowledge.

Fiona Mitchell-Knight: I do not have any specifics. While the board is struggling on issues of recruitment, it is considering its attraction and retention policies across the board as part of workforce planning, through its transformation programme. However, I cannot add any specifics on that point.

Monica Lennon: I have attended a number of evidence sessions on NHS Tayside now, and the picture has proved to be highly challenging. What wider lessons are being taken from Tayside? It has not escaped our attention that the health secretary is local to Tayside. How can we be reassured that the challenges that NHS Tayside has faced will not start to creep in at other boards?

Caroline Gardner: As well as the report that you have before you and Fiona Mitchell-Knight's close engagement with NHS Tayside, I have tried to keep a close eye on what the Government is doing to manage the situation, to support the board and to protect the interests of patients and people across Scotland.

I genuinely think that the approach of having the advisory and assurance group test and challenge the board's thinking robustly, but constructively, together with the work of the transformation support team, which is helping the board to draw on expertise elsewhere in Scotland, provides a positive model for dealing with a problem of this scale. Senior people in the Scottish Government are taking the opportunity to think about how elements of that approach can be applied in other areas, by using benchmarking to understand where costs are higher or where performance is lower than elsewhere. They are looking at using that as a way of sharing good practice and expertise, tapping into new ways of doing things and helping peers from across Scotland to learn from one other. A good start has been made on that, and there is scope to take it further.

That work can be used to inform some of the things that we were describing earlier regarding better workforce planning and better capital investment planning. Although the situation in Tayside is very difficult, there is an opportunity for boards in other parts of Scotland to learn from it and there is an opportunity to use it as a lever for encouraging people to adopt good practice in the approaches that are developed elsewhere.

10:45

Monica Lennon: The advisory and assurance group came up with the report recommendations and there are some points of concern. The report highlights that the group

"reports that there is insufficient evidence of progress with the key elements of the transformation programme",

so there is still a lack of confidence

"that NHS Tayside can achieve its financial plan".

There are some warning signs in your report. We have heard a lot of optimism from witnesses from the board before. How can we be sure that things really are on track?

Caroline Gardner: You have my assurance, which draws on the views of the advisory and assurance group about the balance between the scale of the challenge and the progress that is being made. I hope that we have been able to give you a thorough and balanced view of that. The group genuinely feels that a lot of progress has

been made in understanding the problem and drawing up plans, and it is clear that the next stage—implementing those plans—will be the key one.

We all know that that is not going to be easy. It will require a wide range of staff right across NHS Tayside and the board and the management team to do it. It will mean changes to services for patients. In the longer term, some of those changes may result in services that are better than those that are currently provided, but change is always uncomfortable. There are cost pressures pulling in the other direction: drug costs—as we have described—and pressures on the property market where disposals are part of the plan.

Progress is being made, the problem is understood better and there is a much stronger commitment to what needs to happen to address it, but it is not plain sailing.

Monica Lennon: There are still quite a lot of unknowns there.

My final question is on the recurring savings, which the board is expecting will increase to 60 per cent from 2019-20 onwards. That is quite a big number. Are you satisfied that it is achievable?

Caroline Gardner: In a sense, I am comforted by the fact that the recurring savings are going up at the expense of non-recurring savings. Recurring savings are an indication that the board is genuinely managing to reshape services in ways that can be sustained for the longer term, whereas non-recurring savings are often made by selling properties or not filling vacancies. It is a good sign, but the challenge is whether the board can achieve those savings and maintain the quality of care.

Fiona Mitchell-Knight: There is some evidence that the percentages of recurring savings are on a positive trend. In 2015-16, only 35 per cent were recurring savings, but in 2016-17, the figure was nearer to 50 per cent. That is a positive direction.

Monica Lennon: Are you happy that there is no detriment to patients where those recurring savings are being made?

Fiona Mitchell-Knight: As we said earlier, there is a very mixed picture, based on the indicators in appendix 1. There is no clear evidence of an improvement or decline in performance over the past year. That is something that we will need to monitor.

Liam Kerr: I will try to be brief, as a number of matters have arisen. First, a great deal of non-financial support has been given to NHS Tayside over a considerable time. Other than providing brokerage and reviewing the national resource allocation committee allocations, are there any other feasible ways in which the Scottish Government could assist the board? Are there any other non-financial or financial things that it should be doing?

Caroline Gardner: For understandable reasons, the focus of the Scottish Government has been on helping the board to understand the problems and to address their underlying causes, rather than on continuing to provide short-term funding to close the gap. I have said previously that I think that having the transformation support team, which is there to provide support and advice, and the slightly arm's-length assurance and advisory group, which is there to test out and challenge progress, is a good model. It is one that could be adapted and used elsewhere.

If I had any criticism to make of the approach that has been taken so far, it is that it took a while to put in place the focus on taking a longer-term view of the financial situation and what is needed to address it, instead of providing one-year brokerage to fill a gap each year. Since I took this job in 2013, I have been reporting that we need to take a longer-term approach to financial planning and management. NHS Tayside is a good example of overfocusing on the annual situation making it harder to get a grip on the longer-term position and to start to address it.

Liam Kerr: I will come back to financial management in a second. Has there been a significant cost—including opportunity cost—to the Scottish Government and other parts of the NHS as a result of that extensive support being provided to NHS Tayside? Specifically, I recall—correct me if I am wrong—that NHS Grampian needed about £15 million to meet what the NRAC funding formula required. Is there any suggestion that money is being pulled from other parts of the service to support NHS Tayside?

Caroline Gardner: There is no such suggestion in relation to the micro picture. The amounts of brokerage each year, which are set out in exhibit 2, are very small in the context of Tayside's overall funding, and in the context of the £13 billion or so that is spent on the NHS overall. The bigger opportunity cost is the one that we described earlier, which is that, on average, it costs NHS Tayside more to provide services than it costs other boards. Tackling those differences will free up resources that can be invested right across the country. It has taken the Government longer than it initially expected to get all the boards to their NRAC formula position, but I do not think that NHS Tayside was a significant element in that.

Liam Kerr: Is there a suggestion that NHS Tayside will require permanent additional support, whether it be financial or—more likely—support from the AAG, for example?

Caroline Gardner: The intention is that permanent additional support will not be needed. Earlier, Mr Neil asked about what "financial sustainability" means. It means the board being able to manage within the resources that are available to it under the national funding system—its being able, within that money, to provide the level and quality of services that the people of Tayside need. Getting to that position is the challenge.

Liam Kerr: Fiona Mitchell-Knight talked about the deficit forecast of £4 million for 2017-18 and said that additional brokerage will be required. The AAG believes that that amount is an underestimate. The Auditor General said that previous financial estimates were overoptimistic about the disposals, and now there is recognition after, I think, four years of reporting on the issue, that there is a need for longer-term financial management. Does it concern you that whoever is responsible for the situation apparently still underestimates the size of the hole, and is still trying to fix a problem that some might suggest was caused by the people who are currently on watch?

Caroline Gardner: I will ask Fiona Mitchell-Knight to give you the latest financial position, as we understand it. We have touched on the extent to which there is a new board, and there have been changes in the senior team at Tayside. There is a fuller understanding and a strong commitment to doing what needs to be done. There is genuine complexity in trying to make changes on the scale that is required in NHS Tayside. That is not to say that there is no risk of optimism bias in something of this nature, which is partly because of the commitment that people have to fixing the issues. Therein lies the value of having the assurance and advisory group apply detailed examination and challenge to the board's plans.

I ask Fiona Mitchell-Knight to provide a quick update on the current position this year.

Fiona Mitchell-Knight: The current forecast outturn position for March 2018 is that there will be a savings gap of £5 million, rather than £4 million. The board is working on measures to close that gap; it anticipates being able to do it, but obviously we will have to wait and see.

Liam Kerr: There is a commitment to dealing with the gap.

Fiona Mitchell-Knight: Yes.

Liam Kerr: You know the organisation better than anyone, having examined it. Do you think that it will deal with the gap?

Fiona Mitchell-Knight: As you said, there is definitely a commitment to do so, but the important thing will be the shift away from short-term efficiency savings to real service redesign and transformational change. The actions that the board is taking through the transformation programme are driving that forward.

We are starting to see initiatives coming through. At its meeting in December, the board is due to discuss the overarching clinical strategy, which will set its direction. The workforce plans will be aligned to that clinical strategy. There are, therefore, really important milestones coming up for the board in the near future. However, it is yet to deliver financial savings that are reported in the accounts to date. We will look for those in the future.

Liam Kerr: In your view, will the board deliver?

Caroline Gardner: We have said in both our reports that the situation is challenging. I cannot give you a guarantee.

Liam Kerr: Thank you.

Bill Bowman: Colin Beattie and others have touched on topics that I was going to speak about. I do not have the detailed experience of Tayside NHS Board that others have, but from looking at its history over the past five years, the organisation has, in effect, had to go to its banker to ask for more money and to keep on refinancing it and, not unusually, the banker or lender has put in its own team to try to see what is going on and to oversee that. Not only that, another team has been put in to see that its recommendations are worked through. That is worrying, of course.

The board recognises that it has yet to deliver, and Liam Kerr asked whether it will do that. I presume that, when Fiona Mitchell-Knight was finalising her audit, she was concerned about the organisation's future viability, that she went to the Government—the lender—to get some comfort that it would continue with the existing funding and provide future funds, and that she spoke about future plans. It is not just recognition that the board is yet to deliver that is key; it will also be about the competence of the management. Did the Scottish Government take a view on the competence of the management?

Fiona Mitchell-Knight: The Scottish Government certainly has not spoken to me about the competence of the management. The assurance and advisory group reported the level of commitment among senior executives that I have spoken about. It recognised that the executive team's capacity was stretched because of the scale of change that is required. That is why the transformation support team was brought in to work alongside the executive team and support it. However, there has been no indication that there are capability issues with the senior executive team.

Bill Bowman: Would you expect there to be a discussion about that? How can you be satisfied that the future plans will work if you do not know how competent the management is?

Caroline Gardner: I think that Fiona Mitchell-Knight takes comfort from her experience of the team and the views of the assurance and advisory group. There is also an important difference between public services and the corporate sector, in that the Government can continue to fund at the required level, as it has done in the past. The assurance that it will continue to do that carries more weight than the need to take a view on the competence of the management team.

That said, I share Fiona Mitchell-Knight's view that the main issue is not the competence of the team; it is the scale of the challenge and the scale of the change that is required in the healthcare system, which is complex.

Bill Bowman: I am concerned about the issue that Liam Kerr has uncovered. We are talking about a new finance director, but that person has been there for a long time. I presume that he will carry on as before.

Fiona Mitchell-Knight: That person has certainly been on the board for some time, but was promoted to the post of director of finance only in the past couple of years.

Overall, our annual audit report says that the financial management of the board is effective with the processes that are in place, but it is clear that it is working on the size of the challenge in meeting the financial forecasts through the transformation programme.

Bill Bowman: Okay. I will leave the competence issue there.

The Acting Convener: That is perfect timing. I thank the witnesses for their evidence. The committee will now go into private session.

10:59

Meeting continued in private until 11:12.

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