The Scottish Parliament
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Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 27 February 2013

Session 4

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PUBLIC AUDIT COMMITTEE
3rd Meeting 2013, Session 4

CONVENER

*Iain Gray (East Lothian) (Lab)

DEPUTY CONVENER

*Mary Scanlon (Highlands and Islands) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Bob Doris (Glasgow) (SNP)
*James Dornan (Glasgow Cathcart) (SNP)
*Mark Griffin (Central Scotland) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Tavish Scott (Shetland Islands) (LD)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackie Baillie (Dumbarton) (Lab)
Caroline Gardner (Auditor General for Scotland)
Barbara Hurst (Audit Scotland)
Jillian Matthew (Audit Scotland)
Tricia Meldrum (Audit Scotland)
Dr Richard Simpson (Mid Scotland and Fife) (Lab)

CLERK TO THE COMMITTEE

Roz Thomson

LOCATION

Committee Room 4

Scottish Parliament

Public Audit Committee

Wednesday 27 February 2013

[The Convener *opened the meeting at 10:00*]

Decision on Taking Business in Private

The Convener (Iain Gray): I welcome everyone to the Public Audit Committee's third meeting in 2013. I give a special welcome to Jackie Baillie, who has joined us, as has Richard Simpson—he sneaked in when I was not looking. I ask everybody to ensure that their phones are off. We have received no apologies and all committee members are present.

Agenda item 1 is consideration of whether to take items 5 to 7 in private. Is the committee content to take those items in private?

Members *indicated agreement.*

Section 23 Reports

"Management of patients on NHS waiting lists"

10:01

The Convener: The first substantive item is Audit Scotland's section 23 report "Management of patients on NHS waiting lists". We welcome Caroline Gardner, the Auditor General for Scotland, and, from the performance audit group in Audit Scotland, Barbara Hurst, director; Angela Canning, assistant director; Tricia Meldrum, portfolio manager; and Jillian Matthew, project manager. I invite the Auditor General to present her report to the committee.

Caroline Gardner (Auditor General for Scotland): How the national health service manages waiting lists is very important to patients and the public, who rightly want to know that people are being treated fairly. Reducing waiting times has been a key policy initiative for successive Governments. However, public trust was put at risk following evidence that NHS Lothian manipulated waiting lists and disadvantaged patients in 2011 to avoid reporting that it was failing to meet waiting time targets.

Our audit aimed to identify whether that was a one-off occurrence or an indication of wider problems across the NHS. It covered April to December 2011, when NHS Lothian was discovered to have been manipulating waiting lists. Our work is separate from and independent of the internal audits that were published in December 2012, which looked at a period in 2012.

We carried out a detailed audit of NHS boards' electronic patient management systems and analysed data on more than 3 million transactions that were recorded in patient records in the period. We looked at how boards applied waiting list codes in patient records and we reviewed a small number of patient records in the six boards in which we carried out more detailed fieldwork. We selected those boards because they had high levels of changes to patient records or because we could not extract the data that we needed from their electronic systems. We also analysed the data that was published by ISD Scotland.

Most concerns about waiting times have centred on the use of social unavailability codes, which are intended to give patients more flexibility so that, for example, they do not lose their place on the waiting list when they go on holiday. Social unavailability codes have also been used to indicate that a patient wants to be seen only at a particular hospital or by a particular specialist. The length of time for which a patient is coded as

unavailable does not count against their waiting time target.

The key finding from our work is that the Scottish Government and NHS boards need to improve the management of waiting lists. The systems that boards use to manage waiting lists are not good enough. They have inadequate controls over amendments to patient records, and very limited information was recorded about why codes were applied or changed.

We could not trace all the amendments that might have been made to patient records. In most cases, we could not be sure why changes were made and we could not verify that they were appropriate. For example, we generally found no notes in patient records to explain why a patient had been coded as unavailable and no evidence to confirm that that had happened only after discussion with the patient or their general practitioner.

That means that we cannot be certain that all the amendments were appropriate. We found a small number of cases in which codes had clearly been used inappropriately, but the limitations in the systems and the lack of information recorded mean that we cannot tell whether that was because of human error, incorrect interpretation of the guidance or deliberate manipulation.

The rates of social unavailability increased markedly between 2008 and late 2011. In June 2008, 11 per cent of people on in-patient waiting lists were coded as socially unavailable, compared with just over 30 per cent at the end of June 2011. That was at a time when the NHS was working hard to achieve shorter waiting time targets.

Use of social unavailability codes started to reduce in most NHS boards in late 2011, around the time that concerns were raised about what was happening in NHS Lothian. The percentage of patients waiting more than 12 weeks also started to rise around that time. That is a trend across most boards, not just NHS Lothian.

The reasons for the increase and subsequent reduction are unclear because of the limitations in the systems and the lack of evidence in patient records that I mentioned. The scale of the increase and the increase in the number of patients waiting longer since use of the codes dropped suggest that capacity pressures existed within boards.

During 2011, the Scottish Government and NHS boards were focused on meeting waiting time targets and developing capacity in areas where patients were waiting longer. However, they could have made better use of the available information on the rise in unavailability codes to help identify potential concerns about how the codes were being used, as well as wider capacity pressures that were building up in boards.

It is important that staff and patients be able to raise concerns about any aspect of patients' care and have confidence that their concerns will be acted on. What happened in Lothian became clear only because staff were willing to speak up. Patients also need good information to help them understand the complexities of the system, and we have published a leaflet on our website that aims to help.

Looking forward, I have made a number of recommendations to improve the management, monitoring and scrutiny of waiting lists and to improve the recording of why NHS boards use waiting list codes. They are very complex systems, managing hundreds of thousands of patients a year, and it is important that the NHS makes improvements so that the public and patients can be reassured that they are being treated fairly. Updated guidance that was issued last year should improve recording, monitoring and reporting of waiting times, but it does not address all the risks.

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

The Convener: Thank you very much. There are clearly complex issues to do with information technology and the way in which patient journeys were monitored and recorded, but the core question that the report tries to address is whether the waiting times statistics that were published in recent years could be considered reliable and accurate. Were those figures reliable and accurate?

Caroline Gardner: We know from events over the past 18 months that the waiting times figures that were published for NHS Lothian were not reliable and accurate. We now know from the audit work that we have carried out that it is simply not possible to verify whether all the use of social unavailability codes was in line with the guidance and reflected a true period of unavailability that was discussed with the patient or their GP.

On the one hand, we found only a small number of instances in which the codes were clearly used wrongly. However, because of the gaps in the information systems and information that is recorded, it is not possible to be clear whether they were due to human error, incorrect interpretation of the guidance by the board or deliberate manipulation.

On the other hand, the level of use of unavailability codes fell markedly after the events in Lothian came to light. Again, the information that is available does not allow us or anybody else to verify what the reasons are for that pattern.

The Convener: Can we have confidence in the figures that were published over recent years?

Caroline Gardner: The problems with the waiting list management systems and the information that has been recorded in them means that it is not possible for the NHS boards, the Government or anybody else to verify absolutely that that is the case.

We know that the patterns throughout Scotland demonstrate that the use of unavailability codes has fallen sharply since the middle of June 2011. We also know that the Government is now making changes to the IT systems and the ways in which waiting times are managed and reported. Our key finding is that the management of those waiting lists and the way in which they are scrutinised need to be improved to give patients and the wider public confidence in the figures.

The Convener: The December 2012 figures have been published today. They show that the 18-week waiting time target has been met in 90.9 per cent of patient journeys. Given the changes that have been made and the new guidance that has been issued, can we have confidence that today's figures are reliable and accurate?

Caroline Gardner: My colleague Jillian Matthew has spent the past 24 hours analysing the recently published figures. One of the challenges that we face is that we are now in a transitional phase and the figures are the first ones that reflect the new ways of measuring and managing waiting times that were introduced last autumn. I will ask Jillian to give you a quick picture of what we know so far about the figures, with the caveat that, as you said, they are freshly released.

Jillian Matthew (Audit Scotland): We had a look through the figures yesterday when they were published. The picture is quite a complex one, as Caroline Gardner said, because of the transition. The treatment time guarantee came in on 1 October last year. It took quite a while to work through the statistics. They are presented slightly differently from how they were presented in previous publications. In-patients and day cases are separated according to whether people were added to the list before or after the treatment time guarantee came in. We had to do a bit of work to join those together and to see what was happening.

Under the updated guidance, a patient code has been introduced, which we previously recommended. The code that used to be known as social unavailability is now known as patient-advised unavailability. The data that is presented for the most recent quarter does not break down the patient choice aspect of that, so we still cannot see the patient choice element and the percentage that it makes up of the overall patient-advised unavailability.

In our report, we publish some of the figures on the reported wait and the actual wait, which take into consideration social unavailability and clock resets, but the data on the actual wait is not presented in the most recent statistics. We say in the report that a transition is taking place as the new systems come in, but there is limited information on what that looks like.

The Convener: Are we at the point at which we can have absolute confidence in the reliability and accuracy of the figures?

Jillian Matthew: The most recent publication says that there is limited data available and that the boards are still updating their systems to meet the new guidance. They are saying that that might be done by the summer. At the moment, they have just presented summarised data to ISD. ISD usually gets much more detailed, patient-level information, but it does not have that for the latest quarter, so it cannot monitor what is happening on a patient level as closely as it normally can.

The Convener: Is it fair to say that there is still some dubiety about the figures that have been presented?

Jillian Matthew: The way in which the figures have been presented is such that what we can tell from them is limited.

The Convener: My final question is about the failure to recognise that there might a problem here. In paragraph 64 of your report, you say:

"Available information should have highlighted potential concerns for the Scottish Government and NHS boards to investigate further."

When I put that to the cabinet secretary when he made his statement to Parliament last week, he said:

"Every health board in Scotland is audited every year. Half of them are actually audited by Audit Scotland. Not one audit brought to our attention any of those problems. Auditors are employed to audit the systems as well as the books."—[*Official Report*, 21 February 2013; c 16888.]

Therefore, has there been a failure on your part to identify the problems earlier?

Caroline Gardner: As is the case with all other aspects of the health service, managing waiting times is the responsibility of NHS boards and the Scottish Government rather than of auditors. The point that I was making in my report was that we think that the focus of attention of the Scottish Government and NHS boards during 2011 was on whether the 18-week treatment target time was being achieved rather than on how it was being achieved. If NHS boards and the Government had looked at the other information that was available, such as the information on the increasing use of

social unavailability codes, that should have raised some warning signs that would have merited further investigation. It is very important that wider use is made of the information around any target, and that seems not to have happened in this case.

The Convener: So it is your view that information was available, which the NHS boards and the Scottish Government either turned a blind eye to or failed to notice, and that that was not information that would naturally have emerged as a result of the regular audits of the boards.

10:15

Caroline Gardner: No. As you would expect, the management of clinical services is not the main focus of the annual audit work that is carried out. As we make clear in part 3 of our report, it is true that information was available on the increase in use of social unavailability codes during that period and, for some boards, a high number of retrospective adjustments to the number of patients who had been recorded as being socially unavailable. That information should have rung warning bells for the health boards and the Scottish Government. It was not acted on, but it could have helped to avoid some of the concerns that have been raised since then.

Mary Scanlon (Highlands and Islands) (Con): That takes me nicely to my first question, which is about the warning bells and the fact that they did not ring.

As you said, the use of social unavailability codes rose from 8 per cent in 2008 to more than 30 per cent in 2011. Some 23 per cent of patients had a wait of nine weeks, compared with a reported 3 per cent. I looked through the report and asked who was responsible for the situation, and I found more people than I expected. The health boards' internal auditors did not seem to pick up the issue. Audit Scotland did not pick up the dramatic changes in figures. Paragraph 68 of the report says that

"ISD Scotland has a quality assurance role in monitoring the quality of the waiting time information"

and is

"responsible for providing performance management information to the Scottish Government",

but ISD did not pick up the issue. The health boards did not seem to pick it up. The Scottish Government did not seem to notice. Page 8 of the report says that

"Non-executive directors of NHS boards should ... ensure they have the full range of information available to scrutinise how their board is applying waiting list codes and planning and managing capacity to meet waiting time targets",

but they did not pick up on the issue either.

Not one of those six groups of people, who cost the taxpayer huge amounts of money, noticed that there was an issue, and the only reason why we are sitting here today with this report in front of us is that some brave person dared to speak out. I thank that whistleblower, whoever they were. Why was the matter not picked up? Why did we have to depend on a whistleblower? Why did none of those six groups notice?

Caroline Gardner: We reported on the matter in 2010—three years ago—when the new ways guidance was first introduced. At that point, we recommended that there should be greater clarity about the use of social unavailability codes and, in particular, their use in relation to patient choice and we said that NHS boards had an important role to play in the scrutiny and management of waiting times in their area. We also produced guidance for NHS board members and a checklist for them to use in doing that. We feel that, if our recommendations had been implemented at that time, the system would have been tighter and clearer for patients to understand and for the NHS and the Scottish Government to manage.

You are absolutely right that the events in NHS Lothian were brought to light by the actions of a whistleblower. That is one of the reasons why we recommend in this report that, in addition to the telephone line that the cabinet secretary has announced, the Government and boards need also to focus on ensuring that they have effective whistleblowing procedures and on promoting a culture in which staff, patients and members of the public can raise concerns and be confident that those concerns will be acted on and dealt with appropriately. Clearly, that is an issue that involves not only waiting times but a range of issues across the NHS.

Mary Scanlon: Basically, you are saying that the warnings that you gave three years ago were ignored.

Caroline Gardner: The recommendations were focused on ensuring that the purpose of social unavailability codes was clearer and that NHS boards were carrying out their role effectively in the scrutiny of waiting times more generally.

Mary Scanlon: The fact is that NHS boards did not carry out their role effectively, and that social unavailability codes have not been made clearer. We have a system in which internal auditors, ISD, health boards, the Scottish Government and so on can all ignore what you say. That seems to me to be the system that we have. Audit Scotland made recommendations in good faith, but it has led to an even more complex set of figures that even the Auditor General, with respect, cannot understand.

Caroline Gardner: This committee is an important part of the system, Mrs Scanlon. We

make a report. We do not have powers to direct anybody to do things. We have powers to bring what is happening to the Parliament's and the public's attention, and you have the power to hold people to account for that. That is the way in which the system is intended to work.

Mary Scanlon: My next question is on the management culture and staff being scared to report bad news, which was the case in NHS Lothian. When the waiting time target was reduced from 18 weeks to 12 weeks, health boards were basically expected to carry out the same amount of procedures in 65 per cent of the time and with no additional resources. Did that ring any alarm bells? Was it an impossible task for health boards? Why did they not ask for more resources? Why did they not say that it could not be done? Was it the pressure of the waiting time targets that forced them to muddle and manipulate the figures?

Caroline Gardner: We highlight the fact that the boards with the highest use of social unavailability codes in some specialties appear to have had capacity pressures in those specialties. We also report that the Scottish Government was working with some health boards to develop capacity to tackle the problems. I ask Barbara Hurst to give a bit more detail on that.

Barbara Hurst (Audit Scotland): Waiting time targets in themselves can be a good thing. Obviously, they help people to focus on the issues that matter to patients, but they are also a really good barometer of when there might be capacity pressures. If a service is failing to meet the target, there is something going on in the system. In a sense, a failure to meet a target is not necessarily something to get beaten up about. It is an alert about what is happening in the system.

We feel that the use of social unavailability codes for patient choice—when patients choose to be treated locally—acted as a way for people not to be totally transparent about some of the capacity issues. We know that the Government was looking at the capacity of some of the same boards, but we felt that the boards themselves could have done more to monitor what was happening on the target, what was happening with social unavailability codes and the impact on patients.

Mary Scanlon: That is the point that I am getting at. Rather than muddling or fiddling the figures, why did the boards not say, "Look, we just can't do this in the available time"? There are references throughout the report, but paragraph 60 states that evidence

"resulted in accusations of a more widespread bullying culture in the NHS."

That is also mentioned in your case study of NHS Lothian. Staff were under pressure, boards did not have the capacity to treat patients within the waiting times in the targets and the management culture was such that staff did not want to report bad news. Where did that bullying culture and that fear, which are perhaps the reasons why people felt that they had to manipulate the figures rather than report bad news, come from? Staff were under pressure. Management were under pressure. Was the Government setting impossible targets?

Caroline Gardner: As Barbara Hurst said, the target in itself is not a bad thing. Where it becomes damaging is if there is a focus on the target without people looking at the wider picture and how it is being achieved. We know, because of the investigation that was carried out in NHS Lothian, that there was found to be a bullying culture. Bullying is a difficult issue for auditors to get to grips with, as you will understand.

In the report, we reflect both what we know about NHS Lothian and the accusations that have been made more widely, by whistleblowers and in the press, about what is happening. We focused on what we have evidence for, which is the need for the Scottish Government and boards to use all the available information to examine the way in which targets are being achieved or indeed not being achieved, and to explore that in a way that is absolutely about looking to develop capacity, remove bottlenecks and identify where there are problems. That is what seems not to have happened well enough over the period that we looked at.

Mary Scanlon: If I may correct you, it is not only in Lothian—you mention

"accusations of a more widespread bullying culture in the NHS."

We are all in favour of patients being treated and of staff being given the resources to treat them but, as you have pointed out, there was a direct correlation—as the targets were implemented, there was a directly corresponding increase in the use of social unavailability codes at the same time. That is what I am trying to get at.

Caroline Gardner: That is exactly what our report demonstrates.

Mary Scanlon: Did the codes appear in order to manipulate the figures, because boards were frightened to say that they did not have the capacity to treat the patients within the waiting times?

You mention whistleblowers. This is nothing new. I meet many whistleblowers in NHS Highland, who are forced to sign compromise agreements. I know that that is the case

throughout Scotland. Although it is the caring profession, sometimes staff who dare to speak out as a whistleblower in the NHS in Scotland find that their career is finished. I say that because I have very wide experience of whistleblowing over 14 years. Let us not assume that it is an easy thing to do. Even if someone keeps their job, their career is gone.

The point that I am trying to get at is that, although we can look at the figures now, if a bullying culture remains in the NHS, staff will be forced to find ways to manipulate figures in future, I fear, rather than being honest and saying that they cannot treat the patients as they would want to.

Caroline Gardner: I absolutely understand your point. As auditors, we have to focus on the evidence that is available to us. Because of shortcomings in the way in which waiting lists have been managed, we have very limited evidence, on the one hand, of clear, inappropriate use of the codes. On the other hand, there is a pattern that is very hard to explain involving a significant increase in the use of unavailability codes—which fell off after the problems in NHS Lothian became apparent—at the same time that the number of people waiting 12 weeks and more started to increase.

We have to focus on the evidence that we have, and we have not found evidence of bullying. Our report contains the accusations and allegations that have been in wide circulation since the problems in Lothian came to light. One important recommendation in my report is about promoting a culture in which whistleblowers are able to come forward with confidence that they will be taken seriously and that their concerns will be investigated and acted on.

Mary Scanlon: We have been very critical of NHS Lothian. Is it not the case that you were able to find manipulation and falsifying of figures at NHS Lothian because it was the only health board in Scotland that had accurate figures, and that the figures from the rest of the boards were in such a muddle that you could not find any fiddling of their figures? We should be grateful to NHS Lothian, in fact, because it was the only health board in Scotland with efficiently compiled figures, which proved what we set out to prove. Is it a concern to you that the figures for the 13 other health boards were in such a muddle that you could not find a fiddle?

Caroline Gardner: It is indeed a matter of significant concern that the waiting time systems and information are not good enough to verify that they are being used properly. It is not true to say, however, that NHS Lothian's figures were the only accurate ones. It was clear that the board had been manipulating the number of patients who were recorded as socially unavailable in order to appear to meet the waiting time targets, whereas patients were in fact waiting longer than they should have been waiting.

We have a graph in our report, exhibit 6 on page 20, which demonstrates the pattern in the use of social unavailability codes for both in-patients and out-patients and the number of patients waiting more than 12 weeks. On both the graphs in exhibit 6, that is shown with and without NHS Lothian. The trends are similar. There is a pattern across Scotland, which demonstrates that the use of unavailability codes increased up to June 2011 and then started to fall, that the number of patients waiting 12 weeks or more started to rise at that stage, and that the systems for managing waiting lists—not just the IT systems but the approach for managing and scrutinising performance more generally—do not allow the Scottish Government, NHS boards or anybody else to demonstrate what the reasons are.

10:30

Colin Beattie (Midlothian North and Musselburgh) (SNP): I am having a bit of déjà vu because quite a number of reports that we have considered have highlighted the difficulties of extracting information from legacy systems. Here, again, we are debating statistics.

In your opening statement, Auditor General, you mentioned 3 million patient records. I presume that you did not look at them all, so what sampling did you carry out?

Caroline Gardner: We looked at 3 million transactions. I will ask Jillian Matthew to talk you through the methodology and give you a sense of how we went about that work.

Jillian Matthew: As Mr Beattie suggested, waiting list systems are very complex and hold massive amounts of data. We commissioned specialists with experience of that type of data to extract the data. As for the 3 million transactions that we looked at, any change to, say, unavailability, a start or end date or whatever in a patient record counts as one transaction. Of course, one patient record might have a few transactions, but that was the volume on which we based the data extraction.

When the data was extracted from all the boards in Scotland, we were able to look at patterns, ask specific questions, such as whether unavailability had been changed, whether there were high levels of unavailability at certain times or whether the same person was making a lot of changes; we were also able to examine the reasons for patients being removed from the list. In other words, we were able to look at various

things around how a patient was managed on the list.

After the huge task of breaking down all the transactions for each board, we had the information summarised so that we could examine the patterns and see where the peaks or high numbers of changes were happening. That led us to focus on a number of boards—Fife, Forth Valley, Lanarkshire and Grampian—where we saw more of the high levels of changes or other patterns that we wanted to examine more closely.

We also looked at the records in Greater Glasgow and Clyde and Highland. We did not get any information from Glasgow—the 3 million transactions did not include any transactions made in Glasgow—and had very limited information from Highland, simply because of the systems that were in place and the lack of audit trails.

Things that emerged in the data from all the boards were examined in more detail in the patient records. For example, if there were high levels of unavailability or high numbers of changes, we took a small sample of the masses of transactions from which we extracted the information—after all, as Mr Beattie said, we would not have been able to look at all the patient records—and examined it to get a sense of what was happening and to look for evidence of why a change had been made.

Colin Beattie: So you carried out a trend analysis of the patient records first.

Jillian Matthew: Yes.

Colin Beattie: Then you did some individual sampling within that.

Jillian Matthew: Yes.

Colin Beattie: What percentage did you sample?

Jillian Matthew: We looked at a number in each board. I should note that in exhibit C at the end of the appendix that we published with the report, we break down for each board the number of records that we sampled. The amount is based not on a percentage but on what emerged from the data analysis, and we then looked at a number of records within each board. We looked at a total of 310 patient records, but that was based on large numbers of transactions or patterns that we saw.

Colin Beattie: So you looked at 310 across the boards that you were examining.

Jillian Matthew: We did more detailed field work on those records.

Colin Beattie: Within those 310 records, you found a small number of what you called errors. How many are we talking about?

Jillian Matthew: We found one or two instances of errors in records from all the boards that we looked at, but sometimes it was not possible to tell whether a code change was appropriate or whether there had been an error, because there was a lack of evidence and no notes in the records.

Colin Beattie: So, equally, you could not tell whether it was inappropriate.

Jillian Matthew: Yes. The example from NHS Grampian, which appears in the report at paragraph 43, involved the medical unavailability code being applied in error. There were high numbers and the same end date, and then we saw that the social unavailability code was applied straight afterwards, but that code should have been applied in the first place.

Colin Beattie: It is obvious that you looked at the 310 records that you mentioned for a reason: because they looked suspicious in some way. How many of those records came up with errors?

Jillian Matthew: In around 20 records we could tell that there was an actual error, but, as I said, there was a lack of evidence. The common issue that kept coming up related to social unavailability. NHS Forth Valley had good notes in the records—particularly for in-patients—on why the unavailability codes had been applied and on discussions with the patients, but the other boards had either no notes at all or very limited information about why those codes had been applied, and we could not reach a conclusion about whether the coding had been appropriate.

Colin Beattie: So, across the board, 20 errors were found out of 3 million patient transactions.

Jillian Matthew: That was from the small sample that we looked at, based on all the data analysis that we did for all the transactions.

Barbara Hurst: In all my years in audit, this has been the most data-rich, data-intensive exercise that we have done. I remember sitting in the office poring over the patterns that looked very unusual; in those 3 million transactions, there were a lot of unusual patterns.

We did a very detailed trend analysis and took a detailed look at where we should focus our attention, which is why we picked the boards that Jillian Matthew mentioned. In addition to looking at patient records from those boards to try to understand those unusual patterns, we were also doing work on social unavailability and what was going on with those records.

On page 23, at paragraph 42, there are a lot of examples of very unusual things that we could not explain. For example, in NHS Grampian there were 300 patients with four or more periods of unavailability during the wait. That is quite

unusual, but we could not explain it. That takes us back to what the Auditor General said earlier: we follow quite a lot of trails and then come to a dead end because there is no information to allow us to clarify absolutely why something has happened.

I do not want the committee to go away under the illusion that we looked at only a very little sample. We did an incredibly detailed piece of work that involved looking at the data and at different sources of data. We used national data, the 3 million transactions and local data. It is that mix of evidence that we are trying to portray in the report. I hope that that clarifies the situation for you.

Colin Beattie: I realise that, given the volume of transactions, you can do only trend analysis, as you are clearly not going to check 3 million transactions. I suppose the problem is that you have no benchmarking against which to compare the exercise; you are just making a judgment about what constitutes an anomaly. When you look at the trend analysis and see what looks like a spike, you need to decide whether, logically, there seems to be a problem. Were you able to do any benchmarking against other areas of the United Kingdom?

Barbara Hurst: As far as I am aware, nowhere else in the UK has done such detailed analysis. We say in the report that we felt that the boards were giving reasonable explanations for some of those spikes—for example, there might have been batch transactions. However, we also say that there are other areas in which there was no explanation or evidence. We are trying to get that complexity across in the report.

Paragraph 42 mentions a number of other areas—covering more than the small sample that you mentioned—in which we looked at the records.

Bob Doris (Glasgow) (SNP): Ms Gardner, you said that we must use all the information available and that perhaps not everyone has been as good at that as they should have been. Your report has been interpreted in quite an interesting fashion by some—for example, it has been said, not by Audit Scotland but by some politicians, that it shows that one in three or one in four people are on hidden waiting lists. For the period that you looked at, for people with a wait of more than nine weeks, the figures were 3 per cent reported but 23 per cent actual waits. If we look at the same period using ISD figures, which include everyone who was medically or socially unavailable, they show that only 5.7 per cent of people did not get treatment in under 18 weeks. In other words, ISD has reported that 94.3 per cent of all patients were seen in under 18 weeks. Do you accept that?

Caroline Gardner: I do not recognise those specific figures or the time period that you are talking about. We would be happy to investigate that, if you want to give us more detail. I am happy to say that it is clear that waiting times have shortened markedly over recent years and waiting time performance has improved—there is no question about that. The concern is the extent to which the information that is available to the NHS, patients and the public is reliable enough, given the concerns about the way that it is being managed, and transparent enough.

Bob Doris: I completely agree. Just for clarity, for the time period that you looked at—you did an excellent job in relation to that—did you cross-reference your figures with ISD's reported figures?

Caroline Gardner: Yes.

Bob Doris: It included information on waits of 18 weeks or less. There were two outturns, one of which was when people were removed when social or medical unavailability was applied. However, when those people are included—they are not hidden away somewhere but are in full public glare in the ISD's figures—it is shown that 94.3 per cent of all patients were seen in under 18 weeks. Is that a figure that you recognise? Did someone look at ISD figures for that time period?

Caroline Gardner: Yes. If you look at page 29 of our report, you will see that we have a section that talks about the reported waiting times, the adjusted ones and the actual unadjusted waiting times. It is worth saying that, as far as I understand, Scotland is the only part of the UK that reports both parts of the equation, which is a good thing.

Our concern is two-fold: first, the unadjusted waiting times are quite hard to find; the Scotland performs website, which is the main focus for Scottish Government performance reporting, focuses on the adjusted waiting times. Through the performance report that ISD published yesterday, for example—

The Convener: Sorry to interrupt, but that would refer to the 3 per cent in the case that we have been talking about.

Caroline Gardner: I am reluctant to talk about numbers without being clear what timescale we are talking about, but it refers to the smaller number of patients waiting longer than 18 weeks. The number of patients with unadjusted waits of longer than 18 weeks will be higher, as you would expect, but it is quite hard to find that information through the performance reporting that goes on.

Our second concern is the one that we have been focusing on this morning, which is that the transparency and clarity with which waiting times are managed mean that it is not possible for the

Government or boards to verify that those codes have been used properly in the past. As a result of the conversation between the board and the patient or their GP, we know that in the past periods of delay have been included that were due to reasons other than social unavailability, such as a patient's choice to be treated at a particular hospital or by a particular consultant. The internal auditors and NHS Lothian have all found instances where we know that that has not been well done. The fact is that because of the problems with the information that is available and the way that it has been managed, it is not possible for anybody to say what the true picture is.

Bob Doris: I suppose the reason for asking the question is that I find it concerning when I see figures such as 23 per cent or 31 per cent of patients with social unavailability. What I am trying to get at is that when you include those patients in the overall figures for the waiting time for treatment of 18 weeks, 94.3 per cent are still being treated within 18 weeks. That provides a context. However, I totally agree that the cases in which social unavailability was, perhaps, wrongly applied are completely unsatisfactory.

10:45

I am a Glasgow MSP and you mentioned figures from Glasgow. It would be interesting to know what some of the challenges were.

Case study 3 in the report refers to that. I see from that that 900 patients were coded as socially unavailable for orthopaedic in-patient treatment at the Western general hospital and that 145 patients were unavailable for ophthalmology at the Southern general hospital.

The reason that I raise that is that NHS Greater Glasgow and Clyde issued a press statement—I accept that you want to audit the figures, not press statements—that said that much of the reason for those figures was patients seeking their consultant of choice at their hospital of choice for their operation, for which they were prepared to wait. I believe that the health board then put additional resources into the Western, the Southern and the Royal Alexandra hospital to meet the demand for patient choice. We start to see the figures come down after that.

I cannot speak for the rest of the country, because I do not know about it, but could that, ironically, be a case of a health board seeking to meet patient demand but just not having the IT systems or skills to record properly what was happening?

Caroline Gardner: We had a number of challenges in auditing what was happening at NHS Greater Glasgow and Clyde, starting, as Jillian Matthew said, with the fact that the IT system was not able to give us the large-scale data that we asked all boards for to enable us to analyse the patterns.

As you say, in NHS Greater Glasgow and Clyde, we found particularly high use of the social unavailability code in the orthopaedics and ophthalmology specialties. When the team asked the board for an explanation of that, they were told that it was due to patient choice—patients wanting to be treated at their local hospitals rather than somewhere else. The question that that raises for us is whether there was sufficient capacity locally to meet the demand that existed for services from those hospitals.

It is not possible to verify that the reason was as stated because, at that point, there was not a separate code for patient choice that would have enabled that information to be drawn out from the use of social unavailability to identify people who were not available for other reasons, such as holiday or work commitments.

We have identified what looks to us like high use of social unavailability codes in Glasgow for those two specialties. We have reported the explanation that the board provided to us and drawn the conclusion that that may demonstrate a capacity pressure within the board for those two specialties.

Tricia Meldrum might like to add to that.

Tricia Meldrum (Audit Scotland): When we looked at a sample of those records, we found that little evidence was recorded of the reason why the patient had been coded as unavailable or to confirm that there had been a discussion with the patient or their GP before the code was applied. Again, we did not have evidence in the records to confirm what had happened.

Bob Doris: NHS Greater Glasgow and Clyde has moved from 11 IT systems to three and we hope that it will move to one in the near future. Did that create a significant issue for the board's ability to record and audit?

Caroline Gardner: The board told us that that was the reason why it could not give us the data that we asked for. I do not know whether we can say anything more about the effect of the IT systems in Glasgow than that.

Tricia Meldrum: There were certainly some challenges in the board's ability to record information on the systems that it had. Although one of the systems could record only a small number of characters, there still was some capacity to record information; it was just not always being done.

Bob Doris: The Auditor General mentioned that waiting targets can be positive and that, when they throw up additional demand issues, health boards

should move to resource the demand. In Glasgow, the figures for social unavailability have come down because of that. Is that how the Auditor General would expect health boards to act when such figures become available? Is it an appropriate use of their resources?

Caroline Gardner: It is an appropriate response to any target. As Barbara Hurst said, targets can be helpful in focusing public services' attention on something that matters to the people who use them, but they can become dangerous when they are used in a narrow way that drives behaviour without thought given to the wider consequences. As Mary Scanlon said, the response should always be not to try to hit the target but to ensure that a system is in place that can deliver what the service looks to achieve.

Bob Doris: Thank you very much.

Convener, I will not ask any more questions. There are a million things that I would love to ask, but I know that my colleagues need to get in and ask questions as well. Perhaps I will come back in later.

Tavish Scott (Shetland Islands) (LD): Did health boards prioritise targets over patient care?

Caroline Gardner: I do not think that there is any way for us to answer that, Mr Scott—

Tavish Scott: So how do we find out whether or not that is true?

Caroline Gardner: The information that we have in the report demonstrates that there was a focus on the target in ways that were too narrow during the period that we have reviewed. We have demonstrated that there was other information available that could have highlighted those warning signs. I think that it might be entirely appropriate for the committee to explore with the health boards concerned and with the Government the way in which that information was used.

Tavish Scott: We might be better asking the whistleblowers—the brave people in the NHS who were prepared to stand up and say what was really going on.

Caroline Gardner: For much of this, it is very difficult to see any alternative to members of staff at all levels of the health service and Government being prepared to talk openly about the challenges that people are facing in achieving targets.

Tavish Scott: I think that you said earlier—do correct me if I am wrong—that focusing on the target itself without looking at the wider picture is dangerous. Is that what was going on?

Caroline Gardner: It appears to have been the case during 2011, which was the period that we looked at, that there was a very strong focus on whether patients were waiting 18 weeks or less. There clearly was information available at health board level and at the national level that would have identified emerging pressures in terms of both the increase in the use of the social unavailability code and the number of retrospective changes to that in some wards. That information was available but was not being used, either by NHS boards to manage their own local performance or by the Scottish Government to take a picture of the NHS as a whole.

Tavish Scott: When you say that the information was available, do you mean that it was available to the chief executives of health boards or to the boards themselves? To whom was the information available?

Caroline Gardner: That appears to have varied significantly. We report in part 3 of my report that the roles and responsibilities, between the Scottish Government and ISD, for example, were not clear. ISD had very clear information about the number of retrospective changes to social unavailability codes that were being made in each board. It was not clear to ISD how it should raise those concerns with the Scottish Government—

Tavish Scott: Did ISD raise the issue with the Scottish Government?

Caroline Gardner: Apparently not. The responsibilities for monitoring the information and for acting upon it seem not to have been clear enough all the way through.

Tavish Scott: So, in so far as you were able to ascertain, health board chief executives knew that there were problems. What did they then do with that information?

Caroline Gardner: We know that the information was available, but we do not know who was looking at it and acting upon it, either within the Scottish Government or within health boards. It appears that that varied.

Tavish Scott: Did you ask health board chief executives what they did with the information?

Caroline Gardner: That was a focus of the internal audit reports last year, which found very significant variation in practice. Equally, the report that we published in 2010 included a checklist for NHS board members on what they should focus on. It is very clear that the information highlighted pressures that were worth further investigation.

Tavish Scott: You said earlier that your recommendations in that 2010 report were not acted upon by health boards or the Government. That was your clear evidence. We should ask the respective bodies why that was the case.

Caroline Gardner: Our recommendations were not implemented in full, and we think that they would have helped to avoid these problems.

Tavish Scott: Yes, they could have avoided the problems, and they were not implemented in full.

Health board chief executives and presumably Government officials knew the problems that were being created because the information was there to a greater or lesser extent—I take your point about the variance across the country—but that wider context was not acted upon in any kind of co-ordinated fashion, either at health board level or at Government level.

Caroline Gardner: What we can say is that the information was available. I do not know who was using it and how they were interpreting it, but the information was available. We know that there were discussions between the Scottish Government and a number of health boards about pressures in particular specialties, but the wider picture of not just the target itself but the trend in the use of social unavailability codes and the extent to which they were being adjusted retrospectively was not part of the dialogue that was being had about the way that waiting times were being managed. That scrutiny was not good enough.

Tavish Scott: Indeed. The very warning that you gave in your earlier evidence that the wider context is important was ignored by the NHS system in total.

Caroline Gardner: The recommendations that we made at that point were not fully implemented.

Tavish Scott: Therefore, patient care was put secondary to the target.

Caroline Gardner: I cannot speculate on the reasons for that lack of implementation. That is something that you would have to pursue with the Government.

Tavish Scott: I take that point. It is very fair of you to say so.

Am I right that, in that 2010 report, Audit Scotland made specific recommendations on what should be done with social unavailability codes?

Caroline Gardner: I will ask Tricia Meldrum to give you the detail on that, as I was not here at that point.

Tavish Scott: Sorry, that is very unfair of me.

Tricia Meldrum: At that time, we highlighted the risks around the social unavailability code being used in different ways, such as for physical unavailability—people being on holiday. We also noted that the code was being used in some boards—to a far lesser extent at that time—to reflect patient choice to wait to be seen locally. There was no way of separately identifying that patient choice. We recommended that a new code should be introduced so that any capacity issues could be identified, as we have discussed.

We followed up the 2010 report. Twelve months after publication, we produce a largely internal document—a 12-month impact report—to see what has been done about our report recommendations. We contacted the Scottish Government then, in March 2011, to ask what had happened against our recommendations. At that time, it advised us that new guidance would be issued imminently that would address the recommendations, including the introduction of a code for patient choice. However, the guidance was not issued until August 2012—about 18 months later.

Tavish Scott: That is very fair. We can obviously ask about that.

In the 2013 report, you explain how Audit Scotland conducted the audit. You state in paragraph 9 that you

"reviewed how the Scottish Government monitors wider issues relating to the management of waiting lists alongside its monitoring of ... boards".

My understanding is that there are monthly board meetings involving the chief executive of the NHS and the chief executives of all the boards; there are also monthly board meetings involving the health secretary and all the health board chairs, which have gone on for years—not just during the current Government's time in office, but during that of the previous Government as well. Did you interrogate what was discussed in relation to this crisis at those decision-making meetings?

Caroline Gardner: We focused on the information that was being used by the boards, by ISD and by the Government to monitor waiting times.

Tavish Scott: But in order to understand the wider context point that you have very fairly made a number of times this morning, we need to interrogate what was discussed at those meetings to see whether that wider context was considered at any stage.

Caroline Gardner: You might want to follow up that point with the Scottish Government and with health boards.

James Dornan (Glasgow Cathcart) (SNP): I was delighted to hear you acknowledge the work on waiting times lists that has been done by this Scottish Government since it came in—going from 104,000 down to 65,000 is quite a drop in the numbers.

You talked about the continual rise in the number of people listed under the social unavailability code between 2008 and 2011. That code came in in 2008. Could it be that that increase was because, in many cases, the health boards were getting to grips with the new system? As we have seen from your report, some health

boards do things more quickly and efficiently than others.

Caroline Gardner: We were conscious that the new use of codes was introduced in 2008 and when we were agreeing the factual accuracy of our report with the Government, it raised that as a possible explanation for the pattern that we had seen. We have done some further work to analyse it and it is clear that the levels of use of the old availability status codes, which translated across into the new social unavailability codes, were pretty similar at the time of the transition. There may have been some variation in how quickly health boards made the move, but the levels were not markedly different at that stage.

The downward trend after June 2011 is more interesting. It shows up clearly in the report and it is a trend that affects the whole of Scotland—it is still visible if NHS Lothian is removed. That broader pattern is worth exploring. The challenge that we have is that the information that is recorded in patient records does not let us provide assurance about the reasons for that trend.

Barbara Hurst: If you look at exhibit 7 on page 25, you will see that we were interested in the different patterns of social unavailability. As Tricia Meldrum said earlier, when we did our previous report, the social unavailability figure in 2008, which is the reddish line on the second graph, was pretty similar to what it had been in the previous system.

It is interesting that those two graphs in exhibit 7 show quite a lot of variation between boards. There is not a systems issue as such, if I understand you correctly. If you take a board such as Ayrshire and Arran, its use of the social unavailability code looks pretty flat—it dips a bit. However, if you look at some of the other boards, it is quite dramatically different over that time period. It is not just a systems issue, because some boards were continuing on their trajectory, which was mainlining, if you like.

James Dornan: Would the transfer of the codes include the 35,000 people who were taken off waiting lists?

11:00

Caroline Gardner: I ask Tricia Meldrum whether we can answer that question.

Tricia Meldrum: I do not know. Sorry, but which 35,000 are we talking about?

James Dornan: There were people on waiting lists who were removed from them when they missed their appointment. Would that have included that number of people? Could part of the problem be that those people were not on the lists and then started to be fed into them?

The Convener: This is in 2008.

James Dornan: Yes—sorry. I am talking about in 2008 when the new system started.

Caroline Gardner: I think that, at that stage, there was an exercise to quality assure waiting lists as people moved to the new system. There are various reasons why people can be removed from waiting lists, such as if they miss appointments or if it becomes medically unsuitable for them to be on the list. That is all part of the mix, but it was part of the mix across the period that we looked at. Therefore, we do not feel that that helps to explain the trend between 2008 and 2011. Although that trend is interesting, we are more interested in the reduction in the use of social unavailability codes after June 2011, when the problems in Lothian came to light.

James Dornan: I have just one other question. You have talked about your recommendations to the Scottish Government. Is it not the case that, in the vast majority of cases, the recommendations from internal audit and from Audit Scotland have been taken up by the Scottish Government?

Caroline Gardner: Absolutely. Back in 2010, we identified two particular recommendations that we think could have made a difference. The first was on the use of a separate code for patients who are unavailable because of their choice—because they would prefer to wait longer so that they can be seen by a particular specialist or at a particular hospital. The second recommendation was on the need for patients who have special support needs to be identified and treated appropriately throughout their waiting time period. As Tricia Meldrum explained, neither of those recommendations was implemented fully, and we think that they would have helped to make the figures more transparent and to give us a clearer picture of why the use of codes was as high as it was in some boards and for some specialties.

James Dornan: Do you accept that the new patient unavailability code and the whistleblower phone line should help to alleviate some of the problems? Sorry—I said that I had just one more question, but that takes me on to the real last one. This does not apply to Audit Scotland, but there seems to be a culture of guilty until proven innocent on the bullying. For example, in Tayside it was shown that nothing went wrong, but it is still being used to make it look as if health boards are behaving inappropriately. Do you agree that people should perhaps step back a wee bit, work on the facts and then make their judgments after that, rather than on the basis of supposition, which many people are doing?

Caroline Gardner: You asked two questions there. The first was about whether the new guidance will address all the problems. We

certainly think that, when the guidance is fully implemented, it will help. There is still a risk with outpatients, where there is no requirement to confirm periods of unavailability in writing, and questions still need to be clarified about the definition of a reasonable offer. However, those measures will certainly help if they are implemented fully.

On the question whether the health service is being held to be guilty until proven innocent, that is absolutely the reason why we took such great care in our report to focus on the evidence and what we can conclude from it. On the one hand, we have only a small number of instances in which it is clear that the social unavailability code was used wrongly, and it is not clear why that is, but on the other hand we have a pattern in the use of the code that is hard to explain and evidence of capacity pressures in some areas. Because of the limitations of the systems, we cannot go further than that, and nor could anybody else. It is for the committee to explore the matter further with those in health boards and the Government.

Mark Griffin (Central Scotland) (Lab): We are here because of the reported and confirmed manipulation of waiting list figures at NHS Lothian and we are trying to find out whether that was widespread across the country. The key message that is repeated in the reports and other papers is the rise from 2008 in the use of social unavailability codes. To my mind, the most interesting trend is that, after the abuse of the system in Lothian was reported, all of a sudden, across Scotland, the use of social unavailability codes dropped.

In his statement in the chamber, the cabinet secretary said that more than 400 staff were interviewed as part of the investigation. I struggle to see why it is still unclear why the figures started to drop across Scotland, as so many members of staff were interviewed.

Caroline Gardner: You are absolutely right: that is unclear. That is due to problems with the systems. The audit trails that would let us examine what changes were made are not in place in all the systems that are in use; the fields for recording information about the use of patient unavailability codes, for example, are generally not being completed, except in NHS Forth Valley, which was a real example of good practice; and the staff to whom we spoke did not raise concerns with us. We cannot speculate on the reasons for that: all that we can do is tell members what evidence we have found and report it as clearly as we can.

Can Tricia Meldrum, as the person who did the work, add to that?

Tricia Meldrum: I clarify that we did not speak to 400 staff as part of this audit. That figure includes all the internal audits.

Mark Griffin: If you did not speak to 400 members of staff, were you given access to appropriate members of staff—those who made the changes to patient records and made patients socially unavailable? Were you able to speak to those members of staff at the front line, who could have indicated why the use of the codes dropped all of a sudden after what was found to be happening in NHS Lothian?

Caroline Gardner: I do not think that we had any concerns about the staff to whom we had access. However, Tricia Meldrum and Jillian Matthew carried out the work, and I will let them answer your question, if I may.

Tricia Meldrum: It is fair to say that the boards were all very helpful to us and there were no difficulties with our having access to any staff to whom we wanted to speak.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): I want to return to the theme of guilty until proved innocent, which James Dornan mentioned. There seems to be a sense of that running through the whole debate.

The Auditor General's stated aim in conducting her audit was

"to identify whether NHS Lothian's manipulation of waiting lists ... was an isolated incident or whether it indicated more widespread problems across the NHS."

I ask you to be absolutely clear. Did you find any evidence of manipulation elsewhere during your audit?

Caroline Gardner: As we have said in the reports and as I have said today, we have not found any evidence of manipulation at all. The wording on the aim of the work is very clear. It was about looking for an indication of

"widespread problems across the NHS."

The evidence suggests that there were widespread problems with the use of the unavailability code. Our challenge and the reason why we reported in the way that we did is that the information systems and the information that is recorded do not enable us to clarify what caused codes to be used wrongly or explain the wider pattern in the use of unavailability codes across NHS boards. As the Auditor General, I have to focus on the evidence. I cannot speculate about the likelihood for the patterns that we see in either direction.

Willie Coffey: I fully understand that, and I fully expected that you would answer in that way.

You said that you found no evidence of the manipulation of waiting lists. That takes us to a

theme that we have covered many a time in the committee: the robustness of data in the various public services that we deal with from time to time. The Auditor General's predecessor focused on that issue in many reports to us over many years.

I am interested in the point that Tavish Scott raised earlier and the recommendations that you made in June 2010, I think. I think that we would want to follow up on that. Another recurring theme has been how our committee follows up recommendations that your organisation has made so that we can see that public services take such recommendations seriously.

We can all interpret data in our own particular way—that is quite clear from what has happened with the issue that we are discussing—but a statistic that stands out quite starkly is that 88 per cent of people seem to be satisfied or very satisfied with the NHS's performance on waiting lists. That is a fact from asking real people what their views are, and that surely has to tell us something.

As Ms Hurst said, this is the biggest examination of data that Audit Scotland has ever undertaken. The fact that Audit Scotland could not establish whether there was deliberate manipulation of the data—the fact that we could not glean something meaningful from looking at those 3 million transactions—tells us something about the extent and the volume of the data that we have been looking at. It says a lot about where we are at the moment.

Caroline Gardner: I completely agree that there is an issue with the completeness of data. The data that is needed to manage this very important NHS target needs to improve. However, we also report the fact that the data that is available was not being used to identify where there might be problems, where pressures were building up in the system and so on. There is a real question about the management and scrutiny of this area of work.

More generally, I fully agree that the scrutiny system for the Parliament works by having an independent audit organisation that can provide evidence of what we have found, and by having a committee that is there to hold to account Government and the public bodies that are responsible for that service by exploring the reasons for the pattern of events.

Willie Coffey: We must bear it in mind that we are the Public Audit Committee, not the Health and Sport Committee. The lesson that I am taking from the issue concerns data and the need for an accurate and consistent approach to gathering data to help us to deliver the kind of service that we want. We must listen to advice from the Auditor General about getting systems and processes consistently applied across Scotland. I hope that we are doing that with the new ways tracking system that is in place. We need to embrace that and the recommendations that the Auditor General and her predecessors have made about data gathering and collection.

The Convener: Clearly, there was an issue around data and data collection. Was that simply an IT problem, or did Audit Scotland identify other problems around the way in which the data was recorded and collected? We often conflate IT systems and data collection and I think that they are not always exactly the same thing.

Caroline Gardner: That is right. It is clear that the IT systems need to improve, and the move across Scotland to the use of the TrakCare system should improve things.

It is also important that those systems are used properly. For example, most systems that are currently in use have a facility to record the reason for applying a social unavailability code to a patient and demonstrating that that is a result of a conversation with a patient or their GP. In most places, that was not used, with the exception of NHS Forth Valley. The third step is to ensure that the information that comes out of those systems is being used to focus on the target and the wider picture of how the target is being achieved. We need to identify problems and deal with them.

Willie Coffey: I think that you paid tribute to NHS Forth Valley for the accuracy of its data, which you were able to interpret. Did it add in more than it perhaps should have, given the system that was in place? It seemed as though you were quite happy with looking at its data and the conclusions that you came to about its data. What was it doing that was particularly better than anyone else? We should certainly want to learn that lesson.

Caroline Gardner: The key thing is that NHS Forth Valley was using the facility in the patient management system—which is in every system that is in use—to record the reason for the use of the social unavailability code, so that we could verify that it was being used properly and that its use was in line with the guidance and reflected a conversation with the patient or their GP, which means that the longer waiting time was a result of the patient's unavailability, not a decision that was taken by the health board.

The Convener: The deputy convener has a supplementary question, which she promises me is short.

Mary Scanlon: The words, "guilty" and "not guilty" have been used. We know that NHS Lothian was guilty. Is it the case that the verdict on the other health boards would be "not proven", due to a lack of evidence?

Caroline Gardner: I am sorry, but I cannot answer that question. I can report the evidence that I have found. The committee can speculate on the reasons that underpin that.

Jackie Baillie (Dumbarton) (Lab): I thank the committee for the opportunity to come to today's meeting and I thank Audit Scotland for doing a complex piece of work that I am sure engaged its staff for many hours.

I will start by addressing your 2010 report. From what you have said, I am clear that you told the Scottish Government what the problems were and highlighted them in your recommendations.

I am equally clear from something that Tricia Meldrum said that, in March 2011, you contacted the Scottish Government about those recommendations and about guidelines. Those guidelines did not come out until August 2012, which is some time after NHS Lothian was rumbled. Is that an accurate reflection of the timeline of events?

Caroline Gardner: I will need to ask colleagues to answer, as I was not in Scotland at that point.

Tricia Meldrum: Yes.

11:15

Jackie Baillie: I would like to explore some of the relationships that you will have had some dialogue about, principally the one between ISD and the Scottish Government. I find it inconceivable that there was not discussion between ISD and Scottish Government civil servants or the director of workforce and performance, who has responsibility for waiting times. Did you find evidence of any such discussions, formal or informal? I find it equally inconceivable that, on such an important area of Government policy, no audit or monitoring reports were routinely presented to ministers.

Was that the case, or was the data available? I know that it was—we saw the data that was available; we saw the upward trends. Would it be fair to say that what the Auditor General is saying is that the Government had taken its eye off the ball?

Caroline Gardner: We cover that issue on pages 36 and 37 of the report, in paragraphs 68 to 71. As you say, it is clear that the Information Services Division had more information available than the Scottish Government was publishing about performance on waiting times. It is also clear that the roles and responsibilities were not as clear as they needed to be on such an important issue. In paragraph 68, we highlight that ISD has a role to play in

"providing performance management information to the Scottish Government but it does not have a role in challenging NHS boards on their performance."

It could have been clearer what the role of each party was and what information they needed to carry it out.

Since 2012, those roles have been clarified, and the Government and ISD have increased their scrutiny of the boards' waiting times performance. ISD is now developing more detailed performance reporting. As opposed to having the data, it is developing those reports that focus on the wider range of performance and is starting to enter into the dialogue about what is happening with health boards and with the Government. However, I think that the issue is one that the committee should explore with the Government as part of what the committee decides to do next.

Jackie Baillie: You picked your words very carefully. I think that you suggested that ISD had more data than was published. Was that additional data shared with the Scottish Government?

Caroline Gardner: That is an issue that the committee would need to explore with the Government. Jillian Matthew touched on this earlier, when she talked about the waiting times figures that were published yesterday. ISD has a huge amount of data. That is one of the massive strengths of the NHS in Scotland. ISD does not just have aggregate data on the performance of health boards on waiting times; it also has patient-level data, which allows a great deal of analysis to happen.

I do not think that it is appropriate that all of that data should simply be handed to the Government. There is a role to be played in analysing it and seeing what the key issues are. What we report is that, during the period that we looked at, the expectations of the two parties about how that happened and what data should be reported to Government were not clear enough, given the importance of the issue to patients and the public.

Jackie Baillie: I think that you said earlier that the new 12-week waiting time guarantee was introduced at the time when the use of social unavailability was probably at its highest or was becoming quite high. What would you say was the Government's reason for not scrutinising the data that would have been available, which would have acted as a warning bell for what was about to happen?

Caroline Gardner: Again, I cannot speculate on the Government's motives for that. That is something that the committee would need to explore with the Government.

Jackie Baillie: Would it be fair to say that its eye was off the ball?

Caroline Gardner: I cannot speculate on that.

Jackie Baillie: Okay. Thank you.

I turn to something that I hope that you will not need to speculate on, but which you can assist us with. Today, we have heard that the use of social unavailability codes reached a high point of about 31,000 people in June 2011. That was followed by quite a dramatic fall, as a consequence of NHS Lothian's problems being highlighted and NHS Scotland giving health boards an instruction on what would be appropriate. I understand that you cannot speculate, but Barbara Hurst said quite clearly that this is not a systems issue, although we have been told time and again that it is all down to IT. Why do you believe that it is not a systems issue?

Caroline Gardner: Exhibit 6 of the report highlights the trend for Scotland as a whole and for Scotland excluding Lothian, and it shows a high of about 31 per cent falling to around 15 per cent in September, which were the latest figures that were available until yesterday.

As I said earlier, we know that IT systems need to improve; there is no question about that. The move to TrakCare should help because it is one of the better systems, although it does not have everything in place that is required.

It is also important that the TrakCare system is used fully to record all the necessary information to demonstrate that the new patient choice codes as well as the unavailability codes are being used appropriately and in line with the guidance. The information that can be generated by those systems needs to be used properly to manage the waiting times system—not just the waiting times target—by people in NHS boards and the Scottish Government.

Things will continue to change. We know that the performance on waiting times in Scotland has improved markedly over a number of years, but that brings pressures with it. The purpose of managing waiting times is to identify those pressures and respond to them, looking at the broad range of information that is available and what we have all learned in the past two years about where there might be weak spots in the system. That is the responsibility of NHS boards—we have produced a checklist for what they should be doing—and of the Scottish Government.

Jackie Baillie: Is it reasonable to assume that the dramatic fall that we have seen since June 2011 is down to changes in IT systems?

Caroline Gardner: There has not been a significant change in IT systems over that period. A number of systems are in place across Scotland and either the report or the appendix contains a lot more detail about them.

The challenge of the IT systems is that they do not provide good enough audit trails to identify all the changes that have taken place, let alone the reasons for them. Getting those systems right matters, but it is not the only thing that needs to happen.

Jackie Baillie: The graphs in exhibits 8 and 9 on pages 28 and 29 are quite instructive because they suggest that those health boards and specialties with the highest volumes were the ones in which staff were using the codes the most. That suggests to me that the problem is not with IT but one of capacity and pressure in particular areas that had wide variation across health boards. Is that a fair assumption from my examination of those exhibits?

Caroline Gardner: It is a stretch to make that assumption across those two tables but, for example, on page 26 we highlight the challenges that Greater Glasgow and Clyde Health Board faced with two specific specialties—orthopaedics and ophthalmology—that had high levels of the use of social unavailability codes. The reason that the board gave for that was that patients were choosing to be treated only in their local hospital—the question that that raises for us is about the capacity of those hospitals to meet local demand. However, because there was no separate patient choice code at that point, it is not possible for us to verify that that was the case. That is the sort of interplay between pressure and capacity that we see, with the social unavailability code as the overall umbrella.

Jackie Baillie: Is it reasonable or acceptable that 70 per cent of the 900 patients in Glasgow who were waiting for orthopaedic in-patient treatment received that code? I understand that you did not interview patients, so you have no way of verifying whether what you were told about their choice of consultant is true.

Caroline Gardner: It is certainly a high level compared to what we have seen across the piece for other specialties, although those tend to be high-pressure specialties. Beyond that, I need to come back to where I started. The systems that are available and the information that is recorded in them do not let us verify whether the reasons that the board gave to explain the pattern can be demonstrated in practice.

Jackie Baillie: I have one absolutely final question, convener.

Auditor General, Willie Coffey paraphrased your response to his question as "there wasn't a problem with manipulation."

I heard you say that there were widespread problems with the use of the unavailability code. Is that a fair reflection of what you actually said to the committee?

Caroline Gardner: We have highlighted across the piece that it is not possible to verify that social unavailability codes have been used in line with the guidance, which previously contained some ambiguities. This issue matters to patients and its management really needs to be improved. We reported on it 2010; it is a matter of significant importance that needs to be got right now.

The Convener: I call Mr Keir, to whom I should apologise—I did not see him indicate earlier—and then I will bring in Dr Simpson for a brief question.

Colin Keir (Edinburgh Western) (SNP): I am glad that it has been accepted that the waiting time has come down substantially over the years.

Before I ask my question, I wonder whether you will clarify something for me. The 2010 report has been mentioned but I note that the 2011 follow-up report, which I believe that Ms Meldrum referred to, says:

"This audit provided assurance that the new arrangements are generally working well. ... There should not be any need to conduct a follow up study in the foreseeable future."

On reflection, how do you feel about those statements? After all, it was the follow-up to the 2010 report, so we are basically suggesting that there were flaws in that. As an auditing authority, what do you see as the weaknesses apart from those that we have already mentioned? Was anything fundamental missed that we could not take a robust view on?

Caroline Gardner: As Tricia Meldrum made clear in her earlier response, you are quoting from a report on the impact of the 2010 audit that we produced for internal purposes but which is available on our website as part of our general commitment to transparency. We do that for every piece of work that we carry out to varying degrees of intensity.

The assessment of the team in the 2011 report that you quoted was based on the Government's assurances at that point about the implementation of recommendations, specifically the information we had received that it would imminently be publishing updated guidance to help deal with ambiguities in the new ways guidance. In fact, as Tricia Meldrum pointed out, that guidance was not published until autumn 2012, which might account for the difference that you might draw from the internal report.

Colin Keir: My real question is about IT. Over the years, there have been different forms of patient administration systems; indeed, I believe that, at one time, Glasgow had 11. How satisfied are you with the speed with which what we might call an improved TrakCare system is being put in place by boards around the country? Are we moving at a rate that is acceptable and which provides assurances to audit with regard to a far more robust system of performance management?

Caroline Gardner: We understand from the Scottish Government that all NHS boards are likely to be using TrakCare by the end of this calendar year. It is certainly one of the better systems available; one of the appendices that we have produced, which sets the features of each of the systems against the good practice that we would expect, shows that TrakCare covers most but not all areas. The committee might want to explore the finer details with the Government if it decides to take this work forward, but I repeat that although IT systems are important they are not the only part of this. Even with TrakCare, information about the use of different codes, the confirmation of unavailability with patients and so on will still need to be recorded and health boards will still need to provide a clear definition of a reasonable offer of treatment that patients can understand and which lets them know what they can expect. That all needs to happen if we are to overcome past problems.

Colin Keir: Given the relatively recent information that we have, are there any concerns about the future management audit system that will be put in place? I know that you have made recommendations in the report, but where will the real difficulties arise in providing a robust audit on the waiting time numbers?

Caroline Gardner: I cannot provide any clear answer to that question. However, I can say that my report's recommendations need to be implemented to ensure that every board has and uses an IT system with appropriate controls and audit trails, that they are fully used to record all the necessary information and that NHS boards and the Government use that information to scrutinise the wider picture of performance.

We need a culture in which patients and staff can raise concerns and know that they will be properly investigated. The information that is available to patients must be as clear as it can be, so that they understand what they are entitled to.

11:30

Colin Keir: I have one more question, which relates to the first issue that I raised. I assume that the views in the 12-month internal impact report stand, and what is in the report was correct at the time. Why is there such a massive change between what you found then and what you are seeing now? I am still confused about the difference between the conclusion in your internal report and where you are now.

Caroline Gardner: The distinction is about what that impact report is. The internal report is not an audit report. The report that you have before you

is an audit report, in which we have gone through a significant amount of work to look at the 3 million transactions on patients' records and to drill down to understand what is happening across that as far as possible with the information that is available.

The 12-month impact report is an internal document that is prepared to look at the impact of our reports without repeating the audit work that is carried out. Instead, it looks at things such as the extent to which our recommendations have been implemented—taking assurance from the Government on the action that it says it plans to take—and other things that are visible at that stage.

Colin Keir: The fact is that the report recommended that there was no requirement for a follow-up.

Barbara Hurst: If we roll back a bit, the impact report is our fourth report on waiting lists over the past 10 or 11 years. Clearly, waiting lists are an important topic. We would have followed up the 2010 report at some point. We decided not to in 2010 because the accountable officer for the health service wrote to all the boards instructing them to improve their recording of people with particular special needs. We thought that that was a good response to our report and that it should have generated improvements. As it turns out, it did not generate improvements.

The assurance that we took from the Government in 2011 about revisions to the guidance being imminent was another reason why that would not have been the right time to revisit the report. The matter is on our radar, as are all the other targets. We would have come back to look at the report, but we made the assessment at that time—in good faith—on the basis of what we had been told.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I raised the increase in the number of people who were listed under the social unavailability code with the then cabinet secretary back in early 2010, which was before Audit Scotland's report. I was given that explanation for the increase, which I found unlikely.

My concern was with those groups who might have some problems operating a complex system; that included the elderly, the confused, those with learning or sensory disabilities, people whose second language is English, refugees, Gypsy Travellers and prisoners. Have you looked at what has been happening in the application of social unavailability codes?

Exhibit 1 in your report covers the nine months of waiting lists that you looked at. If that is scaled up to 12 months, 500,000 patients would have received offers of appointments with three days' notice or less, and almost 500,000 patients would have been removed from the list. At the end of the day, we need a human system. Are you happy and comfortable that the systems—as applied—will ensure that individuals are not being treated inappropriately because they have a disability?

Barbara Hurst: We made a recommendation on people's needs back in 2010. While we were carrying out the impact work, we looked into what was happening in that area. We were disappointed to find that people's special needs were not being flagged well enough for those people to be supported through an incredibly complex system.

I find exhibit 3 daunting, too, as I try to track my way through it. However, given the lack of information we did not know which patients had those special needs so we certainly could not correlate or link that with social unavailability. We did not know what was happening in that mix—if I understood your question properly—but it is another area that we recommended be taken seriously. The new guidance flags that.

There may be difficulty around the reasonable offer; that area is quite complicated, because it depends on the definition of reasonable and the definition of what someone's needs are. Therefore, I think that we would continue to monitor that in our own ways. As you said, at the end of the day it is about patients and their getting the treatment that they need. In that regard, we felt that not enough had happened on the recommendation from 2010.

Dr Simpson: Is it clear from the work that you have done that the 393,161 transactions of offers of an appointment within three days, which do not constitute a reasonable offer—the definition of that is 21 days—were not used in any way to indicate that someone had refused an offer?

The committee has concentrated today, quite rightly, on social unavailability. However, I am receiving correspondence that indicates that the system has other significant problems. With paper communications, which are still being used in some cases, referral letters are not being opened and the date on which the GP's letter was written is not being recorded, so the commencement period is wrong. Offers are being classified as reasonable although they are unreasonable, not just in terms of the timing but with regard to the fact that someone may have indicated clearly that they do not wish to be referred outside their area, either to a private establishment outside the health board or to the Golden Jubilee, or indeed to England or even abroad—

The Convener: Mr Simpson, you are testing my definition of brief, although it is a good question.

Dr Simpson: I am sorry.

Is the reasonable offer system working as part of the overall system? Are you clear about that from what you have done so far, or does it need further work?

Caroline Gardner: We have reported that there are problems with the definition of a reasonable offer. For example, there is no reason not to offer the patient treatment outside the local area and outside the terms of what a reasonable offer looks like, if it becomes possible to offer treatment sooner than the patient would otherwise get it. The system goes wrong if the patient does not take up that offer, but is then treated as having turned down an offer under the guidance.

I am sorry; it is hard to explain this clearly, for the reasons that Barbara Hurst described.

Dr Simpson: No, that is very clear.

Caroline Gardner: The limitations in the systems themselves and the limitations in the information that is recorded in patient records mean that it is not possible for us to verify that patients are not being treated as having turned down an offer in the way that I described. We found some examples in which that is happening. For example, the internal audit report on Tayside identified that patients were being told that it was unlikely that they would be treated within 18 weeks and that if they recognised that, they were being coded as unavailable. That clearly is not what the codes were intended to achieve. However, that is another reflection of the broad problem that we have identified: the IT systems are not good enough and are not being used well enough, and the information is not being used as part of that to manage and scrutinise something that is important to patients.

The Convener: I thank our witnesses. We will consider later how we will take the report forward. We are well over time, but clearly it was an important report to discuss.

11:39

Meeting suspended.

11:46

On resuming—

"Commissioning social care"

The Convener: Agenda item 3 is the section 23 report "Commissioning social care". We have a response from the Scottish Government to our submission to its consultation on the integration of adult health and social care in Scotland. This item is on our agenda to enable us to consider and decide what we want to do with the response. We could note it, or we could refer it to the Health and Sport Committee, which is the lead committee on the matter. Alternatively, if we wish, we can write back and ask further questions or ask for further clarification.

I invite members to comment.

Mary Scanlon: Having been on the health committees in the first two sessions of Parliament, I find it quite sad that the Scottish Government's response states:

"We intend to legislate to place a duty on Health Boards and Local Authorities to work together".

I just want to put it on the record that, in a country of 5 million people, I find it incredible that we have to legislate to make people work together. I do not disagree with the proposed legislation, but it is a sad state of affairs given that it has been pointed out so often over almost 14 years—by Audit Scotland and others—that health boards and councils should work better together and put patients first.

Paragraph 32 states:

"We expect the Care Inspectorate to work with a range of partners".

If it was really working with a range of partners and doing what it should be doing, we would not read the stories about deficits in care of the elderly that we have read in the press coverage in the past week.

Having said that, my view is that, given that the Health and Sport Committee is the lead committee on the matter and that I have no doubt about how thoroughly it will look at the issues, I would be content to refer the response to that committee.

James Dornan: I second Mary Scanlon's comments. It is disappointing that the Scottish Government is having to legislate, but it is appropriate that it does so. There is evidence that the will might be there at some levels for health and social care departments to work together, but it does not exist at all levels. It is important that legislation is introduced.

The care inspectorate should be working with everybody. That is the right way to go.

Bob Doris: I should perhaps put on record that I am the deputy convener of the Health and Sport Committee, so I suspect that we will be passing this issue to the other committee on which I sit.

The Convener: You can take it with you.

Bob Doris: If we saved a postage stamp, would that be an efficiency saving? If it was reinvested, I suppose that it would be.

Given that Ms Scanlon mentioned the care inspectorate and the quality of care for older people, it is worth mentioning that that issue has been looked at before by the Health and Sport

Committee. By and large, we found that the quality of care in Scotland is of an exceptionally high standard by international comparisons. The legislation is about picking up on situations in which the quality of care falls below that standard. I have no doubt that the Health and Sport Committee will look in great detail at the integration of health and social care.

Sometimes Governments need to legislate. There was nothing to stop local authorities introducing self-directed support—that was within their gift—but there was cultural resistance to that until legislation was introduced by this Parliament. The Health and Sport Committee adequately scrutinised that piece of legislation, and I am sure that it will do the same on this issue if the Public Audit Committee decides to pass the response to the Health and Sport Committee.

Willie Coffey: On the point that Mary Scanlon made, the focus of the legislation will be on delivering the nationally agreed outcomes rather than just on working together. Quite clearly, the emphasis will be on the national outcomes and it is not about legislating to work together.

Mary Scanlon: The Government's response says that the aim of the legislation is to "to work together".

Willie Coffey: If you read the whole sentence, you can see quite clearly that it says:

"We intend to legislate ... to deliver nationally agreed outcomes."

Other than that, I do not see anything in the Scottish Government's response to cause us any concern. I would be happy to refer the issue on in the way that Mary Scanlon has suggested.

The Convener: The broad consensus is that we should submit the response to the Health and Sport Committee in the full confidence that Mr Doris and his colleagues will do a significant job of scrutiny on the new legislation. Is that agreed?

Members *indicated agreement.*

Land and Buildings Transaction Tax (Scotland) Bill

11:52

The Convener: Agenda item 4 is the Land and Buildings Transaction Tax (Scotland) Bill. We have received correspondence from the Scottish Government and from Audit Scotland on the audit recommendations in the bill.

Once again, our purpose is to hear members' comments on how to take the issue forward. We may wish just to note the responses, or we could highlight any specific issues raised to the Finance Committee, which is the lead committee on the bill. I open the discussion for comments from members.

Mary Scanlon: We took significant evidence on the issue from Mr Paul Gray and from Registers of Scotland, if I remember correctly. We were given a lot of assurances, which seemed fair and reasonable at the time. However, as the Government's response says, under "Risk management",

"planning is at an early stage".

I appreciate that the Finance Committee is looking at the bill, but I feel that there are such significant concerns about the ability of Registers of Scotland to collect the new land and buildings transaction tax that I would just like some reassurance that everything that we were told—the planning was to start at about the end of November or the beginning of December—is actually being done. Whether we just ask the Finance Committee to look into that or whether we come back to the issue in six months or a year, I am not quite sure. Personally, I have significant concerns about the abilities of Registers of Scotland, given its experience with costly IT projects that was highlighted by the Auditor General.

I am sorry that I am not making a firm proposal, but I do not want to ignore the verbal assurances that we were given without being given something more.

The Convener: I take that as a proposal that we might want to flag up those concerns to the Finance Committee, which will take evidence from the cabinet secretary and others on the new set-up. We could do that.

Willie Coffey: I am just trying to see where that is. From my reading of the Auditor General's response about Registers of Scotland, I think that it is true that all its functions will be subject to scrutiny by Audit Scotland, which will be able to keep a close eye on everything that it does. I am content with that response.

James Dornan: I was going to make exactly the point that the convener made. I think that the best thing to do would be to flag up to the lead committee the concerns that are raised in the report and ask the lead committee to keep an eye out for those issues.

Colin Beattie: I agree with that, but I think that this committee should revisit the issue perhaps in a year's time to see how matters have bedded in.

The Convener: I am informed—we should all have remembered this—that the correspondence was also circulated to the Finance Committee, which is taking evidence today not only from the cabinet secretary but from Registers of Scotland. Hopefully, the Finance Committee will have been exploring those issues while we have been meeting today. However, I think that we can also cover the point by taking up Mr Beattie's suggestion to come back to the issue in a year.

Mary Scanlon: I would support that.

The Convener: Do we agree to look at the issue again in a year?

Members *indicated agreement.*

The Convener: The committee will now move into private session, so I ask the press and any media to leave.

11:56

Meeting continued in private until 12:42.

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