The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 28 May 2013

Session 4

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HEALTH AND SPORT COMMITTEE
17th Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)
*David Torrance (Kirkcaldy) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackie Baillie (Dumbarton) (Lab)
Jayne Baxter (Mid Scotland and Fife) (Lab) (Committee Substitute)
John Connaghan (Scottish Government)
Derek Feeley (Scottish Government)
Anne Harkness (NHS Greater Glasgow and Clyde)
Calum Irving (Voluntary Action Scotland)
Heather Kenney (Scottish Ambulance Service)
Peter McColl (Royal Voluntary Service)
Alex Neil (Cabinet Secretary for Health and Wellbeing)
Margaret Paterson (Royal Voluntary Service)
Tom Robson (British Red Cross)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Tuesday 28 May 2013

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

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the 17th meeting in 2013 of the Health and Sport Committee. As usual at this point, I remind everyone to switch off their mobile phones and BlackBerrys because they interfere with the sound system. Those at the table and in the gallery will notice that some members are using iPads; they are doing so instead of receiving hard copies of their committee papers.

The first item on the agenda is a decision on whether to take in private item 6, which is a discussion on our work programme. Such discussions are usually held in private, so do members agree to take that item in private?

Members *indicated agreement.*

National Health Service Waiting Lists

10:00

The Convener: Item 2 is evidence on national health service waiting lists. I welcome to the meeting Alex Neil, who is the Cabinet Secretary for Health and Wellbeing; Derek Feeley, who is the director general of health and social care, and chief executive of NHS Scotland; and John Connaghan, who is the director of health workforce and performance in the Scottish Government. I believe that the cabinet secretary wishes to make an opening statement before we move to questions.

The Cabinet Secretary for Health and Wellbeing (Alex Neil): I will make just a brief statement, if I may, convener.

First of all, I want to take this opportunity to comment on the Public Audit Committee's recent "Report on the management of patients on NHS waiting lists". I welcome that committee's conclusions and accept its recommendations, and I assure this committee that we are already acting on them and will follow them through.

Secondly, I record that deliberate manipulation of waiting lists, such as that which was uncovered in Lothian NHS Board, is completely unacceptable. We have now had the most extensive scrutiny by internal auditors, by Audit Scotland and by the Public Audit Committee; hundreds of thousands of records have been examined and hundreds of staff have been interviewed. It is important to note that no evidence has been found of further deliberate manipulation.

Thirdly, on social unavailablity—which, of course, is now historical, given that we have replaced it with patient unavailability—I stress that it was originally designed as part of the new ways approach of trying to be fairer to patients; indeed, Audit Scotland acknowledged that in a report in 2010. It was intended to offer convenience and choice to patients without their having to leave the waiting list if the appointment that was offered was unsuitable. Our replacement patient unavailability rules are much tighter and mean that unavailability must be agreed in writing by the patient.

Fourthly, I assure the committee that the Government will ensure that all the recommendations in the reports that have been produced by the Public Audit Committee, Audit Scotland and internal auditors will be implemented as quickly as possible. The vast majority of the recommendations have already been implemented and those that remain are being actioned and

should be implemented by late autumn, at the latest.

Instead of merely reacting to audit actions, we have also begun an assessment of the overall control framework for waiting times in order to ensure that we have robust controls at every stage. By December, we will have the reports and follow-up audits by internal auditors and Audit Scotland.

Finally, because of our 155,000 hard-working NHS staff, waiting times are now at their lowest-ever level. There are now 53,000 people on the waiting list, which is a record low for the national health service in Scotland and is, obviously, of enormous benefit. I hope that the committee will not only accept that, when compared with other countries, Scotland leads the way, but will take comfort from my commitment to improving information systems and transparency, as well as performance.

The Convener: Thank you, cabinet secretary. Bob Doris will ask the first question.

Bob Doris (Glasgow) (SNP): Good morning. I should really declare an interest. I sat through the Public Audit Committee inquiry on this matter, so I have to say that this meeting feels a little bit like groundhog day. Unsurprisingly, I might well refer to one or two of that committee's recommendations.

The Public Audit Committee heard that there was no deliberate manipulation of waiting times in health boards other than Lothian NHS Board, and heard reassurances from the Information Services Division of NHS Scotland that 94.3 per cent of patients are being seen in under 18 weeks and that there are no hidden waiting lists. However, that committee also expressed a number of concerns about the checks and balances that are in place to ensure smooth running of the system.

NHS Greater Glasgow and Clyde, for example, has decided to monitor waiting lists monthly by taking a sample and going back through the records to ensure that patient-advised unavailability has been recorded correctly and that the system is robust. The Public Audit Committee recommended that that approach be taken by every health board in Scotland. What assurances can the Scottish Government give that it will work in partnership with each and every health board to ensure that NHS Greater Glasgow and Clyde is not the only one that will be reinforcing checks and balances?

Alex Neil: Instead of giving the committee just an assurance, I will give a commitment; we are insisting that all 14 territorial health boards and the Golden Jubilee hospital do exactly what Bob Doris has just suggested. We are also doing the same at national level; ISD Scotland, my officials and others now meet monthly not only to monitor progress in a very detailed way, but to take an overview of implementation of the new systems and the new set-up that I have briefly described, and to examine issues that need to be addressed with regard to interpretation of statistics, implementation of rules and so on.

At national and board levels, very detailed scrutiny of the figures is taking place each month to ensure that they are robust and that we are providing not only relevant information but information that boards and the national department can believe.

Bob Doris: If a health board were this month to identify an internal issue with the process, would that be fed directly to you at next month's national meeting?

Alex Neil: Such information would probably be fed to me more quickly than that. If such an issue were to emerge, the likelihood is that the chief executive of the NHS board or one of his or her officials would notify my officials and we would tackle the matter right away. Instead of waiting from month to month, we are being much more spontaneous and are tackling, and taking action on, issues and problems. After all, if a problem that emerges in one board area turns out to be a more generic issue that is affecting other board areas, we will want to know about it and deal with it quickly.

So far, one board has highlighted a couple of problems, but they were not that big and it turned out that there were perfectly good and rational explanations for them. We are in constant dialogue with the boards: I am in dialogue with the chairs, Derek Feeley is in constant dialogue with the chief executives, and John Connaghan is in constant dialogue with his counterparts on the boards. At every level, we are ensuring that the statistics are robust in every possible way.

Bob Doris: It appears, in that case, that the checks and balances are about tackling issues in real time instead of waiting from month to month to do so.

ISD Scotland told the Public Audit Committee that it saw nothing particularly unusual in increased use of unavailability codes, given the move from the previous Executive's hidden waiting lists to ensuring that everyone who was waiting was on a mainstream waiting list. One of the reassurances that I received from ISD Scotland was that it collected figures for patients' total waiting times irrespective of any patient-advised unavailability or whatever—indeed, that is where the 94.3 per cent figure came from.

Can any lessons be learned about the relationship between ISD and the vast majority of figures that it collects, and the Scottish

Government, in order to provide another check and balance, or even an early-warning system, with regard to irregular patterns? What would be ISD's role in that respect? Would it simply collect the data or would it analyse them and make representations to Government?

Alex Neil: ISD is the agency that collects the data. It also takes a proactive role with us in monthly monitoring of data and in ensuring that interpretation of the data is carried out at national and board levels. If there are trends—things should not get that far; potential problems should be nipped in the bud before they become trends—or questions regarding aspects of the data, we would raise them with ISD, if it had not already raised them. The purpose of the monthly monitoring meeting is to ensure that issues are identified at national level as well as at board level.

We are doing two things. First, we are monitoring the boards, both with regard to the data and with regard to implementation of robust systems to ensure that the data are reliable, based on the recommendations of the Auditor General for Scotland and the Public Audit Committee. Also, we examine the data ourselves at both local and national levels to ensure that we are satisfied—along with ISD—that the data are robust.

The whole purpose of the data is to provide a management tool. If there are problems with waiting times—we know that some boards have problems and are not yet achieving the target, or are experiencing more breaches than others—we identify those situations and deal with them, in conjunction with the board.

Bob Doris: I have, for now, one more question on this topic, although I will perhaps come back in later.

You have already alluded to the subject of this question, which is the nature of waiting time targets if they are not met or if there is slippage. That is never a good thing, but one of the useful results is that it identifies pressures in the system. The Public Audit Committee heard that one of the reasons for the increase in unavailability codes in Glasgow was increased pressures in the system, into which investment was then put. How do you expect health boards will use information on waiting times to ensure that there is the appropriate resource allocation to meet targets, where there is slippage?

I will ask a second question, because I am not going to come back in after this one. I have a constituency interest in Greater Glasgow and Clyde NHS Board. Technically, that board did not apply the rules regarding social unavailability or the like, because it offered three appointments for which a patient could deem themselves to be socially unavailable—going on holiday or for whatever other reason—before the patient was referred back to their GP. That was technically outwith the two attempts that patients are allowed under the national waiting times policy. The Public Audit Committee discussed whether, by going beyond the minimum requirements, that health board was implementing the policy, as required. Could you confirm whether that would be allowed? More important, if Greater Glasgow and Clyde NHS Board can offer patients three attempts to find a suitable appointment for surgery and the like, could that be done elsewhere?

Alex Neil: I will answer both those questions and I will give Derek Feeley and John Connaghan the opportunity to supplement my answer, as they may wish to introduce some additional points.

First, on the pressures, it is important to understand that we do not consider only waiting times, but have a suite of data; we have data coming out of our ears in the national health service in Scotland. I look at monthly reports that are prepared specifically for me and the management board, which I now chair through monthly meetings of board chairs.

We are examining a wide range of performance issues, including delayed discharges, staff numbers and the staff mix. We are considering investment, capital projects, waiting times in terms of the accident and emergency target, waiting times in terms of the guarantee, waiting times in terms of the 18-week target and waiting times in terms of specific issues such as the 31-day and 62-day targets in relation to cancer, for example.

We consider a wide range of statistical data in order to identify where there are pressures in the system. Where we identify pressures or where a board indicates to us that it has pressures, we work with that board to address them. I could give you many examples of that.

We cannot consider waiting times or any one statistic in total isolation because we are looking at an entire national health system. Sometimes people do not realise the level of demand that the national health service in Scotland is dealing with.

10:15

Some of the statistics are very interesting. For example, 1.5 million people a year present to our 24 accident and emergency units. Half the population at any one time is under the care of the national health service; it might just be for a repeat prescription or it might be for a terminal illness. One third of the entire population has more than one thing wrong with them at any one time and there are 6 million consultations with doctors a year. The scale of the operation has to be understood. In an operation of that scale, we have to look at a wide range of data on an on-going

basis in order to identify problems, and to identify failure and success in the system.

A good example of how we are improving things technologically is the launch of the new digital tracking system that is being piloted in the Borders and will be rolled out to all the health board areas. It is a useful management tool at ward level but, because of the information that it summarises, it is also useful at hospital level. It will eventually produce information at national level. This time next year, therefore, we will have access to much more real-time information and we will be able to identify what is happening almost bed by bed.

Such tools are extremely important and, in the fast-moving environment of many wards where patients are being moved in and out, it is important to have them. We now have an unprecedented level of collection and analysis of statistics using tools like the one in the Borders that I have just described. We will have as much real-time information as we can collect.

We can, therefore, now identify the pressures on the system and deal with them quickly. Sometimes the solution cannot be found in a day; sometimes it takes a bit longer. A good example of that is how we are dealing with the pressures in accident and emergency. Those pressures are not confined to accident and emergency departments; we are talking about the flow of patients through the hospital. If we increase, as we are doing, the percentage of patients who are discharged in the morning, that relieves the pressure from patients who are coming in from accident and emergency and are waiting for a bed in a ward. We have to look at the entire flow of patients right through the hospital. We cannot look at just one department or one statistic; we have to look at the whole thing.

Bob Doris's second question used NHS Greater Glasgow and Clyde as an example of a health board that was exceeding the targets that we set by offering three instead of just two alternative appointment dates. It is really up to each health board whether to go above and beyond the targets that we set. In general, I would encourage them to do so, as long as it is not done at the cost of other, more significant, targets. It is important to be consistent with the minimum standards and targets that are to be achieved right across the health service. If a board believes that it can excel, of course I encourage it to do so, as long as it not at the cost of failure elsewhere in the system. Derek Feeley and John Connaghan will add to that.

Derek Feeley (Scottish Government): As the cabinet secretary said, and as Mr Doris recognised, a reasonable offer in our waiting times guidance is two or more appointments within a minimum of seven days' notice from the date of the offer of the appointment. It is easier for some boards than it is for others to go beyond that. For example, Glasgow has the Golden Jubilee hospital more or less on its doorstep and that increases the reach for NHS Greater Glasgow and Clyde's patients. It is more of a challenge for the health boards in Grampian or Highland to make use of that kind of facility. As the cabinet secretary said, we encourage every board to do as much as it can and to go beyond the guidance if it can, but that can be easier for some than it is for others.

John Connaghan (Scottish Government): The cabinet secretary has laid out clearly the fact that boards are paying a lot of attention to capacity requirements, and to the need to match demand with available capacity and to expand capacity when that is necessary to cope with demand.

We need to look at how the NHS is meeting the targets. It has made a significant investment in redesign and transformation across the entire patient pathway. It has coped in the past 10 years with a significant increase in hip, knee and cataract operations: there were almost twice as many such operations in 2011-12 as there were in 2000. The number of cataract operations stood at 19,000 10 years ago, and it has now reached 32,000; the number of hip replacements, which stood at 4,000 back then, has now reached 7,500.

The NHS could not have done that work without redesigning the patient pathways and investing in the different elements. There is significant extra output, and the number of people on waiting lists at present is the lowest ever recorded.

The Convener: Can we get some clarity on the difference between now and then, and on what brought us to the current situation? Why did we not do in the past what you are telling us that we are doing now? What is different? What were we not doing over that period of years?

Alex Neil: When the revised system was introduced two or three years ago, certain issues developed, particularly in relation to the interpretation of social unavailability, which came to light as a problem after the situation in Lothian. Intense examination of the practices subsequently took place right across the system.

The Convener: Were the figures not available to health department officials? Were they not discussed with the cabinet secretary? My colleague Richard Simpson, who is not here today, first lodged questions about waiting times, lists and codes in 2008-09. What would the reaction of the health department have been to that sort of information? I know that you were not there at that time, but what action would the department have taken?

Alex Neil: As you say, I was not there, so I will pass the question on to Derek Feeley in a minute.

I have spoken to my predecessor, Nicola Sturgeon, who made it clear that excellent information was provided to her on a range of statistics, some of which I have mentioned and which included statistics on waiting times. However, it is clear that the interpretation of some of the rules in some board areas was somewhat different from the interpretation elsewhere.

I will hand over to Derek Feeley, who can give you chapter and verse on what was monitored.

Derek Feeley: The Public Audit Committee's report is quite clear on those points. There was a steady increase in social unavailability, from its introduction in 2008 all the way through to a peak in December 2010. There was subsequently a decline, which was slow at first and then quicker, down to more or less the current levels.

The Convener: I am just thinking about the process. When something like that happens, does someone not look at the codes? Did someone not look into the variance and the problems that existed, and say, "These codes are not proper—there is massive variance here"?

What happens in the health department when something like that is brought to your attention? What did you do about it?

Derek Feeley: There are a number of issues in that question. First, there has been a range of scrutiny of such issues over a long period. Audit Scotland has carried out a number of examinations; it raised some issues regarding the variance in—and certainly some issues regarding the recording of—social unavailability. However, Audit Scotland did not raise any issues with us about the level of social unavailability.

There was nothing in that pattern—the steady increase over 2008 to 2010—that leapt off the page and said, "You've got a big problem here."

The Convener: So it all happened in the health department that you were running along with the cabinet secretary, and it was not a real concern to you. You felt confident that nothing was going wrong. Did you not discuss it? What happened?

Derek Feeley: Again, this is in the evidence to the Public Audit Committee and in the report—

The Convener: Mr Feeley, I am just—

Derek Feeley: Let me be quite clear. We did not raise any alarms or concerns about that steady increase in social unavailability over the period 2008 to 2010.

The Convener: I know what the Public Audit Committee said, but the Health and Sport Committee must look beyond that and ask whether we can trust the boards and processes now. It is obvious that codes were not entered properly, that insufficient information was put into the system, and, indeed, that fraudulent practice happened in your health department.

Derek Feeley: There was no fraudulent practice in my health department.

The Convener: Is manipulation too strong a word?

Derek Feeley: That took place in NHS Lothian, not in my health department. If you mean NHS Scotland, there was evidence of deliberate manipulation in NHS Lothian but no evidence of deliberate manipulation beyond that.

The Convener: Is that not bad enough? Before we can move on, surely we have to understand what happened.

Derek Feeley: As the cabinet secretary said in his opening remarks, we recognise that what happened in Lothian was unacceptable.

The Convener: Does that imply that the other practice, of inputting insufficient information, was acceptable?

Derek Feeley: There is no evidence that that constituted deliberate manipulation.

You asked what is changing. First, we have replaced social unavailability with patient-advised unavailability, to help bring clarity and transparency to the reasons why people are unavailable for treatment.

Secondly, there is an assumption that social unavailability is a bad thing, but that is not the case. Social unavailability is not in itself a bad thing. When it is used properly, it is a proper and appropriate conversation between the health board, the clinical team and the patient about finding a time that is suitable, taking account of the fact that patients can have holidays, caring responsibilities and a whole host of other things that affect their availability for treatment.

Thirdly, there is no question but that our capacity in the NHS to record the reasons for social unavailability has not been as good as it should have been, and we are in the process of putting that right through the introduction of patient-advised unavailability and through the increasing roll-out of the TrakCare system and better information technology systems to help us record that information. There are a number of improvements in place to ensure, so far as we can, that what happened in Lothian does not happen anywhere else.

The Convener: Were you not concerned about figures that were particularly high at one point and then plummeted? Is a 50 per cent cut not an indicator that concerns you?

Derek Feeley: As I said, there was nothing in the steady increase to 2010 that gave us cause for concern.

The Convener: What do you glean from the monthly figures—with all the various codes and numbers—that have been placed in the Scottish Parliament information centre by the cabinet secretary in response to a question by Richard Simpson? I refer to the reference in the answer, "Bib. number: 54884". What do you find from those monthly figures now?

Derek Feeley: I do not have those numbers in front of me, so I cannot comment. I would be happy to write to the committee with an explanation.

The Convener: Cabinet secretary, have you had a discussion on those monthly figures? You indicated that you had regular discussions on the figures. Are there any variances or issues with them? Is there a global picture?

I am trying to get an understanding of the process, of what happened in the past and of what is different now. People are sitting down every month and poring over those figures to provide reports to the cabinet secretary and, if there are variations, peaks and troughs, they should sweep into action. What have the monthly figures shown up over that period of time?

Alex Neil: We have placed a lot of information in SPICe. To clarify, are you talking about the new figures?

The Convener: Yes, I think I am. There are reams of them.

Alex Neil: We have got reams of everything—we have got reams of figures going back for years. Are we talking about the current figures?

The Convener: Yes. They are for the quarters ending 31 March, 30 June and 31 December in the years 2008 to 2012.

10:30

Alex Neil: So you are not talking about the current figures.

The Convener: No, but they are for the period after the first audit report. We are talking about the time after the new package was introduced—it is after the audit scandal. We are examining the figures, and we are talking about the new regime.

You told us earlier that you have a monthly meeting to discuss all the figures. They are provided to you, cabinet secretary, are they not?

Alex Neil: Yes, absolutely.

The Convener: So what have the trends over that period shown us?

Alex Neil: The main trend has been the substantial reduction in waiting times up to today when the figures that were published at 9.30 this morning showed the lowest ever number of people waiting in the national health service in Scotland. I would have thought that the Health and Sport Committee would be glad about that.

The Convener: Yes, and it would be glad about the headline figure, but the figures in SPICe show the failing to attend figures in Glasgow dropped by something like 50 per cent between June and December 2012. Does that ring any bells or dredge up any memories?

Alex Neil: What you will find in Glasgow as elsewhere is that, in the new patient-advised availability system in which patients are being contacted more often and in which confirmation has to be given in writing, some patients are coming back and saying that they are not available. The system is being cleaned out, as it were.

The Convener: So there is nothing in these figures that gives you cause for anxiety.

Alex Neil: No.

The Convener: There is nothing that gives you concern or makes you want to take action or give consideration within the health department.

Alex Neil: I came into the job in September last year and social unavailability was replaced on 1 October with patient-advised availability. The system is much more robust but, in the transition from an old system to a new one, there will be changes. Clearly, the health boards were doing a cleansing exercise to ensure that, when they introduced the new system, its baseline would be as accurate and robust as possible. We have explained before that that exercise was being done.

It should also be remembered that NHS Greater Glasgow and Clyde has gone from 11 information technology systems, which is what it was until we came in, down to three, and it will go down to one. That will also be part of the cleansing process. As someone who has a background in computers, I can tell the committee that, when we rationalise, streamline and put IT systems in order, all the old stuff is dumped if it is inaccurate or no longer in situ.

As part of the process, and the implementation of the recommendations from the NHS Greater Glasgow and Clyde's own audit in its own case, every health board has to clean up its database.

The Convener: Do the variations between the health boards not concern you? If Glasgow is proceeding at such a pace, why are the others not?

Alex Neil: I will bring in John Connaghan, but when a board is moving from 11 databases to three to one database it will mean a lot of cleansing. It is a very big board area.

The Convener: IT has been used as an excuse in the past and Audit Scotland has refuted the reasons given.

John Connaghan: We are talking about a set of statistics that you have, but we do not have them in front of us. We publish hundreds of thousands of statistics every month and quarterly so it would be useful to be talking about the same dataset.

There are some valid reasons why health boards differ. I will take Glasgow as an example. NHS Greater Glasgow and Clyde is a tertiary board that has a number of specialist services. Let us compare that with Orkney, which exports patients to places such as Grampian and Glasgow. Not all boards do the same things. Orkney does not have cancer services or neuroscience but Glasgow does, so each health board will have different treatment rates and did not attend—DNA—rates.

We must therefore understand the basic nature of the function of the health boards to be able to comment adequately. As the director general has said, we would be more than happy to supply any commentary on any published set of statistics that is put into SPICe.

The Convener: That may be useful for all future figures, even those that are not laid in SPICe.

I am trying to establish what the new ways process was. The cabinet secretary and the health board heads were having regular meetings, and they had all the explanations for variations and were completely confident about them. That was the new regime.

John Connaghan: If we are not confident about a set of statistics, we take that up with the local management team. A regular discussion is held with each set of chief executives on a monthly basis. The director general chairs the meeting, and the cabinet secretary chairs a similar meeting with board chairs. The statistics, which are published and are open and transparent to everyone, are discussed at those meetings.

The Convener: How often in the past few months have you been in a position in which you felt that you had to raise the issue of variance with the various chief executives of the boards?

John Connaghan: We seek to understand what is happening in each board. If we spot an issue with the number of cataract operations that are performed in a board area—if it is unnaturally low and the waiting list is growing—we raise that with the board in question.

I will give you a good example. We know that the demand for cataract operations is growing; I have already given you an idea of the 10-year history of that growth. We have an ageing population, and we have taken the decision in the past quarter, in discussion with boards, to increase significantly the capacity in the Golden Jubilee hospital for hip, knee and cataract operations.

That decision came as a result of the conversations that we have with boards to understand the pressures that they are facing from our ageing population and the subsequent increase in demand. It is a prime example of how we have that debate with boards.

The Convener: So it is a normal occurrence to discuss those variations.

John Connaghan: It has been a normal occurrence for the past 10 years.

The Convener: I think that you have said it all, in that case. If such discussions have been taking place regularly for the past 10 years, why did they not address some of the issues that we discussed earlier? What has changed?

Alex Neil: A lot has changed. The data that are collected have changed, and social unavailability has been replaced with patient-advised unavailability. Everything around the process has changed—for example, there is a requirement for a letter to go out to the patient to confirm their unavailability—as a result of the recommendations that were made and implemented.

The Convener: Has the number of people who are being referred back to their GPs increased recently?

John Connaghan: The number of patients who are referred back to their GPs has increased in the past two or three years. There was, in fact, an Audit Scotland recommendation on that issue.

The Public Audit Committee raised some issues regarding patients in Highland. Patients in the system should be formally reviewed every 13 weeks and, if there is no prospect of treatment, they are returned to their GPs. Many boards took a rather benign view of that and decided to keep patients on waiting lists until they were ready for treatment. That is probably understandable in a rural setting, such as the Highlands or Grampian, where many folks are involved in crofting and farming and in the fishing communities.

There has been an increase, and the cabinet secretary has outlined the fact that more rigour has been attached to the scrutiny of the number of people on that list, in line with Audit Scotland's recommendation. The number of patients who have been returned to GPs in the past six to nine months is definitely greater than it was in the previous period.

Drew Smith (Glasgow) (Lab): I will go back to Bob Doris's questions, in which we discussed some of the issues related to capacity and pressure in the health service. Why should there be a correlation between social unavailability and areas of pressure in the health service? We can well understand that such pressures create capacity issues in the health service, but why should there be such a strong correlation with a rise in the unavailability of patients?

Alex Neil: I did not say that there was a correlation between social unavailability and pressures—I was answering a different question. There were two separate questions: one was about social unavailability and the other was about pressure. I have never said—

Drew Smith: The Audit Scotland report said that

"social unavailability tends to be higher in specialties with ... more pressure on capacity".

Alex Neil: It would be higher in specialties, obviously. John Connaghan mentioned a good example. Sometimes people have to travel quite a distance from the north of Scotland to get specialist treatment in Glasgow or Edinburgh, or at the Golden Jubilee hospital. Very often, where long distances are involved, patient unavailability is greater than it would be if the facility was on the patient's doorstep.

John Connaghan: I refer Drew Smith to the interesting evidence that was given to the Public Audit Committee by Robert Calderwood, the chief executive of NHS Greater Glasgow and Clyde. He stated:

"It is clear that Audit Scotland has not identified manipulation across the NHS in Scotland. As I showed with the orthopaedics example, if the report had used the July 2011 figure ... The report quoted the month of May 2011, saying that 40 per cent of the waiting list was socially unavailable—145 patients. If it had quoted the month of July, that number would have dropped to 42."—[*Official Report*, *Public Audit Committee*, 13 March 2013; c 1276.]

The reason why Mr Calderwood gave that example is that, sometimes, consultants themselves can become unavailable to provide treatment because they are sick or because they have moved on and there is an interregnum between appointments with consultants. From time to time, there will be a small spike in the number of patients who are unavailable because they do not wish to travel to another hospital but prefer to remain in situ and wait at their own hospital until a new consultant becomes available. That is usually a relatively small period of time, as per the example of orthopaedics in Glasgow, where it was the case for a month or two.

Drew Smith: You are right to quote Robert Calderwood, and I think that people can understand his perspective on the issue. However, we should note that the first recommendation in the Audit Scotland report tells us that the IT systems did not allow sufficient data to be recorded to be able to establish whether codes were being applied appropriately. I do not think that the data proves anything one way or the other.

The example of orthopaedics at the Western general hospital in Glasgow has been raised a few times. Hundreds of patients were apparently all unavailable at the same time in January and February 2012. Are you saying that the surgeon—or a specialist of some kind—who was responsible for those operations was unavailable?

John Connaghan: Mr Calderwood gave two examples: one from ophthalmology and one from orthopaedics. I cannot remember which was which with regard to the unavailability of consultants, but it is clear in the *Official Report* of the Public Audit Committee meeting on 13 March.

Alex Neil: Such a situation occurs against a background in which there are now very specialist consultants in certain areas. A consultant may specialise not just in one particular discipline but in a very narrow aspect of that particular discipline. There is a range of reasons why people would not be available. In some cases, the consultant might be off sick, and they might be the only consultant who deals with that very narrow specialty.

We are talking about a very complex system. It is not "The Royal" as it appears—or used to appear—on the telly every Sunday night; it is a much more complex modern health service.

Drew Smith: I think that my constituents would understand that, and I think that people who are waiting for treatment for painful conditions at an orthopaedics unit would understand that, too, if they discovered that they had somehow been marked as unavailable and it was suggested in Parliament that a large number of them were all on holiday at the same time, when it is clear that that was not case.

Alex Neil: The Auditor General investigated that issue specifically. As you know, Audit Scotland spoke to a number of people to find out why that spike had happened in Glasgow and found nothing untoward. It interrogated the non-IT system—it commented on the fact that the IT system did not provide enough information to carry out the analysis, so it undertook a paper exercise and did not find anything untoward in that specific example.

We have been through that three or four times.

Drew Smith: The cabinet secretary will probably understand why people will be concerned about any correlation between unavailability and pressures on capacity. We discussed A and E

earlier, and I presume that the cabinet secretary is aware of the information that we got from the Royal College of Nursing this morning, which stated:

"there are not enough staff, beds or resources within the system, in the right places, to deal with the increasing numbers of patients attending A&E".

What would be the RCN's motivation in bringing that to our attention this morning?

10:45

Alex Neil: The RCN is not saying anything new or anything that we have not said. I started by saying that one of the problems for A and E—apart from the increasing demand, which as you know has risen dramatically right across the United Kingdom in the past 10 years—is the complexity of the cases that are being dealt with.

Another problem is the flow through the hospital. During the winter surge period, things at A and E are at their most challenging in Scotland as a whole. The College of Emergency Medicine in Scotland did an exercise looking at the time that people spent at A and E and found that, even during that winter surge period, the median average time that people spent at A and E was under three hours. The problem arose in some hospitals when beds were not available in the wards at the time when they were needed—when people were discharged from A and E.

To give an example, one of the recent changes at the Edinburgh royal infirmary is an increase in much earlier discharge. There can be various reasons why patients who are ready for discharge have not been discharged—for example, the consultant perhaps does his rounds late in the day. In recent times, the ERI has increased the percentage of daily discharges that take place in the morning from 6 per cent to something like 21 per cent. That has a material beneficial impact on the availability of beds for people who are discharged from A and E and who are going to a ward.

One of the areas that we are working on with the College of Emergency Medicine—and other colleagues, because obviously it is consultants who service the wards—is improving the discharge situation. Indeed, one of our joint exercises with the College of Emergency Medicine showed that probably up to a quarter of people in hospital were there beyond the period when they could and should have been discharged. They might not have been discharged because the consultant was available only in the late afternoon and not in the morning or because the hospital was waiting for pharmacy products.

There can be a whole host of reasons for delayed discharge, and better management of discharge in the wards is one of the ways in which we can tackle the issues in A and E. If you analyse it properly, you see that the issues in A and E have not been internal to A and E per se. On average, a third of patients who are seen in A and E are then admitted to hospital, and the problem has been that they have had to wait on a bed before being admitted. By improving discharge from wards, we can improve the availability of beds and therefore reduce the number of people who are waiting for any length of time after discharge from A and E for a bed in a ward.

Drew Smith: I turn to some of the solutions that have been offered for the problem. We are aware of the action plan that is now in place to assist in getting people through A and E and through the rest of the hospital. However, the RCN briefing that we received this morning asks for more clarity. The RCN's perspective is that more front-line staff—nurses and allied health professionals—will need to be available to achieve the results that you are looking for, but it is not necessarily clear that that will happen. The RCN briefing asks about

"where the money that is behind the action plan is coming from".

Is the money coming from elsewhere in the health budget and, if so, where is it coming from?

Alex Neil: As regards the £50 million for the emergency action plan, as you know, we are increasing the territorial board budget substantially above inflation and substantially above the Barnett consequentials overall this year and next year. Therefore, the money available—

Drew Smith: So it is new money outwith the health budget.

Alex Neil: Absolutely. It is new money. The budget for the territorial boards is going up substantially above the overall increase in the Barnett consequentials.

Drew Smith: So is it money that was already in the health board budgets for this year or is it new money from outwith the health board budgets? I want to get clarity on that.

Alex Neil: The budgets for this year—the new financial year that we are in—and for next year show a deliberate decision to substantially increase the budgets for the territorial boards. One of the reasons for doing that is to address the A and E issue, and the £50 million comes out of that additional money.

Drew Smith: We are all supportive of the national confidential alert line, in which I have an interest, and we hope that it leads to some solutions to the issues. However, there were press reports at the weekend about the process that people enter when they call the alert line. Will you take us through that? If someone phones the alert

line this weekend, having been on shift all week, and says, for example, "I've been encouraged to mark somebody as unavailable when I don't really feel that would be appropriate," or makes some other complaint about the health service, how will that be treated? How is the issue escalated? It has been suggested that people are being told that they should raise the issue with their manager or even their trade union, which would take us back to where we started.

Alex Neil: I saw the comments from Kim Holt, and I have to say that I disagree with her when she says that the line is a waste of time. First, we had a number of calls from south of the border and, by definition, we cannot deal with problems in the English health service. Were that the case, things would certainly be done very differently from the way that they are done south of the border. I do not know whether Kim Holt was referring to those cases or to others. I am seeing her later this week or next week and I will ask her for more information on that feedback. Clearly, I would be concerned if she is getting such feedback, given that I set up the whistleblowing line to ensure that action is taken.

The line is run by an independent organisation called Public Concern at Work. I have asked for a monthly report on the outcomes of the calls. Obviously, that information will be anonymised. The alert line started only last month, so I would expect it to be two or three months before we see the outcomes. Some of the procedures might be fairly protracted. However, I asked right at the beginning that a monthly report be made, because I want to be sure that we are not just taking a call, recording it and then not taking the necessary follow-up action. I will ask Kim Holt for more detail about the people to whom she spoke to try to find out why that happened.

We have set up the whistleblowing line because we want it to be effective. There is no point in having it if it is not, and I am taking steps to ensure that it is. I do not think that we can reach a conclusion that it has been a waste of time six weeks after it has been established and after a survey of, possibly, three or four people. We have got to give it much more time. Although there might be cases in which the most appropriate action is to take something up with a line manager, that does not mean that the whole whistleblowing service is brought into disrepute. Public Concern at Work is an expert in the field and it is not part of the national health service, but an independent organisation. If that professional body is giving that advice, I presume that it must be doing so for a good reason. As I say, I will ask Kim Holt for information on the effectiveness of the line.

Nanette Milne (North East Scotland) (Con): I want to stick with the RCN briefing. Cabinet secretary, you mentioned the winter surge in A and E. However, the RCN briefing states that

"The NHS in Scotland is facing a perfect storm of all-year-round pressures",

and that, according to an RCN Scotland survey,

"nine out of 10 nurses ... working in NHS hospitals are experiencing pressures on beds all year round".

That means that the pressure is not just from the winter surge in A and E. Another part of the briefing refers to the increasing pressures on the service, particularly as a result of the impact of demographic change. As you said, the situation is changing rapidly. There is a question about whether we have enough staff, beds and resources to provide the high-quality care within the expected waiting times that have been decreed. Will you comment on that?

Alex Neil: Obviously, those are pretty perennial problems with the national health service. It was clear that we needed a more robust approach than has traditionally been the case. That is why, through the leadership of John Connaghan and Derek Feeley, we introduced the workforce planning tool and made it compulsory as of April for every board. The purpose of the workforce planning tool is to ensure that we have not only the right number of staff, but the right mix of staff in the right place at the right time.

The RCN and other unions have been working closely with us, and the feedback that I have had via Theresa Fyffe from the RCN is that that is the right way in which to deal with the issue. You have probably seen this morning the welcome figures on NHS staff. The number is up, and the number of qualified nurses is up as well. We are dealing with that precise issue in conjunction with the RCN and our other partners.

On the issue of beds, as you know, I announced last month the introduction of a bed capacity planning tool. Again, that is to ensure that we get the right number of beds in the right places at the right time and that we manage the bed resource properly. There are examples in which we have increased bed capacity because of a recognition of challenges in specific areas. For example, one reason why we face challenges in the Lothian area is that the planning that was done 10 or 12 years ago for the new Edinburgh royal infirmary grossly underestimated the increase in population in Edinburgh, by about 20 per cent. That is why we have had to create additional capacity in Edinburgh, on top of the ERI, to deal with that additional population.

On the general point, we recognise the pressures on the national health service, which are primarily because of the ageing population. To put that in perspective, over the next 20 years, the number of over-75s in Scotland will double, and

one fifth of everybody who is born in Scotland today is likely to live until they are at least 100 years of age. That puts into perspective not just today's challenges but tomorrow's challenges for every health service in the developed world.

Nanette Milne: Is there any hope of the NHS coping in the future, given all the challenges?

Alex Neil: Absolutely. I think that we are coping now. Today's figures show that we are coping but, more than that, we are delivering a record low in the number of people on waiting lists, and that is against a background of demand and throughput rising every year in the national health service. I mentioned the A and E figures. Ten or 12 years ago in Scotland, or when this Parliament was formed, just over 1 million people were presenting to A and E every year, but the figure is now 1.5 million. There are various reasons for that. The complexity of comorbidity associated with the ageing population is one of the major drivers of the pressures. However, we recognise the pressures, and that is why we are working with all the royal colleges, including the RCN, and with Unison and all the other people to address the issues.

There is no doubt that we face major challenges, primarily but not exclusively from the ageing population and the comorbidities that are associated with that.

Nanette Milne: It is a work in progress. I was interested in Mr Connaghan's comments about looking at other aspects of the health service and assessing what could be done differently. As you know, the committee has recently been looking in great depth at the scrutiny of medicines. It has been raised with the committee that the same scrutiny is not carried out of other procedures and issues in the NHS. Is there a case for doing throughout the NHS the detailed scrutiny that is currently done of medicines via bodies such as the Scottish Medicines Consortium?

Alex Neil: I will say a few words on that and then hand over to John Connaghan. I do not accept that there is not the same level of scrutiny elsewhere. Given the scrutiny of waiting times and waiting lists that has gone on in the past 12 months, I do not think that anybody who is being realistic could say that there has been a lack of scrutiny. We have had audit reports for every health board in Scotland and a report from the Auditor General, and we have had the Public Audit Committee and this committee examining the issue, as well as the work that we are doing. Lack of scrutiny has not been a problem in relation to waiting lists.

Nanette Milne: I was thinking about individual procedures and assessment of them.

Alex Neil: Right.

John Connaghan: Perhaps one thing that we do not do as well as we could is to broadcast enough of the work that we are doing around transforming the patient pathway. I will give you an idea of the activity that we have been involved in over the past three or four years. We have focused on five key changes to the patient pathway: improving referral and diagnostic pathways; treating day surgery as the norm; actively managing admissions to hospitals; actively managing discharge and length of stay; and actively managing follow-ups. All that work and all the associated redesign and scrutiny of how patients move through the system is adequately captured on our 18 weeks referral-to-treatment standard website, which contains an enormously rich amount of detail that captures the point that you are making.

11:00

Nanette Milne: My final question is on the alert helpline. We might not know yet—it might be far too soon—but have there been any noticeable calls from nurses? The RCN briefing that we received today shows that there are obviously still serious concerns in the nursing profession. Has that been reflected so far in the helpline?

Alex Neil: It is too early to do any analysis on that. We probably need to let the line continue for another two or three months to get any meaningful figures. We are advertising the helpline number on the payslip of every member of staff in the NHS. We are putting up posters and advertising the number widely throughout the NHS. Some people criticised us before we set up the helpline, saying that we would not get any response, and the same people criticised us afterwards, saying that it was ridiculous that we have had 35 complaints from the whole of the health service, which employs 156,000 people. Ye cannae win wi some folk.

Nanette Milne: I will certainly be interested to hear the breakdown of the calls to that helpline.

Alex Neil: We will be happy to share that information at the appropriate time.

Derek Feeley: I have one thing to add that might be helpful to Nanette Milne. Although the work is important and the feedback that we get from the alert helpline is absolutely vital, it is not in itself enough. That is one reason why we have been working up our workforce 2020 vision, a document that we will release in the middle of next month. We spoke to 10,000 NHS staff, who gave us their views on what it is like to work in the NHS in Scotland. We asked them about their values and what is important to them. As you would expect, the majority of those 10,000 staff were nurses. It is important to hear as many of the voices as we can and not just the people who feel

bad enough to phone the alert helpline. We are trying to do both.

Nanette Milne: I look forward to the publication of that report.

The Convener: It was important to put that on the record because, right at the heart of all the political debates about targets and all the rest of it, when we speak to the Royal College of Physicians of Edinburgh we get a similar message to that which we get from the RCN and others. Although waiting times and targets have been popular with successive Scottish Governments, they are not as popular in the health service. If it was left up to those who work in the NHS, they might identify different priorities. We should not forget that.

There is another side to the debate, however. We focus on waiting times and those who deliver the service, and we hear a bit about the change that needs to take place towards preventative strategies and the shifting of budgets, and how they are crucial to the delivery of the service. We are not just talking about the care pathways, although there is an issue there. There are people who are not in this room and not round this table who have a strong view on waiting times.

Gil Paterson (Clydebank and Milngavie) (SNP): I wonder whether the cabinet secretary could put into context what waiting times actually mean and perhaps quantify things by giving us figures from, say, 10 years ago. You say that the figure is at an all-time low, but what does that actually mean in terms of numbers and percentages?

Alex Neil: The up-to-date figures that came out today on the guaranteed treatment time show that 99 per cent of the 93,000 patients who were covered by the report were seen and treated within the guaranteed time of 12 weeks. So 93,000 patients were the catchment for the figures. John Connaghan has been in the NHS for much longer than I have, so if you want us to go back 10 years, I will defer to him. I should stress that he is much younger than me, but he has been in the health service for much longer than me.

John Connaghan: I could go back 20 years, if you fancy that.

About 10 years or so ago, the focus was on waiting lists and numbers. For example, back in March 2005, we had 112,000 patients on our waiting lists. The cabinet secretary has referred to the latest statistics, published today, which show that the figure is just below 53,000. That shows the significant change.

Back in 2005, some patients were waiting many months—in fact, sometimes years—for an out-patient appointment and for subsequent in-patient and day-case treatment. At that point, we in the NHS decided to turn our focus to tackling waiting times as well as looking at and keeping a grip on waiting lists. The cabinet secretary has outlined where we are today with regard to the number of patients who wait longer than 12 weeks.

To put that in context, we also need to look outside Scotland and put it in an international context. I refer the committee to a recent Organisation for Economic Co-operation and Development report that compared Scotland with the other home countries and countries across Europe. Scotland's position in that analysis was exceptionally good. On major procedures such as hip, knee and cataract operations, which are common, Scotland generally performed better than the other home countries. That report, which is dated 2010, will be repeated shortly.

Alex Neil: Derek Feeley has additional information.

Derek Feeley: I will add something that partially refers to a point that Drew Smith mentioned.

We should look at where we were on in-patient and day cases and the unadjusted median, which includes everything, including all unavailability. In March 2008, when social unavailability was at its lowest, the unadjusted median wait was 39 days. In December 2010, when social unavailability was at its highest, the median wait was 34 days. That shows that, in general, there is no direct correlation between the average amount of time that people wait and the extent of social unavailability. The trend has continued steadily downwards. There is no comparison between where we were 10 years ago and where we are today. As the cabinet secretary said in his opening remarks, that is down to the huge efforts that 150,000 NHS staff have put in to benefit patients in that way.

That is the connection between the two points that the convener made. We must remember that we are doing this for patients. The statistics only help to paint the picture about what is happening for patients. To return to John Connaghan's point, there is no question but that patients get care more quickly now than they did 10 years ago.

Gil Paterson: On the theme of the future for patients, the cabinet secretary explained that the number of people who present at accident and emergency is up by 1.5 million per year. Have you taken any account of or are you assessing how welfare reform will impact on the service? Is any work being done on that?

Alex Neil: We are looking at benefit reform. An obvious and immediate issue is that of the additional workload for GPs in providing letters to the Department for Work and Pensions. Nicola Sturgeon and I have raised that issue directly with Iain Duncan Smith and we have yet to receive any

assurance about how that situation can be improved. That is putting major pressure on GPs, particularly in GP surgeries in the more deprived parts of Scotland, where there are higher levels of unemployment.

From my experience as an MSP, let alone as Cabinet Secretary for Health and Wellbeing, I think that the additional stress that is being placed on people who rely on benefits because of worry about their income will have the impact of putting additional pressures on the NHS, not least on mental health services. The stress that people are being put under is affecting their mental health as well as their physical health. At a recent constituency surgery, I spoke to somebody who has been left with £18 a week to live on by the Department for Work and Pensions. That would put anybody under enormous stress.

The Convener: Has any work been done on whether social unavailability impacts on a particular group of people? We have an evidence session on community transport later in the meeting. You have all the figures on the people and groups and so on. Have you done any work with regard to people who are sent back to their GP, those who cannot make an appointment because they have to go to Clydebank, for instance, or people who cannot move or experience transport barriers? Have you determined whether inequalities are being affected and whether poorer people are more likely to be on the lists of those who have been sent back or failed to attend or whatever?

John Connaghan: We have considered that extensively over the years. I refer you to one of our newer policies, which seeks to address that very issue: the detect cancer early programme. It is interesting to note that patients from the lower-income deciles are less likely to access healthcare, and that is precisely where we are bending more effort to encourage patients to come forward, see their GP and visit the facilities. We want to raise the profile of the NHS and widen access for those folks. The detect cancer early programme has significant extra funds, with £30 million or so to invest in the course of the programme. We consider the issue, and some action is being undertaken in that area.

The Convener: Detect cancer early has been in place for a couple of years, has it not?

John Connaghan: It has. The programme started rolling out over the course of the last year.

The Convener: But we have not done any work in respect of the situation that we had with the codes and so on. It seems that the people who would be more likely to fail to attend or not to go through the system are more likely to be in the groups concerned. It might be wrong to suggest this, but they will not be sufficiently engaged in the first place, and they will be harder to reach. Would it not be worth doing some work to find out whether those people are being disproportionately impacted by recent events? I will not call it a scandal.

Derek Feeley: Some work has been done in the past on did-not-attends, and as a result we have been targeting some of the reminder systems, but I do not think that we have ever done an analysis of unavailability, either medical or social. We could certainly undertake to see what could be done.

The Convener: We will leave that up to the cabinet secretary, of course.

Aileen McLeod (South Scotland) (SNP): I welcome the latest stats, which show that waiting times are at a record low; I also welcome the fact that the number of qualified nurses is on the up. It is important to remember the progress that has been made over the past 10 years to ensure that patients across Scotland get quicker care. The 153,000 staff in the NHS are to be commended for their efforts.

Cabinet secretary, you said at the beginning of your opening statement that we have been through the most thorough investigations into our waiting times, with Audit Scotland reviewing around 273,000 transactions that took place between April and December 2011. The internal auditors interviewed 400 staff and are reviewing a further 200,000 transactions that took place between January and June 2012.

The Public Audit Committee made a number of recommendations in its report, and I am conscious that the Government will respond to those in due course. As you said, by the end of this year, you will have all the reports on the follow-up audits by the internal auditors and Audit Scotland.

Where do we go from here? What improvements do we need to consider making, so that we can identify pressures and address areas in which there are issues? For example, there is the £50 million unscheduled care action plan, which has been mentioned, and a new digital ward is being trialled by NHS Borders.

11:15

Alex Neil: We have a wide-ranging strategy for improvement throughout the national health service's field of activity. This morning, we are talking about waiting times and improving the flow of patients, and we have talked about the emergency and unscheduled care plan. We could go on to talk about the £45 million that we spent on research and development last year and the benefit that that is bringing.

For example, a lot of money has been spent on informatics in recent years, and as a result of the informatics research team's work the percentage of amputations resulting from diabetes has dropped by—I think—40 per cent. That is a very good example of how innovative scientific work can help us enormously in improving the health of the nation. I could give you many other such examples. The role of innovation and science and technology is essential to our realising our vision for 2020.

Family nurse partnerships are another example of the innovative work that is being done in Scotland. People are coming from the rest of Europe to see what we are doing in that regard.

I could give you a list of initiatives in various parts of the country. I was in East Ayrshire about a month ago to visit a telecare pilot project, as part of a conference. From Kilmarnock, we talked remotely to a patient in Dalmellington, 25 miles away. That patient is typical of the patients whom we deal with who have a number of long-term conditions. She is in her mid-70s and has chronic obstructive pulmonary disease and diabetes, and until a year and a half ago she was never out of hospital. Then she had a pod installed in her home as part of the telecare pilot—another 19 patients in her GP practice were involved in the pilot—and she speaks to the practice nurse almost every morning. She takes her own temperature and bloods, for diabetes, and other measurements. Her health has been much, much better in the past year and a half; she has not been back in hospital—she is back at the bingo. Among the 20 patients in the pilot, there has been a 70 per cent reduction in hospital admissions. That is where we are taking the health service, and we need to focus on such initiatives.

Richard Lyle (Central Scotland) (SNP): I have several questions. First, John Connaghan mentioned the tremendous increase in cataract operations. I am one of the patients who has benefited. At the end of last year I had one eye done. Prior to that, I had worn glasses for 30 years and could hardly have seen you, even though you are only five or six feet away from me. Now I have had the other eye done, and I can see 40, 50 or 60 yards away—unfortunately I still have to use glasses if I want to read something. I was impressed by the service that I got from the national health service. Thank you for that.

I was aware already that there are times when clinicians are not available, because of holidays and so on.

John Connaghan mentioned Robert Calderwood's evidence. I remind members that Robert Calderwood said:

"It was highlighted that in April 2011, 924 patients were on the waiting list at the Western infirmary under the term 'socially unavailable'. Had Audit Scotland picked July 2011, it would have found that the number was 343"—

that is, nearly two-thirds fewer patients. He went on to say:

"There was a very selective approach, whereby one waiting list was picked out of eight, in one month."—[*Official Report*, *Public Audit Committee*, 13 March 2013; c 1268.]

Do you want to revise that comment?

John Connaghan: No, I think that the comment is fairly accurate and has been lifted straight from the evidence to the Public Audit Committee. As I recall, Mr Calderwood made the remark to illustrate how swiftly things can change. The situation arose against a background of consultants or a service not being available locally and folks simply saying, "I'd rather wait to be seen in Stobhill than travel to the Victoria," for example.

We are lucky in that we have the Golden Jubilee hospital on board. We recently announced a £1.7 million expansion at the Jubilee, to increase the number of cataract operations that are carried out there by approximately 200 per cent. You know about our achievements on cataracts. We have achieved two things: we have not just reduced waiting lists but managed that against a significant increase in capacity. In 2000, the median wait was just under 100 days; it is now about half of that. In 2000, 19,000 cataract operations were performed; now 32,500 are being performed. As I said, all that has happened in the context of a treatment guarantee.

Mr Calderwood's remarks were accurate and I think that he was making the point that people should not look at selective and isolated statistics.

Richard Lyle: Cabinet secretary, you said that every year more than 1.5 million people go to A and E and that nearly half the population of Scotland is constantly in touch with the health service. As you know, in a previous life, I worked for two years with the out-of-hours service, and I visited all the A and E departments in Lanarkshire—at Hairmyres, Wishaw and Monklands. Do you agree that most people want to go to an A and E department in the first instance because they know that they will be treated well and as soon as possible, on the spot?

Alex Neil: A visit to A and E has become the default position for people when something goes wrong, particularly out of hours, but that is part of the issue that we must address, because it is clear that people turn up at A and E who are not there because of an accident or an emergency and who would be more appropriately treated through other means, such as going to their GP, if the problem is not urgent, using the NHS 24 service or going to a minor injuries unit, of which we have a number.

Part of the issue is to do with managing demand and looking at the demand profile in the health service across the board, but particularly in accident and emergency. Innovative work has been done at Ninewells hospital in Dundee to segment the people who present at A and E in a way that facilitates the management of urgent and perhaps life-threatening cases, which need to be dealt with right away, as opposed to minor, non-urgent cases. Many boards are doing something similar to manage people who present at A and E, to ensure that real emergencies are dealt with appropriately and that people who present with minor ailments are dealt with appropriately but perhaps not as urgently.

Richard Lyle: My final question is for Derek Feeley. The cabinet secretary commented earlier that you have data coming out of your ears. I go back to when the situation happened—I would not call it a scandal. Do you agree that some staff may not have been trained correctly and may have miscoded records because they did not know how to record someone who was unavailable?

I have done well over the past couple of months. When I attended my dentist last week for the first time in eight years, I saw a notice on the wall that said 52 appointments had been missed the previous week by people who had not turned up. I referred to my cataract operations. I received letters that said that if I was unavailable I was to phone a number, or if I was okay I was to go along. I did not want to miss the appointments, even though I was going on holiday.

Barbara Hurst of Audit Scotland said:

"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."—[*Official Report*, *Public Audit Committee*, 27 February 2013; c 1221.]

In your earlier comments, you indicated that you did not feel beaten up about the fact that unavailability had risen. Had unavailability risen not just because the system was bedding in, but because people had recorded it wrongly and inappropriately, because of a lack of training? Now that the new system is in place, we know exactly everything that is on the table. The data that the cabinet secretary said is coming out of your ears will now show what is happening.

I compliment you on the reduction in the number of people on the waiting list and on how well the staff in the health service have worked. Having been to an A and E department two years ago, I recommend that people should go to one to see how quickly and well they work.

Can you say that we are getting to grips with the situation?

Derek Feeley: Yes.

Evidence that some of the chief executives gave to the Public Audit Committee and findings in the Audit Scotland report definitely identified training as an issue. It is entirely realistic to say that training was a factor.

You mentioned Barbara Hurst's point about targets. I told your colleagues on the Public Audit Committee that targets focus attention. As long as we constantly strive to have the right targets—and not too many of them—they have a place. However, setting targets is not always the answer.

We try other means of improvement. Today in Glasgow the second learning session is taking place of the early years collaborative, through which we are trying to improve outcomes for young people. Although that is a completely different approach to improvement, it demonstrates that we are still trying to improve.

There are two things that are important when you set a target. The first is that a target should be accompanied by the things that John Connaghan mentioned in the context of redesign: you have to provide people with the means to deliver it. The second is that you have to think about what principles to apply when you performance manage it all. One of our big strengths in the NHS in Scotland is our partnership working. When we sat down with partnership organisations, we agreed some principles for performance management. One was that we put patients first, so patients come before the target.

Richard Lyle: Thank you.

Jayne Baxter (Mid Scotland and Fife) (Lab): I am new to the committee but have listened with great interest to all the information that has been shared this morning.

I note that the Public Audit Committee felt that the information supplied to members of NHS boards

"should be sufficient to allow non-executive directors to provide an effective challenge function."

I have had the pleasure of being a non-executive director of an NHS board. Sometimes, we were given copious amounts of impenetrable information. Have NHS boards been given any guidance on how to translate all the information of the sort that we have heard about this morning into knowledge and understanding? That and some consistency throughout the country are what need to come out of this situation. Is there any guidance to boards and managers at board level about how the information should be presented and interpreted?

11:30

Alex Neil: At the last chairs' meeting, we discussed making sure that the non-executive directors fulfil their scrutiny role and know what questions to ask. We indicated some questions that should be asked, given that the role of non-executive directors is to hold the executives in the health board to account.

To be frank, I would like non-executive directors to be more robust. As part of the review process, I have initiated a series of bilateral meetings between me and the non-executive directors, with none of the executive directors present—my first one was with Ayrshire and Arran NHS Board's non-executive directors—so that they get the message clearly that I expect them to hold the executives in the health boards to account. That means that they must probe and ask questions. If information is presented to them in an unacceptable fashion, as you described happening in Fife, they should say to the executives that it is not acceptable and that they want information in a much more understandable format. That is the non-executives' job, and I would like them to take a more robust approach.

Jayne Baxter: I am glad to hear you say that. Thank you.

Drew Smith: We have the advantage of working in real time this morning with the new waiting times information that the cabinet secretary has given us. Will he also give us the detail on the accident and emergency target, which was downgraded from 98 per cent to 95 per cent? Did we achieve the old target or the new target this time?

Alex Neil: It was not a downgrade. We are saying that we must get to 95 per cent before we get to 98 per cent, which is obvious.

Drew Smith: Did we make 98 per cent today?

Alex Neil: A number of boards are at 98 per cent, and a number are at 95 per cent and are aiming towards 98 per cent. This morning's figure for Scotland as a whole is 92 per cent. That is not as high as I would like it to be, but it is certainly moving in the right direction. We need to get to 95 per cent and 98 per cent. That is our objective.

Jackie Baillie (Dumbarton) (Lab): That just teaches us that we should be careful in the claims that we make.

The number of nurses was originally cut by 2,000. I understand the figures to represent a cut of 1,500 or so. I do not regard it as good news for you simply to replace a quarter of the number that you cut—but heigh-ho.

I will focus on the codes that the convener raised with you. There are a variety of codes—I assume that you know them. Codes 20, 21, 37, 38 and 40 to 42 relate to monitoring information from 2008 to 2012 based on quarterly snapshots.

Code 38 is used when a patient does not attend for an in-patient appointment or an out-patient appointment. You record the numbers separately, which is helpful. Is that information recorded as part of the overall social unavailability statistics that have been the subject of much discussion over the past few months?

Alex Neil: I do not accept the point that you make about nurses. The key point is that the number of qualified nurses is on the increase. We will park that for the purposes of this discussion, which is about waiting times, although I would have thought that the increased numbers that were published this morning would be welcomed.

A number of the codes are no longer used. Code 20, which was the subject of some attention, is no longer used for fairly obvious reasons. Basically, it allowed people to say that they were still unavailable but wanted to stay on the list, when the medical decision was that it was not appropriate for them to stay on it.

Some of the codes are no longer relevant, but I ask John Connaghan to reply on the detail of code 38.

John Connaghan: If I understand Jackie Baillie's question correctly, she is asking whether we record CNAs—cannot attend—and DNAs separately from social unavailability. The answer is that we publish all those statistics separately on the ISD website. The number of CNAs and DNAs and the level of social unavailability can be seen.

Jackie Baillie: They are published separately.

John Connaghan: You can see them on the ISD website as separate statistics.

Jackie Baillie: I want to be absolutely clear, because this is an important point. What we have been talking about—whether or not you call it a scandal—

Richard Lyle: You called it a scandal. [*Interruption*.]

Jackie Baillie: We have been talking about the social unavailability figures and how the codes are used. I am trying to establish whether a code 38—a patient who did not attend—is recorded as part of the statistics that we have been looking at, or whether that is recorded separately.

John Connaghan: I will certainly write to the committee to clarify the point, but it is published separately. The number of patients who are recorded as CNA, socially unavailable or DNA can be seen clearly.

Jackie Baillie: It is genuinely a simple question. Are the figures within the socially unavailable figures that were quoted, or are they separate? If they are separate, there will be thousands of people who have not even been recorded under the social unavailability statistics.

John Connaghan: Social unavailability follows contact with the patient. Such records now show patients who have advised that they cannot attend or wish to change their appointment. If there is a DNA, it is clear that there has been no contact with the patient—the appointment has been made and the patient has simply not turned up. That is completely separate from social unavailability.

Jackie Baillie: That is very helpful—that is what I was driving at. There are potentially thousands more people who are not counted in those sets of statistics because they are detailed as a code 38—they did not attend.

John Connaghan: I am not quite sure that I agree with your interpretation. However, as I said, I will write about the operation of code 38 if you think that that would be helpful.

Jackie Baillie: It would be helpful, yes.

NHS Greater Glasgow and Clyde has been the subject of much discussion this morning. So that you understand my point, I will quote the figures that you supplied as you do not have them in front of you. The out-patient non-availability figure, which was 2,574 in June 2012, drops to 548 in December 2012. The figure for in-patient and day-case treatment, which was 382 in June 2012, was 11 in December 2012. Are the good people of Glasgow getting much more organised and punctual? What else is going on?

John Connaghan: I suspect that you may be looking at the residue of patients still recorded under new ways. You will remember that we have introduced a new system. If you look at the operation of the new system across Scotland, you will find that the number of patients recorded as "patient-advised unavailability" was zero on its introduction. Now, with the latest statistics, you will find that the number so recorded is around 9,000. You need to be careful not to confuse old data sets with the new data sets that have been introduced. I am happy to write and explain how the statistics interrelate.

Jackie Baillie: That would be helpful—particularly, going back over the old data set, how the figures were recorded and whether figures were recorded in addition to social unavailability. That could mean—this is my interpretation—that thousands more people were parked on a different kind of waiting list from the one that we have uncovered.

Alex Neil: As I said to the convener when he raised the issue about Glasgow, we should be careful not to compare apples with oranges.

The Convener: It is genuinely puzzling. You should be mindful that we are not experts, so this is a genuine point on which I am looking for clarification. We had a big shift in the numbers that has been explained away by the fact that there is a new system. Does the drop in the numbers mean that those people have been treated, or are they on other lists?

Alex Neil: I think that the best way in which to deal with this is for us to take away the specific points that have been raised and give you a very detailed response. We do not have the numbers that are in front of you and to which you have referred. I want to be absolutely sure so that something does not go on the record and we are then accused of misleading the committee.

The Convener: No, that has never happened, cabinet secretary.

Alex Neil: That is because we are so cautious—that is why it does not happen.

The Convener: If it happened, it would be a first. However, Mr Connaghan seemed to have the figures, because he gave us some detail about how the position would shift and some possible scenarios. So, have those people been treated? Are they on other lists?

John Connaghan: If I had the figures in front of me, I might be able to give you more detail, but I do not have them. My point to Ms Baillie was the general one that you should not confuse two data sets: one relates to an older system in which we would see patients naturally dropping off the list; and the other relates to our starting to populate a new system of patient-advised unavailability, where we will begin to see a rise in the figures. Both of those will naturally fade in and fade out of the statistics.

The Convener: We look forward to seeing the figures, which will inform the committee.

I return to the earlier question of why, if that is what happened in Glasgow, we are not seeing that trend elsewhere. Given our experience, surely a red flag goes up now if we see a variation. There is a variation in Glasgow that is not shown in other health boards. There has been a drop of about 80 per cent in Glasgow in failures to attend—they have disappeared: boom! However, the trend has not been reflected in other health boards. Why?

John Connaghan: The cabinet secretary referred to the fact that Glasgow moved from having about 11 IT systems to having a single system. Some boards have operated the TrakCare system for a number of years. As boards move towards implementation of the recommendations

on better recording and better systems, as outlined in the Audit Scotland report, they will have to move away from their old systems and start to populate new ones. That is one reason why some different trends will emerge as that relatively enormous task unfolds over the next few months.

The Convener: Perhaps we will just have to wait, but I am pleased that you have attempted to give some explanation for the variation, despite not having the figures. When the committee gets the figures from you, perhaps you will give us a proper explanation of the variation between different health boards. That would be helpful.

Jackie Baillie: There was criticism, which I think was touched on earlier, about the level of monitoring undertaken by the Scottish Government and ISD alongside health boards. Did you not have monthly meetings with chairs, chief executives and ISD previously? Is that something new? What have you done in the relationships and governance structures that is different from what happened previously?

Alex Neil: I understand—in fact, I am sure—that, like me, my predecessor held monthly meetings with the chairs. Derek Feeley holds monthly meetings with the chief executives and all performance issues are discussed.

Jackie Baillie: My concern is that Audit Scotland and the Public Audit Committee reflected on the fact that at some point communications were just not helpful in identifying that there was a problem. I am keen to know that the Scottish Government—alongside health boards—has learned a lesson from that and has a more robust approach in place. That is what you described earlier, but I am not hearing the difference. I come back to the same question: what difference is there in your scrutiny, governance and communication arrangements that can give us confidence moving forward?

Alex Neil: There are a number of differences. First, we are not operating in Glasgow, for example, with 11 systems and we will not be operating with three: we will be operating with one. The TrakCare system, or a version of it, will be introduced in every board area, which means that information will be much more directly comparable between boards. Secondly, we have got rid of social unavailability and all the questions about that and we have replaced it with patient-advised unavailability and with a new set of rules. Thirdly, we have implemented a lot of the Auditor General's recommendations to tighten up in certain areas.

All those things have been done. We will also carry out a review to ensure that enough is being done on robust monitoring, on the collection, analysis, interpretation and consistency of data and on the application of the rules throughout every board by the end of this year.

11:45

Derek Feeley: In addition, we will share in our monthly meetings all the outputs from all the internal audit reports with all the boards, rather than just with each board individually, so that each board might learn from a neighbouring board. That reinforces the trend of showing everyone everybody else's data, which we have applied in the sessions with the chief executives and in the cabinet secretary's meetings with the chairs.

Jackie Baillie: I think that the cabinet secretary will forgive me if I pursue the point, because we need to have confidence in the system as we move forward. You have said in debates that the data is published and that there are no hidden waiting lists: all the data is out there. You have spoken about data coming out of your ears.

The data was all there before, but no one spotted that there was a problem. It is clear that there was a problem, because you have changed the system. How can I have confidence that you will spot the problem now?

Alex Neil: Well—

Derek Feeley: Sorry—I will come in, as Jackie Baillie and I have had this exchange before. It is important to be clear about the problem that Audit Scotland identified, which concerned not the level of social unavailability but the nature of that social unavailability and the absence of any systems that would help us to better understand why people were being coded as socially unavailable. The improvement that the cabinet secretary identified will come, not only through the introduction of patient-advised unavailability, which involves the exchange of letters with the patient, but through much stronger coding and better IT systems.

Jackie Baillie: I say with respect that part of the problem that Audit Scotland clearly identified lay in the governance arrangements and the communication between ISD, the Government and health boards. I have heard nothing today that gives me confidence that the oversight that I expect from Government—no matter which systems you change or put in place—is being delivered. I am genuinely concerned that you have described no change other than a change to the system on the ground.

Alex Neil: I do not think that you picked up what I said earlier. There is now a monthly meeting that involves ISD going through all the statistics, and a level of concentration is dedicated to this issue. That did not happen before.

Jackie Baillie: I was told that everything is the same.

Alex Neil: The approach involves every key player. The issues are addressed at Derek Feeley's management board meeting and at the meetings with chairs, chief executives and all the rest but, to ensure that we get it right, we have a dedicated monthly meeting that involves ISD discussing the statistics.

Jackie Baillie: Did that never happen before?

Alex Neil: Not as such, I think. Did it?

Derek Feeley: John Connaghan is better able than me to comment on that.

John Connaghan: We never had such a meeting with ISD. We had many meetings with ISD on systems development and statistics, but looking at unusual patterns or a response from a board with which ISD is not quite satisfied provides added security.

It is worth while considering Audit Scotland's recommendations. A relatively positive Audit Scotland report—in fact, one of the more positive reports—was produced on waiting times in 2010. Audit Scotland recorded that the NHS had done well to implement the new ways system. There was no recommendation prior to the publication of Audit Scotland's report at the start of this year that we should record the reasons for unavailability. That is new, and it is at the heart of what has changed in the system.

Alex Neil: I should point out that all the data was available and none of the Opposition parties picked up on the issue either.

Jackie Baillie: Convener, I seek to correct the record, because factual accuracy is important. My colleague Richard Simpson asked parliamentary questions on the issue and we raised it in debate. It is a shame that the Government, with all its resources, failed where we succeeded in highlighting the problem.

Can I ask one final question?

The Convener: You can have one final question, then Bob Doris can come in.

Jackie Baillie: Thank you. My question is about social unavailability codes more generally. Everybody struggles to explain why, in June 2008, 11 per cent of in-patients were socially unavailable, and then the figure rose—rapidly, I think—to 31 per cent in June 2011, before dropping to 15 per cent in September 2012. It is no coincidence that that was after NHS Lothian was exposed.

The cabinet secretary has said on the radio and in the chamber that the issue was down to IT problems, and he has repeated that today. However, none of the health board chief executives who came before the Public Audit Committee agreed that that was a problem. Mr Feeley, who has just passed the cabinet secretary a note, did not jump to the cabinet secretary's defence at that committee. No computer system in any health board was being changed when the dramatic drop occurred. Does the cabinet secretary therefore accept that it was not an IT problem?

Alex Neil: I am saying that, as the Auditor General has said, the IT systems were not robust enough to pick up the problem, which refers to a point that was made earlier. That is what I was saying, and I am saying nothing other than that. That is why the problem was not picked up.

After the NHS Lothian scandal was revealed, every other board double checked its systems. At that point, boards realised that some things were not as robust as they should be—sometimes it was a board's IT system and sometimes it was just the application of policy, with double counting and various other things. The issue varied from board to board. I stick by what I said.

Jackie Baillie: Convener, I think that the cabinet secretary is the only person in Scotland who says that the issue was to do with IT systems, but there you go.

Alex Neil: No, I do not think that I am. If you look at the Auditor General's report, you will find that she says that, too.

The Convener: We are not having conversations across the table between members. I say that for today and for future reference. That is not the way in which we will conduct the committee's meetings.

Bob Doris: I thank Jackie Baillie for drawing the committee's attention to the need for accuracy. I am a member of the Public Audit Committee, and I draw the attention of Jackie Baillie and this committee to one of that committee's recommendations, which is:

> "The IT systems did not allow sufficient data to be recorded in order to establish whether the codes were being applied appropriately. The PAC therefore recommended that the Scottish Government should set out the key audit data that NHS Board systems must be able to record."

That is a recommendation from that committee, which believed that the IT systems were a reason why we could not audit the situation properly. That committee found no evidence of the inappropriate use of unavailability codes outwith Lothian. I suggest to Ms Baillie that a degree of accuracy is important from everyone for a balanced discussion.

Ms Baillie referred to ISD, on which I have a question. In an earlier question, I sought clarification, but I will ask another question, given the tenuous points that Ms Baillie sought to make

in relation to ISD. I should say first that representatives of ISD told the Public Audit Committee—this is not a direct quote, because I do not have the *Official Report* in front of me—that there was nothing unusual or irregular in the increase in the use of unavailability codes throughout the year. The issue is not that ISD did not identify the situation but that the situation caused no concern, because ISD expected the use of unavailability codes to fall thereafter.

However, the Public Audit Committee recommended that certain

"data ... should also be presented to ISD Scotland in order to help identify where capacity pressures are occurring alongside an increase in the use of availability codes. Emerging trends from these reports can then be discussed at meetings between Chief Executives and between Boards and the Scottish Government."

It has taken me a long time to set the context, but it is important. ISD collects a huge amount of data. It says that it picked up on the trend but did not find it to be of concern. Is there a role for ISD to be more proactive with data and to raise concerns with the Government and health boards not only on waiting times but in general? The Public Audit Committee picked up on that.

Alex Neil: I am encouraging ISD and everybody else to be as proactive as possible. Obviously, ISD has a fantastic amount of able statisticians who keep us well informed. As John Connaghan said, over the years, ISD has highlighted a range of concerns. It did not see the use of unavailability codes as a concern at the time. As I said, ISD is now more involved in our monthly review of where we are on the reforms and the statistics. I encourage ISD and everybody else to take a proactive approach to statistical analysis.

Richard Lyle: Convener, I apologise for the comments that I made earlier. However, for the sake of accuracy, I point out that Ms Baillie, while looking at me, suggested that I called the situation a scandal. If she checks the record, she will find that I said that other people called it a scandal, and that I did not suggest that it was a scandal. As I said, I apologise for my comments, but I do not take kindly to people suggesting that I said one thing when in fact I said something else.

Jackie Baillie: It might be helpful if I clear this up now. If Richard Lyle looks at the record, he will see that I said:

"whether or not you call it a scandal",

and, clearly, he did not. I hope that, when he reflects on the record, he will see that I was not casting aspersions on him at all.

The Convener: On that happy note, as there are no other questions, I thank the cabinet secretary and his colleagues for being with us for such a long time. I apologise to our next panel of witnesses, who have waited patiently to come before us.

11:56

Meeting suspended.

12:02

On resuming—

Community Transport Inquiry

The Convener: Item 3 is an evidence-taking session on community transport to feed into the Infrastructure and Capital Investment Committee's inquiry on the subject. The committee has a particular interest in access to health and social care and, indeed, many members regularly come across such issues in their constituencies.

At this round-table session, we will supposedly do more listening than talking; we will see whether we, as politicians, can meet that challenge. I am conscious that we have run on quite a bit so, to save a wee bit of time, I suggest that we introduce ourselves when we ask questions or make comments.

To kick off the session, I note that we received a briefing this morning from Audit Scotland, which, as you will be aware, produced a report some time ago on transport for health and social care, in which it made a number of recommendations and highlighted certain issues. Its main findings included the need to work together and the need to introduce integrated transport strategies that focus on people. Does anyone want to talk about Audit Scotland's work and its findings?

Heather Kenney (Scottish Ambulance Service): Would you like me to start, convener?

The Convener: That would be helpful.

Heather Kenney: It might be helpful if I point out first of all that I was a member of the advisory group on the Audit Scotland report. I will not recapitulate it in any great detail—I am sure that all committee members have read it—but I will say that, since its publication, partnership work has been going on across Scotland to look at how we might take the recommendations forward. The Scottish Ambulance Service is keen to see how we can work towards implementing Audit Scotland's recommendations, and with other colleagues I have been contributing to a short-life working group on how we might take that forward. Indeed, we await the group's report and recommendations, which will be published imminently.

We have also been trying to be a bit more proactive by taking forward some pilot work and, to that end, we have been working in partnership with regional transport partnerships, health boards and councils right across Scotland, and in three areas in particular. An integrated transport pilot will go live in Lochaber in July, and as we speak another pilot programme is up and running and developing in Elgin for the north Aberdeenshire and Moray area. In those pilots, the partners are bringing together resources in those areas for those communities and providing a much more integrated solution for patients who need to access healthcare appointments. We are also in the process of scoping work with Strathclyde partnership for transport in the NHS Greater Glasgow and Clyde area.

In short, we have been progressing the recommendations in the Audit Scotland report and looking at how we use the resources that sit within communities and, indeed, the Scottish Ambulance Service and how we can collaborate and work in partnership to secure for patients much better and easier access to healthcare appointments. Although Scotland's geographical landscape, the configuration of health boards and the relationships between health boards and councils make what we are doing quite challenging, I think that we are making good progress.

The Convener: As we have heard, the Scottish Ambulance Service deals with different groups of people and, indeed, is more organised in that respect. In fact, your organisation got a tick from Audit Scotland in its briefing. However, is what you have described representative of what is happening across the country? Are the other people round the table seeing the same progress? Are the strategic partnerships coming together and are the needs of these groups being met?

Tom Robson (British Red Cross): First, I thank the committee for inviting me to give evidence. As senior service manager for the British Red Cross's east Scotland area, which covers Perth, Tayside, the Forth valley, Fife, Lothian and the Borders, I cannot speak for the whole of Scotland, but I certainly know what is going on there.

We work in partnership with loads of organisations throughout Scotland. For example, we work with the Scottish Ambulance Service to deliver programmes and with the NHS, mainly in relation to our home-from-hospital and discharge schemes. We deal with discharges from St John's hospital in Livingston, from the Borders general hospital and in the west of Scotland.

We also work in partnership with different voluntary organisations. With Macmillan Cancer Support, for example, we run a transport initiative that takes patients from the Scottish Borders to their chemotherapy sessions at the Western general hospital. We are willing to work in partnership; indeed, we believe that that is the way forward.

Calum Irving (Voluntary Action Scotland): I work for Voluntary Action Scotland, which is the network body for third sector interfaces in Scotland. Members will probably know those

interfaces better as centres for voluntary service, volunteer centres and so on.

What we have found—I mean this in a good way—is a patchwork of different solutions that meet the local need in the country. One of the downsides of that situation is that there is highly varied provision across the country. The voluntary action Lochaber example that Heather Kenney mentioned might be a model that could be considered elsewhere. Because of its connectedness with community groups, its relationship with community planning partners and so on, it is in a good position to broker local relationships and develop and run a community transport service in areas where the British Red Cross and others might not be present.

There are other examples of the third sector interface trying to develop that relationship. In Aberdeen, a model is being developed with support from the business school and other partners locally. That might offer a way forward. The feeling on the part of the third sector interface is that, although there is a backcloth of increasing demand given the ageing population, there is also an opportunity because, if community transport can be seen as part of the reshaping care agenda, we can see how improvements to accessibility and mobility could form part of the preventative approach. That area is extremely important for Voluntary Action Scotland.

Margaret Paterson (Royal Voluntary Service): I am head of operations for the Royal Voluntary Service, which was until recently the Women's Royal Voluntary Service, so I am able to give an across-Scotland picture.

Community transport underpins absolutely everything that our organisation does in the services that we deliver for older people. There is a rising need across the country. There are areas in which partnership working is developing and showing signs of improving, but there are other areas where that is simply not happening. In two areas, I have had funding for transport services but I have had to pull them because I have not been able to get engaged in local partnership working and have therefore not been able to establish the service. One of those areas is Elgin. That is quite a disappointing situation to be in.

Anne Harkness (NHS Greater Glasgow and Clyde): I am the director of emergency care and medicine at NHS Greater Glasgow and Clyde, and I lead for ambulance services in our health board. The Scottish Ambulance Service is the main provider of transport to and from hospital. However, we work closely with SPT on improving access and services for people in our health board area. We work with community transport on things such as our evening visitors service, and we engage with community transport providers to help people—particularly frail, elderly people—to get to services that we run such as community exercise classes. Further, as Tom Robson mentioned, we work with the Red Cross on an accident and emergency take-home service. There is a huge opportunity for more joint working but, again, the strategic direction at a regional level should allow the local variation that Calum Irving mentioned, because community transport providers are diverse.

The other issue concerns integration and the relationship with social care. As we move further towards an integrated health and social care service, particularly for older people, there is a huge opportunity for us to work closely with our social care partners who, in the main, fund community transport and are big providers of transport in the way that the Ambulance Service is for the NHS. That is another area in which regional collaboration would be hugely helpful. Within our area—actually, in your area, convener—we are about to do a piece of work with the community healthcare partnership to consider what opportunities there might be to use health transport for non-patient-related transport and social care transport, in order to help us with patient transport arrangements.

The Convener: I am glad to hear that we are making some progress locally. There are lots of opportunities. I have been banging on about that for some time.

Peter McColl (Royal Voluntary Service): I am also from the recently renamed Royal Voluntary Service and I, too, thank you for inviting me here today.

Last month, I gave evidence to the Infrastructure and Capital Investment Committee on community transport, and the point was well taken at that meeting that there is a need for a strategic focus on the issue in health and social care integration. Until now, the debate on health and social care integration, although interesting, has focused on structures, and we think that thinking about services is a useful way to understand what the benefits of that integration will be. A key service that we do not think has received a great deal of consideration in that regard is community transport. At the risk of talking further about appointments, it is pretty clear that community transport is one of the best ways to ensure that appointments are not missed, which is a good way to prevent unnecessary costs. We are keen to be involved in that, but we feel that there needs to be a more strategic focus on the issue and that it needs to be built into the systems that are being created for health and social care integration.

12:15

The Convener: The other question that came up in the Public Audit Committee was who pays for the service. That goes back to my experience of services going out, particularly at a time of change, in my community. Nobody had considered the impact of that. The health board was reluctant to take on a commitment to transport people from Greenock to Paisley to visit or support patients or for them to attend appointments.

Calum Irving: At present, there is a patchwork quilt of arrangements that can be developed locally. One of the challenges is one-year funding, about which you will hear talk on other issues relating to the third sector. It is extremely difficult to develop and broker a decent quality of service that has a more strategic approach and builds relationships with only one-year funding for assets that relate to community transport. The fact that local authorities, as well as the Scottish Government, are going in that direction creates a significant challenge.

One benefit of involving the third sector in community transport is that there is a good supply of willing volunteers, cars and other vehicles in that sector. It is a matter of finding small amounts of support to be able to co-ordinate and focus that better in the longer term so that we are able to lever in the resources that exist in the community in a better and more co-ordinated way.

Anne Harkness: The reality is that the Scottish Ambulance Service and the NHS fund the transport for people who need it on medical and mobility grounds. Transport for people who need it on social or isolation grounds is funded in the main by local authorities. One of the challenges with an integrated model is to adopt a slightly different approach to funding. Although there are many pilots where we can do that flexibly, which I am sure Heather Kenney will describe, they tend to be on a small scale at present.

In NHS Greater Glasgow and Clyde, we have, on occasion, used our NHS funding to fund community transport when we have made a service change and recognised that it will impact on people's ability to get to hospital. The Vale of Leven hospital is an example of where we funded additional ambulance services, worked with transport partners to ensure that public transport was available and put in place additional community transport.

We have a community engagement and transport manager who works with us when we make a service change to ensure that we consider and allow for the impact that it might have on people's ability to travel.

The Convener: Will the new clinical strategy from NHS Greater Glasgow and Clyde include a transport strategy for how you manage such change? It did not in the past.

Anne Harkness: Yes, it will. Any strategic change that any NHS organisation undertakes must include a transport needs assessment and impact assessment. That is required of us by the Government. Absolutely—we will have to do that.

The Convener: Has the budget that is available in NHS Greater Glasgow and Clyde for transport gone up or down over the piece?

Anne Harkness: The budget is held by the Ambulance Service.

The Convener: So access to that is not directly through your budget.

Anne Harkness: No.

The Convener: How much does NHS Greater Glasgow and Clyde pay for taxis to take people from Inverclyde to Dumbarton, for example, or to take files all over the place?

Anne Harkness: I do not have that information with me, but I can certainly get it if it would be useful.

The Convener: It would. Thanks.

Heather Kenney: Anne Harkness talked about volunteer car services. The Scottish Ambulance Service is funded primarily to take those patients who have a clinical and medical need for ambulance care and transport, but the committee must not lose sight of the fact that we still employ 200 volunteer car drivers. We do that because we recognise the difficulties that exist throughout Scotland for patients in remote communities and people who have real transport needs and need to get to a hospital. We try to focus that service primarily on ambulant patients who do not need care or assistance but have a social and geographical need for transport.

The number of patients who use the volunteer car service and the number of journeys that it provides have diminished over the past few years—there is no doubt about that. That is primarily a result of some changes that Her Majesty's Revenue and Customs made in the guidelines on taxation. Volunteers drop out at a certain limit at which their payment reduces as a result of some of those guidelines.

For the volunteer car service, we need clear governance as regards the selection of patients, as we need to be careful that we do not select patients for the service who will probably need care and assistance en route to hospital. For that reason, we worked quite extensively with clinicians in the 14 health boards to develop the eligibility criteria, which some people will have heard of. Those criteria are not new but have been around for a long time, as they are based on guidance

from the early 2000s—I think that the latest guidance is from 2007. We want to be clear that, from a clinical perspective, we truly understand the needs and care requirements of patients to ensure that we select the right mode of transport for them.

I stress that point because, in many debates on the provision of integrated solutions, people lose sight of the fact that we do not just provide a transport solution. We deal with many patients who have multiple comorbidities or long-term conditions and we often transport people who are on oxygen therapy or on a stretcher or who need complex assistance with moving and handling. I just wanted to reiterate that point.

Peter McColl: On the issue of who pays, over the past four or five years, it has been quite clear that we can save money by preventing need, so getting patients to their appointments is a good way to save money. The costs involved in community transport are relatively small compared with the costs of missed appointments. Looking at the global cost of missed appointments may be one way in which to release more funding for community transport.

Similarly, on the use of taxis, we think that our services could replace some existing taxi services. Rather than just replace the point-to-point journey, we could provide additionality by providing a safe, warm and well check with individuals in their home and signposting them to other services. That could add value to the journey while almost certainly being cheaper than a taxi.

The Convener: We are unsure whether work has been carried out on whether the availability of good-quality transport creates savings and reduces exclusion in respect of, say, admissions. Does anyone know whether any work has been done on that?

Heather Kenney: The Lochaber pilot flagged up that there is a lack of information. Although the committee heard in the previous evidence session that we have data coming out of our ears, for community transport networks and providers there is a real lack of accurate data on what resources are available in communities, how they are used and what volume of journeys is undertaken. To be fair, until a couple of years ago, the Scottish Ambulance Service's data was not particularly robust either, but we have invested about £2 million in mobile technology to track vehicles so that, just as for our A and E service functions, every journey has a patient record attached to it.

The data gathering is getting better. That has been really beneficial in the Lochaber area, where people were happy to share their data and improve the data that they collected on what resources sat in the community, to what extent they were utilised and what potential there was to build a much more integrated solution in the community. That is probably where we would want to go, particularly in areas of high levels of deprivation or where there is a social and geographical challenge in commuting to hospital.

Alongside that, as well as working on transport solutions, we have developed really quite advanced thinking on the emergency side about how we might care for people in the community rather than transport them to hospital. For example, for out-patient programmes, we can sometimes take a patient 100 miles for a 10-minute consultation. We would like to work with the boards on how we might encourage such patients to be taken to their local community health centre to have that consultation done by telehealth or telecare. For some patient groups—although not all, I accept—that would be far more effective if the consultation is just a relatively simple conversation about a follow-up procedure.

Given that we are still moving patients around a lot for short, non-emergency consultations, part of our work programme is to work with the health boards on how we might encourage such developments. That would put much more resource back into the local community and help us to progress the integrated health and social care agenda, which is about providing care in the community. If those resources are not travelling long distances to transport small numbers of patients, they would be available to move people around in their communities.

The Convener: That is an interesting point.

Anne Harkness: SPT is now involved in the west of Scotland community transport network, which brings together all the community transport providers in that region. That will allow us to co-ordinate resources better.

We produced a two-day snapshot of every journey that was made in NHS Greater Glasgow and Clyde by taxi and by our own NHS vans—not by the Scottish Ambulance Service—and we have shared that information with SPT. We are starting our work by looking at the synergies in order to pick up on the point about where the synergies are and where alternative and more cost-effective solutions could be used.

In the NHS—certainly in NHS Greater Glasgow and Clyde—we use taxis for patient journeys on occasion, but that would be in exceptional or emergency situations. We would not routinely use taxis for transfers to and from hospital on a planned basis—it would happen on a one-off basis to suit a particular individual circumstance.

The Convener: It might be interesting for the committee to see that work, if it is available.

Anne Harkness: I do not have the detail, but I can check.

The Convener: I would appreciate that. Does any of the other witnesses want to come in on that issue?

Tom Robson: The main challenge that the British Red Cross faces is funding. In order to provide a quality service, as the Scottish Ambulance Service does, all the British Red Cross vehicles comply with Care Quality Commission standards. We have a range of vehicles, which includes all-wheel-drive and wheelchair-accessible vehicles. The volunteer vehicles and drivers' licences are all checked, and the volunteers have all done their first-aid and moving-and-handling training. The service that they provide for people is excellent for a donation-based service. Unfortunately, however, it is not sustainable for us to keep on providing a donation-based service because it costs money to run the vehicles and to provide all the training that goes with such a service.

Bob Doris: It is always better when witnesses have a conversation with one another rather than just answering the politicians' questions, but I have a very specific question. Peter McColl spoke about how there is money in the system that can be taken out. For example, the cost to the NHS of missed appointments, whether those are general practitioner or community health appointments, is far greater than the cost of a modest increase in investment in community transport.

We heard this morning from the cabinet secretary about the various pressures on the NHS from in-patients and the knock-on effects of those pressures. For example, one reason for delayed discharge may be that consultants are not reviewing patients until the afternoon rotation rather than in the morning. The slowness of getting medication for patients on discharge and the lack of support at home or in a home-type setting are also factors.

One factor could be the lack of transport for taking home a patient who is fit to go home with the relevant support. Is that a particular problem? If so, how large a problem is it? More important, are there any on-going initiatives in any of the health boards—using change fund moneys or whatever—to work with the Scottish Ambulance Service and community transport partners to ease that problem? The knock-on effects from delayed discharge on A and E waiting times and everything else are significant. Such an initiative would be a way of taking the cost back out of the system and reinvesting it in community transport.

Margaret Paterson: There are examples dotted around the country. The Royal Voluntary Service is involved in providing transport on discharge; for example, here in Edinburgh we run a scheme in which the discharge is organised in hospital and the volunteer drivers are available throughout the day, according to need, to take people home. That often links with another reason for which we would have a volunteer available—namely, so that when the person is discharged home, they get the necessary support. The Edinburgh scheme is funded via the NHS.

12:30

We are also working on change fund schemes to ensure that people get to appointments. We have an interesting scheme in East Lothian in which GPs refer patients whom they know require transport to get to GP, hospital or clinic appointments. That is an effective way of ensuring that appointments are not missed.

Those are just two examples; there are many others.

Heather Kenney: The Scottish Ambulance Service has also been working in Lothian, particularly with Edinburgh royal infirmary. We embarked on a five-year improvement programme for our patient transport service, which has been very successful. One of our primary aims is to support health boards with their acute discharges to keep the flow moving in hospitals. Patients who need ambulance assistance are high on our priority list. NHS Lothian also uses other services for patients who, although they are ambulant, need a transport solution to get home. However, it has been using private ambulances because of the pressure on demand. Over the past six months, NHS Lothian has developed an internal transport hub, in which we work in partnership. We jointly staff a health board liaison officer, who can help us to bridge the communication gap that often exists with regard to immediate requests.

Bob Doris is right that decision making in hospitals is sometimes under pressure. The demand for discharge from hospital on the day of treatment has increased over the past few months. We have focused on trying to assist with that issue, so that we can help our colleagues to keep moving. I would not like to mislead the committee by giving figures, because I do not have the up-to-date ones. I understand that our service has helped to reduce significantly the cost of private ambulances by increasing utilisation and productivity within the resources that we have around the Edinburgh royal infirmary. We want to spread that kind of work over the next year or so with some of our other colleagues. Glasgow, in particular, has significant challenges.

Our programme of work is incremental, but on-going. As well as working around patients with voluntary agencies so that they can provide those

services, we are very keen to ensure that the Scottish Ambulance Service can increase its contribution with hospital discharges.

Tom Robson: There is another example in Fife of the Red Cross getting patients to hospital; we escort people with blood-borne viruses to the Western general hospital for their treatment. The type of patient means that if the transport was not there to take them to hospital on a particular date, they would just not turn up.

Anne Harkness: We have similar projects. As part of our routine discharge arrangements, we have services from the Ambulance Service in the evening; as Bob Doris said, many people now go home in the early evening, following the change in hospital admission patterns whereby people are often admitted later in the day. We have ambulances routinely available to take people home from hospital and we are working with the Red Cross as one of our change fund projects in Glasgow.

In the south of Glasgow, the Red Cross helps us to take home A and E patients who do not need to be admitted to hospital; it then provides care and follow-up. As our RVS colleagues said, they ensure that people have something to eat and that their heating is on. Local change fund partnerships are looking at community transport with a care element that is much wider than just providing a vehicle. There are a range of options on how to do that. As we heard, a range of providers can provide that service.

Bob Doris: That all sounds reassuring. I was going to say, "That structure sounds reassuring," but flexibility seems to be the key word when we are working in partnership.

Are there examples of individual health boards, hospitals or wards that have identified transport as one of the reasons for routine delayed discharge? Are any of the partnership organisations asked to focus on certain areas, or to provide more volunteers to relieve those pressures?

One of the issues that we are looking at is your real-time responsiveness to pressures or pinchpoints that might arise in the system. I know that you do lots more, including getting patients to appointments, and I realise that I am looking very narrowly at a patient's admission to hospital, but do you collect data in real time and say, "We need more resource here. Let's talk to this or that partnership organisation, see whether they are top heavy in certain parts of the country and ask whether they can deploy some volunteers here"?

Anne Harkness: The short answer is probably no. We would look at our own local resources and see whether we had a shortage of, say, renal beds, which is a west of Scotland service. If there is particular pressure on renal beds, we will link with the Ambulance Service and prioritise getting people home from the renal unit rather than from another area. Our real-time responsiveness lies with the Ambulance Service or alternative providers. We do not have the same flexibility with community transport, which, with the exception of the Red Cross A and E service, provides a more scheduled service.

I should also point out that the Red Cross service was developed in response to feedback from patients, carers and clinicians that people were being admitted to hospital because we could not get them home. In some cases, we would not want to use a taxi because we would be worried that the person would not be safe when they got home. The fact that the Red Cross service was, as I have said, developed on the back of feedback from clinicians, particularly those in emergency departments, links back to the earlier conversation about year-round pressures and increases in admissions and attendances.

Nanette Milne: I do not know how the eligibility criteria for patient transport are set, particularly in relatively remote areas, but I know a constituent from a very small Aberdeenshire village who had to attend the eye department in Aberdeen a number of times but who was assessed as not requiring patient transport. He was able to drive to the hospital, but as the treatment involved pupil dilation he was unable to drive back home; however, the public transport in his area is pretty poor. How are such decisions made? Are they made centrally or by individual health boards? It struck me that that chap was getting a particularly raw deal.

Heather Kenney: I will not mislead you: we have faced some challenges with the new patient-focused booking system that we have introduced. Historically, GPs and hospital clinics booked patient transport for the patient. We consulted the public quite widely about a direct access patient self-booking system, but in the early days our call handlers' skills in using the triage assessment tool varied and we found that some patients who absolutely required ambulance transport had fallen through the net. We are improving in that regard. We had a few months when the number of complaints that we received was a bit higher than we would have liked and patients were raising a number of challenges to the needs assessment and eligibility criteria, but we have done a lot of training and development with the staff. They used to be dispersed across 30 local offices around Scotland, but they are now embedded in three regional control centres and are supported by clinical advisers, who are either trained nurses or trained paramedics and who can give advice on screening patients.

We have developed the triage tool to ensure that we ask the right questions about, for example, the clinic that the patient is attending. Obviously, we do not want confidential information about a patient's condition, so the questions have become much more conversational and focus on what their visit might entail. In some cases, a patient might not know at the outset that their treatment might affect their return journey, but in some areas—it is not an holistic approach across the country—we have embedded a request system in which we can flag up issues from the clinic to the control centre in order to identify patients who should have received ambulance transport. As a result, we have been able to put in place a feedback loop from the Crewe Road staff and the hospital clinics. We are trying to close that gap, because it is pretty important that we do so. It is certainly an issue for us.

Nanette Milne: I dealt with the constituent whom I mentioned about two or three years ago. Has that system been introduced since then? The person I was talking about would probably not need an ambulance, but they would need a car of some kind.

Heather Kenney: He is probably the kind of patient for whom we would use the volunteer car scheme. That system was introduced in the north of Scotland in April last year. We rolled it out to the east of Scotland in October, and the roll-out to the west of Scotland was in the middle—in June. We created the three call centres.

Nanette Milne: You mentioned the north and the east of Scotland. Is the north-east somewhere within that loop?

Heather Kenney: The north-east—the Grampian region—is in the north. The control centre is in Inverness.

Gil Paterson: I will make an observation about the nature of community transport, and I will be happy to hear comments about it. It is not possible to roll out the system across Scotland in the same way, given the diversity that is involved. The idea that Greater Glasgow and Clyde and the Highlands could operate a similar system seems impossible. Managing the greater Glasgow area alone requires a diverse community transport system. Given its nature, community transport must be locally focused and controlled. I am keen to hear whether people wish to contradict that.

My main point is about one of the pinchpoints for the third sector: the ability to use capital to replace vehicles. There are local authority and health service organisations, as well as public transport systems, in which some vehicles are not used during the day. Have the witnesses thought about that? Would it be possible to make use of such vehicles by allowing the third sector to use vehicles during what might be downtime for the organisations concerned?

Peter McColl: I accept the point about diversity. You are quite correct in saying that different services are provided in different ways in different places, but we must not allow that to lead to a lack of a strategic, structured approach to encouraging the use of community transport where possible. Sometimes, the two things become conflated. Community transport is different everywhere, but that does not mean that such encouragement cannot be provided in some places, and it does not meant that we should not consider it in some places.

On your second point, about vehicles that are owned by public authorities, the WRVS—I apologise: it is now the Royal Voluntary Service—uses local authority vehicles in some circumstances, although councils are not necessarily very good at letting us know what vehicles they have or when they are available. Were the arrangements to be more structured, that would encourage the provision of a lot more community transport services and we would be able to deliver more in more areas.

Gil Paterson: When it comes to diversity, I take it that you are really looking for a blueprint, rather than control. Perhaps that would fit the bill as far as your comments are concerned.

Peter McColl: Yes.

Calum Irving: Part of the issue concerns expectations. The work and co-ordination in Aberdeen have come about partly because of frustration on the part of some third sector agencies that no community transport thinking was going into previously funded projects. To a degree, it is a matter of considering the case for community transport as part of the reshaping care agenda and health and social care integration, as we have been discussing.

It is not that services must be the same everywhere. However, community transport should be considered when people are planning services locally, because it underpins all the other health issues that the committee has been talking about. If such a view of community transport were sold better, for example in community planning circles, we would be able to think about how the third sector could step in and make the case for the resource sharing that would fill the gaps around Scotland.

12:45

Aileen McLeod: Audit Scotland talked in its report about the benefits of integrated transport units. In that context, I want to talk about a project that has not been mentioned, which took place in

part of the area that I represent. Dumfries and Galloway Council was one of the main partners in the rural transport solutions project, which is European Union funded, through the northern periphery programme, with partners from Finland, Sweden, Iceland and Shetland.

The project was piloted in Wigtownshire from May 2011 and was completed in December 2012. Partners included the south west of Scotland transport partnership, NHS Dumfries and Galloway and the Scottish Ambulance Service—I see that Heather Kenney is nodding. The partners worked closely with the local community transport provider, Wigtownshire Community Transport, to try to address transport issues in a vast remote and rural area, particularly in the context of health and social care services.

An evaluation report was published in February. It would probably be worth the committee's while to look at the report, because it contains interesting conclusions. If the convener will bear with me, I think that it is important to share some of the conclusions. The report's authors said:

"In providing transport through the project, WCT has increased its passenger and journey numbers as well as utilising the shared vehicles efficiently and significantly reducing vehicle downtime. Resources including vehicles and drivers have been shared between partner organisations to provide sustainable and flexible transport solutions. The central coordination of vehicles has provided the ability to service different sections of the community including ARCs, schools, community groups, youth groups and sports clubs in Wigtownshire. WCT has also secured an income source through delivering services"

for the partners that I mentioned. I understand from the report that

"It is intended that the RTS model be extended across Dumfries and Galloway, to include more community transport providers, bus operators and taxi firms, in addition to further involving the NHS Dumfries and Galloway and the Scottish Ambulance Service",

and that

"Work is currently underway with all local partners to develop a detailed plan for rollout of RTS"—

that is, rural transport solutions—

"and some potential opportunities have been identified including assistance with transport to attend NHS appointments; transport to rehabilitation centres and transport for 'out-of-hours' patient releases. NHS Dumfries and Galloway has also indicated that funding support is available for co-ordination activities relating to RTS delivery."

I was keen to get that on the record. Do the witnesses have comments on the model?

Heather Kenney: I apologise to Aileen McLeod; I should have mentioned the rural transport solutions pilot. The three pilots that I mentioned have taken place since the publication of the Audit Scotland report, and that work was under way beforehand. An interesting and helpful aspect of the rural transport solutions pilot was the work that NHS Dumfries and Galloway did around zoning patients and improving scheduling, so that we could better co-ordinate transport solutions in healthcare. We have built on an awful lot of the work in our thinking about how to work with other remote and rural communities. The project was particularly helpful.

Drew Smith: This question probably falls into the Infrastructure and Capital Investment Committee's remit. What is the impact of inadequate public transport and changes to public transport on the delivery of services to people who rely, or who perceive themselves to rely, on community transport? When you are bringing together people and coming up with an integrated strategy, what happens if there is a change in the public transport setting that means that more people contact the Ambulance Service—or any other point in the system—to say that they think that they will need community transport, not necessarily because of clinical need but because there is simply no other provision for them?

Margaret Paterson: We do not have any studies on the impact of public transport on take-up of community transport, but we are aware of the impact on some older people of the availability of public transport and how to access it. There might be sufficient public transport in an area, with a bus running six times a day, providing an adequate means for people to get into their nearest populated area, and if they also want to go to the theatre there is a bus that will take them home. Often, the problem is that they cannot access the bus, because they cannot get to the bus stop or they are not able to use public transport. A community transport service might involve getting them there and buddying them on the public transport part of their journey, and that can be complicated. We have not made a specific study, but we develop and flex our services in response to the comments that we receive about the availability and accessibility of public transport.

Anne Harkness: That is primarily an issue for local authorities, and changes in public transport have led to more of a focus on community transport, either by subsidising bus routes or by looking at alternative solutions. We have done some joint work with local authorities in our area on bus routes that we are aware might not be profit making for the operator. The Vale of Leven bus that crosses the river from the Vale of Leven on the north of the Clyde to Paisley on the south of the Clyde is a public transport service that we jointly subsidise, because we provide health services both north and south of the Clyde. There are changes that have led to us looking at different solutions that involve both community transport and alternative public sector solutions.

Heather Kenney: In the Aberdeen pilot to which Gil Paterson referred, the Aberdeen dot.rural team at Aberdeen university has been working on a technology solution that can be made available to hospitals and clinics and to the information centre in Elgin to help people who phone up for information. It is like a more advanced version of Traveline Scotland, pulling in all the solutions in a local area to link journeys, so that if there is not one single solution but there is a combination that might help people to make their journey, that can be identified. The service can also give people information about variations in their journey and provide costings.

We are testing out that system with transport to the healthcare information centre in Elgin. We have a database, but it is not live yet, so we have not managed to set up the real-time information function but aim to get it embedded this year so that people can understand the transport options. Sometimes people do not know what transport solutions exist in their area, but, given a start point and an end point to their journey, we can help them to plan it and cost it.

The Convener: I know from my casework that that is an important point. We always use the classic example of the family in which the grandfather had a terminal illness and was in the Inverclyde royal hospital at Paisley. The grandmother and their daughter were unemployed, the granddaughter was in part-time employment, and it cost that family £30 on a Saturday to visit that terminally ill grandfather in the IRH. The services were reconfigured; although the reconfiguration might have taken into account the issue of getting a patient to Paisley, it did not look at any of the other issues.

Anne Harkness is the only health board representative here, so I will put the question to her. Is one of the barriers to improvement the fact that, although there is a need to look at transport areas and at the impact of ambulance services and patient transport on patients, people do not want to get too involved because there may be budget implications? Do people in health boards feel that it is not their job to get people to hospital, other than in an emergency, and that it is the local authorities' responsibility, although they are also reluctant to take it on? Is there a fear of claiming responsibility for this issue?

Anne Harkness: That example just illustrates why we need to address the issue in partnership. Health and social care integration and regional transport structures will help us do that, but there is no doubt that we need to work much more closely together and to link in the Scottish Ambulance Service.

Although it might not be our responsibility to ensure that people get their visitors, we take that into account in our transport assessment. In a recent exercise that I was involved in, we surveyed all the patients who had visitors on how the visitors got to the hospital and what mode of transport they used—whether they took public transport, walked, drove, or whether someone else brought them. All that information is presented to the NHS board and the Government so that we are absolutely clear about the implications and the arrangements that we would put in place to mitigate problems. The arrangements might include a community transport solution or work with a bus provider to ensure that a bus route is running later in the evening. We have to find a solution to any issue that we identify. Although transport is not our funding responsibility, that does not mean that we would not take it into account in our planning.

The Convener: This is a bit of a hobby horse of mine. In my area—this is replicated in other areas, I am sure—we have out-and-out community transport, volunteers at the hospice who take cancer patients for treatment in Glasgow, and the Ambulance Service. We also have MyBus; depending on where you are, there might be a debate about whether the service will or will not take you to a hospital appointment or the doctor. I have heard that others, including the Royal Voluntary Service, also intervene.

All that is sustained by public money and voluntary contributions. Software is, and has been, available in the Strathclyde region that could ensure more effective use of those assets to cover all the instances that we have talked about today. Why do we need to push people to do what they are doing more effectively? Collectively, why has that not happened?

Nobody here knows.

Is there a worry, in that some voluntary providers do not want to be sucked in? Have they lost their ethos? Have they lost their volunteers or lost control of their charity or organisation?

Calum Irving: I cannot speak for my third sector colleagues here, but from the point of view of third sector interfaces in their different guises, there is no such concern. For many years in previous guises, part of their job would have been to build those kinds of relationships with the statutory sector and to provide co-ordination, where that works. In some instances, it has for various reasons been a challenge to do that job.

I am afraid that sometimes it just comes down to resource. Although Scotland-wide there is funding for the core work of interfaces, in places such as Lochaber, other rural areas or even Glasgow itself, that funding is relatively small, so there is a limit on how much co-ordination and planning can be done. Part of my pitch is to say that if we want to

do this in a different way, there is an infrastructure that could be better supported to provide the co-ordination function. We could then make the case to, for example, the SPT, the local authority or whoever to say, "Let's share those resources."

In Scotland, we expect a bigger role for the third sector, but the resources are not anywhere near realistic enough to achieve that. The third sector is still a relatively small feature in many of the things that you are talking about.

13:00

The Convener: A lot of what you do is organising and planning journeys, which is pretty expensive. There is a software model in Strathclyde. An old lady who wants to go to the hospital to see the consultant will not care whether she goes by MyBus, the social work van or whatever, as long as the transport is efficient and of good quality, and as long as it gets her there. How much does it cost to run such organisations and to have the clerical staff behind the scenes to plan all the services? Those issues do not arise only in Inverclyde.

Anne Harkness: I am not an expert on community transport. I know that evidence to the Infrastructure and Capital Investment Committee has described barriers that providers have found in working with the statutory sector, relating to lots of technical detail about driving licences and so forth. There is no doubt that the next challenge for the regional transport hubs is to do exactly what the convener suggests and to more robustly challenge both the NHS-provided transport and the social care transport, and to link community transport to those. I do not know whether there are technical and legal barriers to that. You would need an expert to give evidence on that.

Jayne Baxter: I declare an interest as a councillor in Fife; I am going to talk about Fife, so I thought that I should do that first.

We are discussing transport to healthcare, health and social care integration and health and wellbeing. It is also about people being able to get to the bingo, because that is important too. Colleagues might be aware that there is very little community transport in Fife, but lots of people are transported because the council runs the service in-house, for all the reasons that the convener alluded to—cost, co-ordination, the need for investment and the need to be able to track the spend.

I draw colleagues' attention to the interesting data that are collected in Fife about where people go if they have the choice, and the costs of that. That might be useful to inform transport planning, if we discover that people are going to the bingo or to the hospital a lot, we can talk to Stagecoach about putting some routes on, for instance. There is a strong need to work together, but it costs a lot of money. Fife Council spends millions of pounds every year delivering door-to-door demand-responsive transport, which is what we are talking about. Cost is an issue and it is a barrier.

I was smiling earlier, because we have in Fife the software that was mentioned. It is a good way to make the most of all our resources, but it involves new partnerships, a lot of honesty and changed relationships.

I throw those comments into the mix. I am not trying to be controversial, but there are huge challenges. Today's discussion has been about health, but it is really about people just getting where they need to go when they need to be there.

Nanette Milne: What Jayne Baxter said ties in with what Audit Scotland said to us this morning. It sees a need for central leadership and direction across Scotland to bring everything together.

The Convener: I have a final question—I promise committee members—about the lack of information in the public sector, which has been alluded to. At my hospital, there is still no timetable for the buses that run there, despite people going on and on about that. That is also an issue with general practices and other places, but the people who run them say, "It's nothing to do with me."

How do people know how to get access? There is no co-ordination, even of what is currently available. Indeed, there is confusion about what MyBus, for instance, does. I have tried it, I have debated it, and I have phoned up. We did a straw poll of general practices in the Inverclyde area some time ago, and we got different answers. Some people said, "It's nothing to do with me. That's up to them."

There is an issue, here and now, about whether people know what is available, so that they have a range of options for visiting a patient, for getting to an appointment in hospital, for going to their general practice and so on. There seems to be an absence of information. Is that a general thing, or is it just me getting a bee in my bonnet?

Anne Harkness: Within NHS Greater Glasgow and Clyde, the information that patients get when they are to be admitted to hospital or must attend an out-patient appointment should include information about transport options, information about eligibility for an ambulance and information about Traveline, which Heather Kenney mentioned, for journey planning. We make that information available in our patient information centres. Instead of publishing a timetable, it is a case of providing information on how to make a journey from A to B. As Heather Kenney said, sometimes that might involve two buses, a bus

and a train or—in the case of Inverclyde—a bus and a ferry. We would use Traveline to provide that information. I cannot speak about the situation in GP surgeries, but I can certainly pick that up with the CHP director.

The Convener: Such information is not provided when a person is told by their GP to take their child to the children's ward at the IRH in Paisley. On one such occasion, it was the WRVS, through a connection with a social worker or whoever, in a network that was working, who came and picked up the person—who I think was a grandmother, rather than a parent—and the child and took them to Paisley. On such occasions, if people had a car, they would go in the car, but not everyone has a car.

Peter McColl: All this points to two things: the first is to do with better relationships at the local level and the need to link services with technology, and the second is about structures. It is very welcome that the committee is looking at community transport in the contexts of health and social care integration and of reshaping care for older people, because those structures will allow us to create services that much better meet the needs that the convener is talking about.

It might be slightly unfair to say this, but for some time community transport has been a little bit of a Cinderella service; it has been at the end of the list of services that health boards and local authorities think about providing. Raising the profile of community transport and improving the relationships with it and the quality of thinking about it will lead us to better outcomes. Knowing who the right people are and having the right structures in place will deliver that.

The Convener: No other members have questions, so I thank all the witnesses very much for their time and for their evidence.

13:07

Meeting suspended.

13:09

On resuming—

Annual Report

The Convener: We move to agenda item 4, which is consideration of our draft annual report. It follows a standard format as regards length and so on, as the Conveners Group set out. Are members content with the draft annual report?

Members *indicated agreement.*

The Convener: Thank you very much. I thank everyone who helped to bring the report together. All their hard work is duly recognised.

13:09

Meeting continued in private until 13:19.

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