The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 19 February 2014

Session 4

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PUBLIC AUDIT COMMITTEE
3rd Meeting 2014, Session 4

CONVENER

*Hugh Henry (Renfrewshire South) (Lab)

DEPUTY CONVENER

*Mary Scanlon (Highlands and Islands) (Con)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

John Connaghan (Scottish Government)
Caroline Gardner (Auditor General for Scotland)
Paul Gray (Scottish Government)
Professor Jason Leitch (Scottish Government)
John Matheson (Scottish Government)
Fraser McKinlay (Audit Scotland)
Alex Neil (Cabinet Secretary for Health and Wellbeing)
Rebecca Smallwood (Audit Scotland)
Claire Sweeney (Audit Scotland)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

Committee Room 6

Scottish Parliament

Public Audit Committee

Wednesday 19 February 2014

[The Convener *opened the meeting at 09:30*]

Decision on Taking Business in Private

The Convener (Hugh Henry): Good morning and welcome to the third meeting in 2014 of the Public Audit Committee. I ask everyone to ensure that electronic devices are switched off so that they do not interfere with the recording equipment.

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

Members *indicated agreement.*

Section 23 Reports

"NHS Financial Performance 2012/13" and "Management of patients on NHS waiting lists—audit update"

09:30

The Convener: Agenda item 2 is two section 23 reports: "NHS Financial Performance 2012/13" and "Management of patients on NHS waiting lists—audit update". At our previous meeting, we heard from Paul Gray, the director general for health and social care, who is here again, as is the Cabinet Secretary for Health and Wellbeing, Alex Neil, who is accompanied by John Connaghan and John Matheson, who have been at the committee previously, and Professor Jason Leitch. I welcome them all to the committee.

Cabinet secretary, I believe that you would like to make an opening statement.

The Cabinet Secretary for Health and Wellbeing (Alex Neil): Yes, if that is okay.

The Convener: You have never been shy about talking, so on you go.

Alex Neil: I learned that from you, convener.

I thank the committee for allowing me to make some opening remarks. I will start with the excellent financial performance of the national health service in Scotland. I welcome the Audit Scotland report on that, which acknowledges that the NHS managed its overall finances well and that, for the fifth year running, all boards achieved their financial targets. As the committee has had a particular interest in how we can improve long-term planning and increase financial flexibility, I will briefly outline what we are doing in those two areas.

We believe that there is a strong and effective focus on long-term financial planning, and we have evidenced that in discussions with Audit Scotland. As part of NHS boards' local delivery planning, they develop a three to five-year financial plan, which is submitted annually to the Scottish Government. Of course, boards look much further ahead in planning long-term delivery of services, and major investment in the NHS is informed by the Scottish capital investment manual, which takes a horizon of 25 years plus.

The committee is also interested in flexibility, so I would like to advise that we have, and make available, the facility to afford boards sensible flexibility to accommodate local circumstances, such as brokerage. One component of that greater flexibility is the use of the Government's arrangements with the Treasury to carry forward an agreed level of resource from one year to the

next. That type of wider financial planning allows us to ensure that resources for health are fully utilised and to provide flexibility to individual boards based on their need.

I will say a few words about NHS performance. Much has been said in recent months on the delivery of waiting time targets. We should acknowledge that Scotland's consistent record of improved delivery over the past 10 years has seen waiting times progressively reduced to being the best in the United Kingdom and at their current all-time low. Although I am pleased that Scotland is delivering more than 98 per cent of the treatment time guarantee, I have advised all boards of the need to meet and then sustain that guarantee.

Since the committee's previous meeting, we have obtained the plans for 2014 from the boards with the biggest challenges, which are NHS Grampian and NHS Lothian. I have been personally advised by their chairs and chief executives that, with the investment and recruitment plans that are in place for 2014, they will meet and then maintain the treatment time guarantee—for Grampian, that will be from the end of summer 2014 and, for Lothian, it will be from the end of the calendar year 2014.

Confidentiality clauses were also a topic of discussion at the previous committee meeting. In fact, those are used in settlement agreements not only across the national health service in Scotland but with employees elsewhere in the public sector and in the private sector. In response to the committee's interest in the number of such settlements, I can advise that, in the national health service, we have used them approximately 150 times in the past three years. I should say that we are absolutely clear that no NHS board will use such settlements to prevent staff from voicing concerns about any aspect of patient safety or malpractice—indeed, it would be illegal to do so.

More generally, the Public Audit Committee may be aware from previous correspondence from Sir Peter Housden, the permanent secretary, that we are committed to strengthening the process by requiring public bodies and health boards not only to consult Government before committing to a settlement agreement but to report on their use of such agreements in a transparent manner in their annual reports. Proposals are currently being developed, and health boards will be consulted as part of that exercise across the public sector.

Thank you, convener, for allowing me to make an opening statement. I look forward to the questions.

The Convener: Thank you, cabinet secretary. It is worth emphasising what I have said about excellence in the national health service—it would be wrong to take any criticism as a criticism of the efforts of individual staff or to question their commitment to a publicly funded NHS. The issue for us is to look at the strains and stresses on the NHS and to consider whether the Government is properly factoring them in, so that we can assess whether we are adequately resourcing the service and planning for future demand.

I return to what you said about the treatment time guarantee. You have said what will be done to ensure that health boards meet that guarantee, and you will be aware from the Audit Scotland report that few of them were doing so. Mr Gray previously told the committee that he has accepted that the Government was not fulfilling the will of Parliament in that regard. Do you agree with that?

Alex Neil: The treatment time guarantee was set down by Parliament in the Patient Rights (Scotland) Act 2011 and is now a legal duty on the national health service. By definition, if a health board is not meeting the treatment time guarantee it will not meet the requirements of the legislation. That is why we are insisting that every health board meet the guarantee, and I have made it absolutely clear to the two health boards that have had the greatest challenge in doing that—NHS Grampian and NHS Lothian—that they have no option in the matter; it is a legal requirement and they must get themselves into a position, as they are doing, to meet the guarantee.

The Convener: Do you agree with Mr Gray that it may not be possible to ensure that there are no breaches of the guarantee?

Alex Neil: In a system that deals with the number of patients that we deal with every year, there will always be a substantial risk. For example, in a small hospital where there is only one consultant in a particular discipline, if that consultant becomes ill suddenly and is absent for a period of time, there is a chance that the guarantee may not be met. However, until now, across the health service as a whole, we have achieved a rate of more than 98 per cent in relation to meeting the treatment time guarantee, even with the problems in Grampian and Lothian. I think that, by any standard, most folk would accept that that is a credible performance, but the law says that we must reach 100 per cent and we will get there.

The Convener: Why put into law that particular target but not, for example, the right to be treated in accident and emergency within a defined time period?

Alex Neil: That relates to legislation that the Parliament passed three or four years ago, and obviously—

The Convener: The legislation was promoted by your Government. Why that target?

Alex Neil: The legislation was also supported by other parties.

The Convener: But it was promoted by your Government, so why that target and not others?

Alex Neil: I will explain that if you will let me finish my sentence. It was the wish of the Parliament to pass that into legislation, and it emanated from the terrible waiting times that we had prior to 2007. As a former Deputy Minister for Health and Community Care, you will remember that, way back in 2001-02, waiting times for some procedures that are now down to 12 weeks were measured not only in months but, in some cases, in years. The public's primary concern was that waiting times and waiting lists were far too long, and that was the top priority.

The reason for not putting other targets into law is that the degree of public concern about waiting times and waiting lists—for A and E, for example—has not been so great. The latest statistics on A and E show that we are meeting our 95 per cent target, and most folk would accept that that is a reasonable performance.

The Convener: Tell me, then, what is meant by a legal right to treatment.

Alex Neil: It means that everybody who has been referred for treatment has to have that treatment within the 12-week period. There is also the 18-week target, which is from the initial contact with the general practitioner to treatment, but within the 18 weeks we have the 12-week target, which is from referral for treatment to the treatment. That is what it means, and that is, in law, what every patient is entitled to expect.

The Convener: If the patient does not get that, what happens?

Alex Neil: A whole range of things happen. First, there is redress under the legislation that pre-dated the 2011 act. Patients can go through the formal national health service complaints procedure, and if they are not happy with the outcome they can go to the Scottish Public Services Ombudsman. In addition, they can, if they so wish, resort to law.

Under the legislation and the specific guarantee, there are additional measures that boards are duty bound in law to carry out if they do not meet the guarantee. They have to write to the patient and explain why they have not met the guarantee, and they have to ensure that, where a patient has not been treated within the 12-week period, they are treated as soon as possible after it. Our statistics show that the vast bulk of people are treated well within a 15-week period.

I am sure that you are aware that that is what the legislation states.

The Convener: You said that patients have the right to use the complaints procedure and to go to the ombudsman, but those things would be there anyway, for example for those whose accident and emergency waiting time guarantee is not fulfilled, or whose out-patient requirements are not met. They are there for anyone. A legal right is not required. What is different about the legal right compared with other aspects of complaints procedures?

Mr Gray told us that, if someone's legal right is not fulfilled, they can go to judicial review. You and I know that judicial review is both time consuming and exceedingly expensive. It might be an option for you or me, on the salaries that we earn, but it is not easily available to most of our constituents. What rights, other than those that exist in relation to any aspect of the NHS, distinguish the legal right from the other targets?

Alex Neil: The additional rights in respect of the treatment time guarantee that were built into the Patient Rights (Scotland) Act 2011 are as follows. First,

"The Health Board must—

(a) make such arrangements as are necessary to ensure that the agreed treatment starts at the next available opportunity".

That is not in law for any other target, although we tried to introduce it.

Secondly, it must

"(b) provide an explanation to the patient as to why the treatment did not start within the maximum waiting time".

Again, that is not in law for any other target.

Thirdly, it must

"(c) give the patient details of—

(i) the advice and support available (including in particular the patient advice and support service described in section 18)."

That is not there for any other target. The patient must also be given details of

"(ii) how to give feedback or comments or raise concerns or complaints."

That is not in law for any other target.

Fourthly,

"In making the arrangements mentioned in subsection (2)(a), the Health Board—

(a) must not give priority to the start of any treatment where such prioritisation would, in the Health Board's opinion, be detrimental to another patient with a greater clinical need for treatment,

(b) must have regard to the patient's availability, and

(c) must have regard to other relevant factors."

Although we tried to introduce those things for every target, they are not in law elsewhere. It is

unique to the 2011 act that they are built in as legal requirements.

If you go back and look at the stage 1 evidence, the stage 2 amendments and the stage 3 debate on the bill that set up the treatment time guarantee, you will see that a universal view was held right across the Parliament that there should not be additional legal redress.

Let me quote Jackie Baillie—I quote her often because she is full of wisdom. Speaking as the Labour Party's official health spokesman, she agreed that we do not want to create a compensation culture or a "bonanza for lawyers". We would all agree that we do not want to end up with an American system in which the lawyers dictate everything and we lose sight of what the patient needs. Of course, that is why your own party did not move an amendment for further legal redress beyond what was already in the bill, and Parliament signed up to that.

09:45

The Convener: But that brings us back to the question why we should bother putting the provision in legislation in the first place when it is so complicated, there is no evident easy route for patients to exercise their legal rights, and there does not appear to be any impact on the health boards that fail. It becomes a farce because, even if people know their legal rights, they are not able to exercise them. Paul Gray has said that the option is then to go to judicial review.

Cabinet secretary, this morning you have read out a list of things that should happen if the target is not met. Through you, I ask Mr Gray to provide the committee with details of the number of times that each health board has had to do the things on the list that you read out. That will let us know both the scale of the problem and, for example, that people who are having to wait are being informed and the requirements are being met. Presumably those statistics exist.

Alex Neil: To describe the situation as a farce is ridiculous. The farce was when people had to wait months for treatment.

The Convener: We accept that.

Alex Neil: They are now getting their treatment within 12 weeks. We inherited the farce of long waiting times and long waiting lists, and at the time our priority was to deal with waiting lists and waiting times. We have done that so dramatically that we now have by far the best waiting times in the whole of the United Kingdom. If you compare us with Wales, where the waiting times and the accident and emergency turnaround times are way out of control, you will see that the Scottish health system is doing brilliantly. To describe that as a farce is a bit ridiculous.

You also said that people are not able to exercise their legal rights. That is not true. They are exercising their legal rights under the 2011 act. All the procedures that I outlined are being used.

The statistics that you asked for are available, convener. We will send them to the committee. They have already been published, and we will send any additional information that the committee wants, because I am keen to ensure that it has all the information that it requires to do its job of scrutiny in order to make sure that we are delivering on the legislation.

The Convener: I am asking for information on each of the categories that you listed. I want to know how many times each health board has actioned each.

Alex Neil: We will provide that.

The Convener: That is fine, if the information is there.

You misinterpret what I say if you suggest that I was describing what has happened with waiting lists as a farce. What I said was that it is a farce if people cannot exercise their legal rights. Mr Gray has previously told us that people could end up going to judicial review.

I have not come across any cases in which health boards have written to people. Have you had to intervene with any health boards in the past couple of months in relation to individual cases in which people are telling you that their legal rights have not been met?

Alex Neil: No one has come to me and said that their legal rights have not been met when they have had a problem with the treatment time guarantee. Every patient who has come to me as the constituency MSP for Airdrie and Shotts has been told why there is a problem.

We will absolutely give the committee information on any health board that has not carried out its legal duty. If any member of the committee, the Parliament or the public believes that they have an example of when such a legal duty has not been carried out, they should write to us and let us know because we will then take corrective action to make sure that it is carried out.

The Convener: That is helpful.

Are you saying that you have not had to contact any health board on behalf of any individual who has said that their treatment time guarantee has not been met?

Alex Neil: Do you mean as an MSP or as the cabinet secretary?

The Convener: Either.

Alex Neil: As an MSP, I certainly have not had to do so, and as the cabinet secretary I do not recall having had to do that. However, we will double check to ensure whether any of us has had to do that, and we will certainly provide the information. I am determined to ensure—it is in our interests to do so—that every health board in Scotland abides by the law.

The Convener: Could you also provide us with the details that are given to each patient on how they can exercise their legal right? Is that in the form of a leaflet, or is a letter issued to them?

Alex Neil: I have two points on that. First, information is given to patients at every stage. For example, if a patient is unable, for their own reasons, to attend within the 12 weeks, they are told what will happen and what their legal rights are. As the primary legislation says, if for any reason a health board is unable to fulfil the guarantee, the patient has to be told. At that stage, the health board has to tell the patient why that is the case, when they can expect to get their treatment and whether there is a choice of locations where the treatment can take place. We will give the committee a flow chart that shows, right through the system, from the time that a patient goes to their general practitioner, what should happen in law if the treatment time guarantee is not met and what information they should be given.

Secondly, we are reviewing the process. The treatment time guarantee has been up and running for more than a year, as it was introduced from 1 October 2012. I want to ensure that we not only tell patients but tell them timeously and in language that is easy for them to understand, is not too legalistic and is in various formats. Obviously, many patients like to be emailed. I would like us to use the method of communication that is preferred by the patient. We are reviewing the process, and we will publish the report of that review by the end of June.

The Convener: What sanctions are taken against health boards if they do not meet the target?

Alex Neil: If a health board does not meet the target, we sit down with it, as we have done with NHS Grampian and NHS Lothian. Rather than take a legalistic approach, our preferred approach is to work with a board to get it into a position whereby we can ensure that it will deliver. In the cases of Grampian and Lothian, that involves a fairly substantial investment programme. For example, the investment programme in Grampian includes the commissioning of three new theatres in the area between now and the summer of 2014 to ensure that the board can deliver on the treatment time guarantee. Most other boards have met the guarantee in most months, although there might be the odd month in which they have not met it. Overall, as I say, even with the problems in Grampian and Lothian, we are still at more than 98 per cent. I think that, as far as the public are concerned, that is a fantastic achievement.

Bob Doris (Glasgow) (SNP): I will ask briefly about patients' rights, and then come on to an audit question. The 12-week waiting time guarantee is entrenched in legislation, and the convener explored how people can exercise that right. However, in relation to the responsibilities of Government and health boards, would new primary legislation be required to withdraw the target? My reading is that the 12-week target is a Government target that is entrenched in law so, if a future Government wished to disavow the target, it would have to pass primary legislation. Is that the case?

Alex Neil: To abolish the treatment time guarantee, the primary legislation would have to be changed. An act of this Parliament created the treatment time guarantee.

Bob Doris: That is a pretty strong protection, so it is important to put that on the record. Time and again, whenever I raise issues in relation to targets on waiting times or whatever, I always take the view that, when targets are missed, it is important to identify that that has happened, but it is more important to consider what is done to address the issue. That is a clear role for the committee in auditing the process. My questions will refer to that and to budget decisions.

I am delighted that the Auditor General's audit update shows that in my health board area in Glasgow the waiting time guarantee target is being met in 100 per cent of cases but I note that, as has been mentioned, the figure for NHS Grampian is 96.1 per cent. The cabinet secretary mentioned the development of three new operating theatres in that area. I would certainly find it helpful if the audit process showed not just the part of the picture in which waiting times targets, which are a legally entrenched right, are missed but the investment decisions that each health board has taken in order to address the problem.

I do not know whether there is a role for the cabinet secretary in that regard or whether we need to raise the issue with the Auditor General. However, as far as audit scrutiny is concerned—and, as a member of the Health and Sport Committee, I know that its scrutiny of the matter is very different—can you give us any information or signpost us to anything that would allow us to look at the health boards that are doing well and those that might have capacity or financial issues, consider what they are doing to address those issues and find out whether that sort of thing can

be quantified in a way that we can audit and scrutinise?

Alex Neil: Absolutely. We will send you the full list but let me give you some examples, starting with Grampian and Lothian, of what we are doing.

NHS Grampian has invested £18 million in a programme to increase capacity by building three new theatres and employing more doctors, nurses and support staff. That project has been planned over this year, and its final phases will be completed shortly. NHS Lothian has a £37 million investment plan for increasing internal capacity over the next three years, and it reckons that it will reach the treatment time guarantee by the end of the financial year.

We have provided NHS boards with £29 million specifically to deal with waiting times in the current year, and you might have noticed that yesterday I announced an additional £1.5 million for increasing capacity at the Golden Jubilee hospital. Of the 1,500 extra operations that will be carried out at that hospital as a result, 1,200 will be for cataracts and 300 will be for joint replacements.

I can give you more examples from my list. NHS Ayrshire and Arran is investing around £9.7 million in recruiting 13.5 whole-time-equivalent consultants, nursing and other clinical support staff to increase capacity in orthopaedics, cardiology and oral and maxillofacial services. Borders is investing £1.46 million for the same purpose, Dumfries and Galloway £2 million and Fife an additional £2.3 million. All that is on top of their normal investment programmes. Supplying the committee with a full list and that information will not be a problem.

Bob Doris: That would be very helpful, cabinet secretary. When the committee returns to the issue this time next year or whatever the appropriate time might be, the question in my head will be whether, given the levels of investment that you have identified, there has been any improvement. If there has, that will be fantastic and we will recognise that; if not, we will certainly ask questions about why the money has not been used in the most appropriate and effective way. If you can provide the committee with a list setting out a financial sum for each health board and a summary of their action plans using those finances, we will be able to audit whether that money has been used effectively to meet their 12-week guarantee.

Alex Neil: We will do that.

Bob Doris: I am glad that the whole committee shares that commitment.

Colin Beattie (Midlothian North and Musselburgh) (SNP): A recurring theme that the committee has noticed is the availability and quality of information on which decisions are being taken. Clearly there is a deficiency across the public sector in the way that figures are being produced—and indeed a question whether they are being produced at all. Page 24 of the report says:

"ISD Scotland is developing an electronic benchmarking tool of key indicators".

I note that

"The ... tool will be available from January 2014"

but are there any implementation dates for the different health boards?

Moreover, paragraph 41 of the report says:

"NHS boards should continue to improve their own internal monitoring."

Clearly the boards are having to build on their current systems in order to produce meaningful figures, but are we satisfied that the process is being adequately monitored and driven forward?

10:00

Alex Neil: The NHS's electronic benchmarking system is up and running. Indeed, yesterday, John Connaghan, who has overall responsibility for performance and delivery, and I were going through a number of areas, looking at the benchmarking of certain procedures and how well some boards were doing compared with others. Now that the system is up and running, we are benchmarking regularly to compare boards and find out where some could do better.

Of course, we benchmark not just procedures. We also benchmark the use of prescription drugs, the bill for which will be about £1.3 billion this year for the national health service, because we reckon that if every health board was as good as the best we could save a significant amount of money. In implementing the Auditor General's recommendations for saving £26 million by doing certain things, we are, in that benchmarking exercise, also looking at how we can improve on those savings. After all, we want to save money where we can and ensure that it goes to front-line services.

Similarly, I draw your attention to the report on the NHS estates that we published last Friday and which contains a very interesting table summarising the benchmarking of certain costs right across the health service, broken down by board. For example, it compares cleaning costs per square metre and sets out the range of costs across the boards in that respect. We are benchmarking that information to find out where we can get better value for money by getting those boards whose costs are out of line into line with best practice. All that work is being driven by the

electronic version of the benchmarking information that you mentioned; in fact, it is allowing us to step on the accelerator.

Colin Beattie: That sounds like good news.

My only other question is about whistleblowing procedures, which the committee has discussed at length in the past. Of course, everyone has referred to the whistleblowing in the Lothians. Can you assure us that such procedures are in place across the whole of the NHS and that they would prevent the recurrence of the situation that happened in NHS Lothian?

Alex Neil: Absolutely. We have put in place very robust whistleblowing policies and procedures. For a start, we have the whistleblowing line. Ironically, we get more calls from the rest of the UK than we do from Scotland, but we cannot do anything about them.

As I have iterated time and again when given the opportunity, I want people who see anything going wrong in the national health service or any practice being applied that should not be to blow the whistle. In fact, they have a legal duty to do so if something is going wrong or if some practice or malpractice is taking place.

Secondly, I want to ensure—and we are ensuring—that there is no victimisation of any whistleblower. It is important for people to know that, if they blow the whistle, there will be no adverse impact on their career opportunities or any other aspect of their work for the NHS.

With regard to confidentiality agreements and gagging orders, the *Daily Mail*—a wonderful, wonderful newspaper that I would be the last to criticise—does not seem to be able to make the distinction between a confidentiality agreement and a gagging clause that does not permit a person to disclose malpractice or whatever. Gagging clauses are illegal, and we do not do them. We still have confidentiality agreements, which are very often put in place at the request of the person who is signing them with us because there might be something about their own medical information or something else that they do not want to become public knowledge.

We are looking at what more we can do to make the policy even more robust, because I am absolutely determined to get to a situation in which people know that we will not sanction in any way anyone trying to gag a current or former employee, or anyone else related to the national health service, who wants to blow the whistle on something. I make that absolutely clear.

I will make something else clear, too. I have been looking at the information that is available to the Auditor General and, indeed, to this committee, and at the information that is available on confidentiality agreements in parallel organisations south of the border. I have asked officials to work with the Auditor General and this committee to ensure that both the Auditor General and the committee get whatever financial information is needed from confidentiality agreements to allow you to do your job of scrutinising public spending. That is another example of my being very keen to give—where I can, and in the spirit and the legal requirements of confidentiality agreements—both the Auditor General and this committee the information that they need to do their job.

I have asked Paul Gray and his team to look at that and to discuss with the Auditor General and the committee how best we can make that happen.

Ken Macintosh (Eastwood) (Lab): I will continue the same line of questioning, if I may. I welcome your comments, cabinet secretary. I think that people will be encouraged, at least, by your intention in this regard. However, I am not quite sure that what you describe is happening in practice. Were you pleased to see the decline in the use of unavailability codes, which the Auditor General flagged up in her report?

Alex Neil: A lot of the unavailability is patient unavailability. In terms of the treatment time guarantee, patients have the right to say that they are not available because, for example, they are on holiday or on some business. We have tightened up the system enormously compared with the previous system. We have implemented the Auditor General's recommendations to ensure that unavailability codes cannot be abused in any way or used to hide anything that is going on that should not be going on in measuring the time that it takes for people to get their treatment.

Ken Macintosh: Can you clarify that you agree that the codes were misused by NHS Lothian?

Alex Neil: I do not think that there is any doubt about that. I think that the report into NHS Lothian made that absolutely clear. Obviously, we have all learned a lot of lessons from the NHS Lothian experience. As you know, we have been working in a very detailed way with the Health and Sport Committee to ensure that we now have a much more robust system for ensuring that we have validated statistics and information to measure waiting times for patients.

Ken Macintosh: I am glad that there is a new system. The Auditor General highlighted in her report that the general use of unavailability codes began to decline after it was identified as a problem in NHS Lothian; she also pointed out that that was not because it was revealed by scrutiny. In other words, she could not reveal the misuse of unavailability codes through audit, and it was

revealed by a whistleblower. Do you accept that that is what happened?

Alex Neil: I think that we all know that what happened in NHS Lothian was an abuse of the system. We have taken appropriate action. For example, the chief executive at the time is no longer with NHS Lothian. I think that my predecessor took very decisive action to deal with the NHS Lothian situation.

In her report last year, the Auditor General did a complete review of the way in which we measure waiting times across all NHS boards. Although she was critical of some of the systems, a paper audit that was done to see whether any fiddling was going on found that there was no fiddling in any board other than what had taken place in NHS Lothian. I think that the Auditor General is now satisfied on that issue.

Of course, we are improving the systems all the time. In NHS Greater Glasgow and Clyde, for example, when we came in in 2007 11 different information technology systems were being used to measure waiting times in Glasgow. We have got that down this year to one IT system. That is one way in which we can ensure the authenticity of the information that we are being given.

Ken Macintosh: I just ask again: were you pleased by, and do you recognise the importance of, the whistleblower in revealing the misuse of unavailability codes?

Alex Neil: Absolutely. I have just said that I want people who see malpractice to whistleblow, because I am not here to defend malpractice in any way, shape or form.

I have had discussions with whistleblowers, some of whom have felt in the past as though they have been victimised. Where I, or any of us, can ensure that that does not happen, we will do so. I have made it absolutely clear on more than one occasion and in writing to every chair, board and chief executive throughout the national health service in Scotland that people who blow the whistle should be welcomed and we should listen to what they are saying and check it out to see whether it stacks up. We should ensure that people who blow the whistle are in no way victimised within or by the national health service or anyone working within it.

Ken Macintosh: In that case, why is a confidentiality agreement inserted automatically in every single settlement arrangement or compromise agreement within the NHS?

Alex Neil: That has been standard procedure for a long time. As I said, I am looking at how we can be more robust. I am quite happy about looking at whether we can relax some of the procedures in terms of confidentiality agreements. There are of course legal implications. We need to be very cognisant of employment law and various other things. However, the one thing that I should stress is that even where there is a confidentiality agreement, the information on whistleblowing-type activity is specifically included in the agreement. It is written in that the person cannot in any way have action taken against them.

If someone signs a confidentiality agreement as part of a settlement, and they leave the employ of the national health service and the next day they phone up the newspapers or get in touch with a local MSP to whistleblow, that would not be a breach of the confidentiality agreement and no action could be taken against them per the confidentiality agreement. No action would be taken against them; in fact, I would welcome such whistleblowing, because I think that where there is malpractice, people should blow the whistle.

Ken Macintosh: In that case, do you recognise that in a confidentiality agreement it is illegal for someone to even declare that there is a confidentiality agreement?

Alex Neil: That is one of the areas that I am looking at. Obviously, this is historical because confidentiality agreements have grown up over time. I am looking at whether, even leaving aside the gagging issue, they are too restrictive. I am reviewing that at present.

Ken Macintosh: You suggested earlier that very often the agreements are inserted at the request of the individual concerned.

Alex Neil: Yes.

Ken Macintosh: In how many cases do individuals request confidentiality agreements?

Alex Neil: Over the past three years we have signed 150 or so confidentiality agreements.

Paul Gray (Scottish Government): It is 148.

Alex Neil: Sorry. I was two out. I do not have to hand the exact number of cases when an employee asked for the confidentiality agreement, but I am happy to see whether we can provide that, provided of course that doing so would not breach part of the confidentially agreement.

Ken Macintosh: Interestingly, in your written response to the committee, you said that of the 148 settlement agreements over the past couple of years

"all but one contained a confidentiality clause".

That sounds to me like it is automatic.

Alex Neil: What is automatic?

Ken Macintosh: Well, perhaps I should ask Mr Gray this. I asked Mr Gray this question at our previous meeting, and it was in a letter that the

committee sent to you, cabinet secretary. There have been 697—almost 700—of these agreements over the past five years. The specific question that we asked was how many of those contained confidentiality agreements.

Alex Neil: I will let Paul Gray answer that.

Paul Gray: Mr Macintosh, as I explained in my letter, the data is held by the boards. In an attempt to be helpful to the committee, I asked them to go back to the 2011-12 financial year for the data. I genuinely do not want to put in front of the committee information that is inaccurate or unvalidated, but my understanding is that the 697 agreements referred to included a number that were not in fact to do with settlements outside the normal early severance scheme. There was some confusion in relation to the response on that number, which I think was given via a freedom of information request.

What I sought to provide to the committee was as accurate a number as I could back to 2011-12. That number is 148, of which 147 did, as you say, contain a confidentiality agreement. As I said to you when we spoke about this at my evidence session on 29 January, that is one of the issues that I have been discussing with the cabinet secretary. He has made clear that he will take a view on that level of usage of confidentiality agreements. When that view is reached, I have no doubt that the cabinet secretary will inform the committee.

10:15

Ken Macintosh: I am sure that the committee is pleased that you found out about the 148 agreements going back over the past couple of years. Can you conduct the same exercise going back to 2007-08 for this committee?

Paul Gray: If I can, I will.

Ken Macintosh: Thank you. Given that 147 of the 148 agreements in the past couple of years have contained confidentiality clauses, how many of the 697 agreements over the past five years do you think contain confidentiality clauses?

Paul Gray: I am not prepared to answer that until I have done the exercise, Mr Macintosh. I would like to put accurate information in front of the committee.

Ken Macintosh: Given that 147 of the 148 agreements contained confidentiality clauses, do you think that it is almost a matter of automatic policy?

Paul Gray: It appears to be so.

Ken Macintosh: So do you think that maybe the vast majority—maybe 99 per cent—of the 697 agreements contain confidentiality clauses too? Is that a likely scenario?

Paul Gray: I would be speculating, but it is probable.

Ken Macintosh: The cabinet secretary stated earlier that very often such clauses are inserted at the request of the individuals concerned. Can you give me any examples of that?

Alex Neil: I said that sometimes they are inserted at the request of individuals.

Ken Macintosh: No, cabinet secretary, you said that they are very often inserted at the request of the individual concerned. Those were your exact words—"very often". How many examples do you think you will be able to find of individuals requesting such clauses, given that they are automatically inserted in every agreement?

Alex Neil: It would be very difficult to get a precise figure, but we will see whether we can give some indication to the committee of the number of requests—

Ken Macintosh: Cabinet secretary, why did you say that the clauses are very often inserted at the request of the individual concerned if you cannot back that up with any evidence whatsoever?

Alex Neil: I am just going by the anecdotal evidence that I have collected in my 18 months in this job. When I have spoken to individuals as well as to people on the health boards, I have heard that sometimes there is information that the individuals themselves do not want to be disclosed.

Ken Macintosh: So—hang on a second—we have gone from the statement that they are "very often" inserted at the individual's request to the statement that you understand, anecdotally, that they are "sometimes" inserted at the individual's request. Is that right?

Alex Neil: I am saying that confidentiality agreements should not be abused. They cannot legally include gagging orders. When people leave the national health service under difficult circumstances, traditionally—going right back through many previous Administrations—confidentiality agreements are drawn up. That is not new; it has been done for many, many years.

Sometimes, the individual does not want to have some of the information released, apparently, but obviously, there has been no statistical collection to date of the level of detail that you are looking for. We will establish whether we can quantify the number of times that there have been specific requests from the person signing the confidentiality agreement. If we cannot quantify that, we will come back to you.

I meet patients, staff and NHS people generally day in, day out in this job and, obviously, I have 15 years' experience of hearing from constituents as an MSP as well. I am telling you that, certainly, a number of people have told me over the years—both people who have signed agreements on behalf of the health board and people who have been signatories—that there were elements within the contract that the individual concerned did not want to be released to the public.

Ken Macintosh: Health secretary, you are saying that this has been going on for years and that—

Alex Neil: The confidentiality agreements have been standing practice for a long time.

Ken Macintosh: You say that you have no statistical information but that you would like to try to gather some. Perhaps I can refer you to my own parliamentary questions on this issue, because the use of compromise agreements in the NHS has been rising over the past few years, particularly since 2007. Perhaps you could refer to the answers to those questions. The point is that this involves an extensive use of public money. How much money do you think is spent—or could you find out how much is spent—enforcing or including these confidentiality clauses in NHS contracts?

Alex Neil: As I said earlier, I am happy—unlike any of my predecessors—to get any information on the costs to the Auditor General and to the committee to allow the committee whatever information it needs to do the proper scrutiny. I am further reviewing the role of confidentiality clauses precisely because I have concerns that they may be unnecessary or overrestrictive in many cases. One of the reasons why the number has gone up is that there has been a substantial increase in the number of people who are employed in the national health service since we came to power.

Ken Macintosh: Will you find out exactly how much is being spent on enforcing gagging clauses?

Alex Neil: If the figure can be obtained, we will be happy to share it with the committee. I honestly doubt that it can be obtained, but we will ask the central legal office.

Ken Macintosh: I may ask you later to comment on the cases of Dr Jane Hamilton and Mr Rab Wilson, who has petitioned the Parliament.

How many public interest disclosures, or protected disclosures, have there been in the NHS in the past five years?

Alex Neil: We can give you that information—we will try to get it for you.

Ken Macintosh: Do you believe that any of the 697 people who have signed confidentiality agreements has made a protected disclosure?

Alex Neil: We will come back to you on that. I will not give you information that I have not checked out beforehand.

Ken Macintosh: Does the use of these clauses encourage an attitude of transparency in the NHS, which you spoke about earlier?

Alex Neil: One of the reasons why I—unlike any of my predecessors—am reviewing their use is that I want to ensure that they are not being used to hide what should be transparent. I am sure that many such agreements were signed when Mr Henry was a junior health minister.

The Convener: Not by me.

Alex Neil: Well, the agreements were not signed by the minister, but they would have been signed at that time.

Ken Macintosh: Does the health service in Scotland have anything to learn from the Mid Staffordshire NHS Foundation Trust scandal in particular?

Alex Neil: Absolutely. We have responded not just to the Mid Staffordshire situation but to subsequent reviews, such as the Keogh inquiry and the Berwick inquiry that followed it. Professor Leitch was a member of the team that was chaired by Professor Don Berwick, who describes the health service in Scotland as the safest in the world.

Ken Macintosh: Is legal protection for whistleblowers as strong in Scotland as it now is in England?

Alex Neil: I am not legally qualified to make a judgment on that. You will have to ask a lawyer.

The Convener: Before I bring in Tavish Scott, I note that Mr Connaghan told the committee twice that he was the whistleblower in the NHS Lothian situation. Why did a senior member of your management team have to use the whistleblowing process to rectify a problem?

Alex Neil: Mr Connaghan said that he identified the problem in reviewing the management of information. I am happy for him to expand on that.

The Convener: Before he comes in, I will give you his exact words.

Alex Neil: I have read them.

The Convener: He said:

"I can remember exactly what happened with NHS Lothian because I was the whistleblower."

He went on to say:

"That report was made public in, I think, March 2012. As I said, I was the whistleblower."—[*Official Report*, *Public Audit Committee*, 29 January 2014; c 2097.]

Alex Neil: As I said, my interpretation of that—John Connaghan can speak for himself—was that he, as the person who has primary responsibility for reviewing performance in delivering information, identified that there was a problem.

John Connaghan (Scottish Government): I am happy to amplify that, convener. In any such complex situation, there are a number of layers. It is true to say that unfair offers by NHS Lothian of treatment by an English healthcare provider were identified, so we need to acknowledge that the very first issue was raised by a member of the public, probably around October 2011.

However, there is a world of difference between that issue and the issue of the deliberate manipulation of statistics that eventually unravelled in NHS Lothian. It is in that respect that I made my remarks about being a whistleblower on the matter. I have checked my assumptions on that with the investigating officer in NHS Lothian, with ISD Scotland and with my team. It is clear that deliberate manipulation was uncovered by that team, so I am happy to stand with some degree of humility alongside the other whistleblowers in that situation.

The Convener: Was there someone other than you who was the whistleblower?

John Connaghan: I am not quite sure, but I certainly recall what we did in the team that uncovered the deliberate manipulation. I am not aware of anyone else who wrote to NHS Lothian at that time to say that that area needed to be subjected to detailed internal audits; I referred at the previous committee meeting to my letter of 6 January.

The Convener: Does the health service keep a record of whistleblower complaints?

Alex Neil: In the sense that we have a register?

The Convener: Yes.

Alex Neil: We do not per se, because the whistleblowing takes place primarily in the boards. Each board would be able to tell you how many times someone has raised an issue internally.

The Convener: But there is a whistleblowing procedure—is that correct?

Alex Neil: Yes.

The Convener: When someone uses the whistleblowing procedure, is a record kept of the complaint that is made?

Alex Neil: Each board will have its own record, yes.

The Convener: Right. So NHS Lothian will have a record of the whistleblowing complaints that have been made.

Alex Neil: It should have, yes.

The Convener: Will the records show that, on the matter that we are discussing, Mr Connaghan—and not anyone else—was the whistleblower?

Alex Neil: No, convener—you know fine that that is not the case. Mr Connaghan was operating as the director for delivery and performance, and he was using the word "whistleblowing" in a slightly different context.

We are having an adult conversation about whistleblowing, and we are talking about people working in national health service boards who see malpractice and report it. Mr Connaghan's job is to audit the performance of each board. In that respect he said that he was, in essence, the equivalent of the whistleblower.

The Convener: No, no, no—

Alex Neil: You are playing with words, quite frankly.

The Convener: I am not playing with words. You are trying to introduce words that were not there, such as "in essence." Ken Macintosh asked Mr Connaghan a very specific question—he asked:

"Are you suggesting that the whistleblowing about NHS Lothian had nothing to do with what happened?"

John Connaghan said:

"I can remember exactly what happened ... because I was the whistleblower."

He then repeated that, saying:

"As I said, I was the whistleblower."—[*Official Report*, *Public Audit Committee*, 29 January 2014; c 2097.]

That was all in the context of a discussion about whistleblowing. You have told me today that NHS boards keep a register of whistleblowing. Mr Connaghan has said that he was—

Alex Neil: I did not say that boards keep a register; I said that they will have a record of every case.

The Convener: Okay—they will have a record. So we can go back to NHS Lothian and ask for that record, and ask the board to confirm that Mr Connaghan was in fact the whistleblower. He did not say "in essence"—he said, "I was the whistleblower", twice.

Alex Neil: Fine—why don't you do that, then?

John Connaghan: I will make a suggestion. I said that the NHS situation was complex, like peeling back the layers of an onion. It may well be worth your while asking NHS Lothian to give you a sequence of events.

The Convener: Okay.

Tavish Scott (Shetland Islands) (LD): Never let it be said that this committee is not full of entertainment and liveliness.

Cabinet secretary, you mentioned NHS Lothian in the context of investment planning to deal with the treatment time guarantee. The letter that Paul Gray helpfully provided to the committee states:

"NHS Lothian has the biggest backlog, and as the Committee is aware, is making use of private sector facillties to manage this down. I expect a significant reduction in the use of the private sector as their internal capacity comes on stream."

That is a statement of fact about what is currently happening.

Alex Neil: Yes.

Tavish Scott: How much will the use come down by? Do you accept that there will always be some degree of private sector involvement in NHS Lothian?

Alex Neil: Not just in NHS Lothian. There are certain types of services that are available only in the private sector, for various reasons, so there will always be a small private sector contribution in the health service in Scotland.

However, the latest available figures, from last year, show that 0.8 per cent of our budget was used in the private sector, which can be compared with a figure of 11 per cent south of the border. For the purposes of this conversation we would not define the private sector as including GP contractors or dental contractors; we are talking about the use of private hospitals and so on.

With regard to capacity in NHS Lothian, two things are happening. First, we are improving the capacity in the NHS. I have referred to the Golden Jubilee hospital—where patients from the Lothian area are prepared to go there, that facility is made available.

Tavish Scott: But it is a statement of fact, as you have indicated, that the private sector will have a small but significant role in continuing to manage the complex issue that NHS Lothian and other boards are facing.

Alex Neil: Yes. Indeed, as part of the local delivery planning guidance, I have asked every health board to review their use of the private sector with a view to reducing that use, particularly where the capacity exists in the national health service in Scotland. There is little point in our using taxpayers' money to double fund capacity, in effect, if capacity exists in the health service.

Tavish Scott: Will you be so good as to keep the committee updated with that programme?

Alex Neil: Absolutely.

10:30

Tavish Scott: I have a question about the difference between the 12 weeks and the 18 weeks that you helpfully mentioned in your earlier remarks to the convener. Does the NHS keep statistics on the period between 12 weeks and 18 weeks?

Alex Neil: We measure the whole thing, and ISD regularly publishes validated figures on waiting times. We publish information on how many people are seen within the 18-week period. There is a threshold of 10 per cent, and in recent times we have consistently met that, with over 90 per cent of people being seen within 18 weeks.

Tavish Scott: But there is no legal attachment to the 18-week period. It is purely—

Alex Neil: That is correct. The only legal attachment is to the 12-week period.

Tavish Scott: It may be that most patients are seen within 18 weeks—90 per cent are, according to your figures. However, do you accept that, for most patients—for you and me and our constituents—the period between first seeing a GP and seeing a consultant is just as important as the 12-week period that is covered by the legal guarantee?

Alex Neil: Absolutely.

Tavish Scott: So why not have a legal guarantee for the full 18-week period?

Alex Neil: Again, we are going over the discussion that took place during the passage of the bill.

Tavish Scott: I am well aware of that.

Alex Neil: As you know, there were various opinions at that time on whether we should have any targets. Some people took the position that there should be no targets in statute. The Government's position was that, because of the particular concern around the period from referral for treatment to receipt of treatment, we should put a target for that into statute, but that was the only target that we would put in statute. That debate was had at the time, at stages 1, 2 and 3 of the bill.

Tavish Scott: I understand and accept that. I did not agree at the time, and I made my position clear, but—

Alex Neil: I do not have any quotes from you, Tavish.

Tavish Scott: Don't tempt me. I presume that you accept that, when ordinary folk go to their GP to get sorted out because something is wrong with them, that is where it starts.

Alex Neil: Of course. Aye.

Tavish Scott: You have made some strong statements this morning about wanting to review particular areas of NHS policy. Ken Macintosh has just raised that with you. If you believe in the point about a legal guarantee, is there not a public expectation and desire, which you have been keen to mention this morning in relation to the 12-week period, for a guarantee for the full journey from the point at which the person sees their GP?

Alex Neil: Absolutely. If people go to their GP and the GP says that they need to see a consultant, they will obviously want to see the consultant as soon as possible, particularly if certain conditions that are potentially life threatening are suspected. As you know, we have the specific 31-day and 62-day targets for cancer. That reflects the degree of anxiety felt by anyone who has suspected cancer. We do not have a parallel target for every condition under the sun. If you have a wart on your finger that needs to be burned off, the anxiety about that will be a lot less than the anxiety about other, potentially serious illnesses. We have the generic 12-week and 18-week targets, and then, for example, we have the two cancer targets of 31 days and 62 days.

Tavish Scott: But the Government has no plans to bring forward legislation in relation to the 18-week period. It is just a target.

Alex Neil: I have absolutely no plans to extend legal guarantees.

Tavish Scott: Thank you. I have a further question about this area. I presume that you accept that you are putting health boards under some significant ministerial pressure in relation to meeting the statutory targets. You said that clearly to the convener and the committee this morning. Does that have consequences for how boards deal with all the other responsibilities that they have to deal with, not least the financial ones?

Alex Neil: I am keen to ensure two things. The first is that we plan appropriately for the national health service. We are working on the 2020 strategy. We have the vision and the route map, and we are working on the detailed plan for how we will realise the vision for 2020. We carry out fairly regular reviews of the health improvement, efficiency and governance, access and treatment targets and standards—indeed, we are about to start one—and I am anxious to ensure that we meet the targets. We have to achieve the treatment time guarantee target, but I want to do it in such a way that we do not misallocate resource or prioritise areas that should not be prioritised vis-à-vis other areas that should be prioritised. Indeed, that is built in to the legislation at an individual level.

Secondly, I want to make sure that the way in which we achieve targets is driven by clinical judgment not just by bureaucratic targets set by politicians, and that is obvious in the way in which we issue guidance and try to manage these targets. For example, one of the reasons why we have the threshold for the 18-week target is that there is an element of clinical judgment. Cataract operations are a very good example. I am not a medic and Jason Leitch can correct me if I am wrong, but I am told that if someone has had a cataract operation in one eye, a minimum period of time should pass before they have the operation for the cataract in the second eye. It would not be the right thing to do, clinically, to have that second operation too quickly after the first. There might well be a target for that operation, but clinical judgment must reign supreme because it is the right thing for the patient.

Tavish Scott: That is fair. I asked you a general question and you gave me a general answer.

The reason that I raised the subject of oncology in Aberdeen for parliamentary debate was because of my concern, which I think is understandable, about patients from the northern isles being transferred to other places, including Little France and NHS Lothian. I have been told by health professionals and managers in the system that some of those transfers were caused simply by targets. The managers were under pressure. How will you rationalise a process that puts a huge amount of ministerial and bureaucratic pressure on health boards to deliver when, as you rightly say, they have to make clinical judgments all the time?

Alex Neil: First, before we set the targets, we obviously take into consideration the need to ensure that we are not cutting across what should be the right clinical judgment. That is why we consult widely before we establish a target or a standard.

Secondly, we review targets and standards from time to time. For example, I recently had a discussion with the Royal College of Physicians and Surgeons of Glasgow about the application of targets to make sure that they are not undermining the role of clinical judgment. I want to be sure that none of our targets do that. That is why, for example, the threshold on the 18-week target prevents that pressure from building up.

On oncology in the north of Scotland, we have had an issue around the availability of oncologist

specialist consultants, and we are recruiting vigorously to fill those vacancies. I think that I am right in saying that there is a particular challenge in the north of Scotland and the rest of the UK in recruiting colorectal oncologists. There seems to be a particular shortage of them. When something like that happens, particularly when we are talking about cancer, rather than wait until we have recruited new oncologists, we make sure that patients are treated elsewhere in the system so that they get the treatment that they require as a matter of clinical urgency.

Tavish Scott: I have one final question on information relating to the monitoring of performance. The matter was raised by the Audit Scotland report. It is about ISD publishing detailed data back to October 2012 to address trend analysis for the period in relation to the Patient Rights (Scotland) Act 2011. Is that what is going to happen?

Alex Neil: I am not charge of when official statistics come out. There is now the UK Statistics Authority and the UK statistics code. ISD, I and all my officials are governed by the codes. We provide ISD with all the relevant support, co-operation and information that we can, but it has to follow the code and all the instructions from the UK Statistics Authority.

Tavish Scott: I understand that. The committee is being told that all NHS boards will be providing detailed waiting time data to ISD by April this year, which is two months later than was reported to Audit Scotland, and that data will not be published until the end of August 2014. Is that your understanding of the position?

Alex Neil: Yes. That is because, once we supply the information, my understanding is that it then has to go through the validation procedure that is laid down by the UK Statistics Authority.

Tavish Scott: So it will be published in the summer, by August 2014.

Alex Neil: Yes.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): Cabinet secretary, in your opening remarks you talked about the financial performance of NHS boards and you said that all boards met their targets. We know that the NHS in Scotland is an £11-billion-a-year service and that, overall, the service reported surpluses and actually made some savings. However, one of the recommendations in the Auditor General's report was to look at the flexibility in setting the financial annual resource limits. Is it in the Scottish Government's current thinking to allow the boards a bit more flexibility from one year to the next to plan their work?

Alex Neil: Absolutely. At present, it is like trying to land a helicopter on the eye of a needle at the end of every financial year in every board area. Within our powers, we have as much flexibility as is required among the boards. We have 22 boards plus the central agencies and the Mental Welfare Commission for Scotland. From time to time, particularly towards the year end, it is necessary to reallocate funds, vire funds or brokerage funds internally, and we do that.

A good example relates to the Victoria hospital project in Fife. The completion date was slightly behind schedule, so the original financial plan for Fife was affected. We therefore took action to ensure that NHS Fife had the necessary funding to complete the Victoria and that that did not affect the on-going provision for existing patients and facilities in Fife. That is a fairly standard part of the financial management.

We think that the best way of facilitating our ability to do that more is the budget exchange mechanism, which would allow us to carry forward in the order of £30 million towards the end of the year. If we allow the health boards themselves to carry forward funding, there is a danger that they will start to build up reserves. In the college sector, some colleges built up very large reserves that were not being spent on college provision, and I do not want the same thing to happen in the health service. We think that using the budget exchange mechanism is a better way to work.

I ask John Matheson to explain it in more detail.

John Matheson (Scottish Government): I have a couple of points. We have flexibility at the moment, although we welcome the Auditor General's comments. We focus on long-term financial planning, but the artificiality of having to deliver something by 31 March each year can run counter to that. We agree three to five-year financial plans with boards and look at their financial planning assumptions.

The brokerage and the banking arrangements that the cabinet secretary referred to are designed to allow boards some flexibility, in recognition that they might have double-running costs. For example, that happened when NHS Forth Valley moved to the new hospital in Larbert, and we are in discussions with NHS Greater Glasgow and Clyde as it looks to the commissioning of the south Glasgow development in a couple of years. We are considering the double-running costs that will be involved in that and whether the board can bank some money with us. We have a similar arrangement in relation to Dumfries and Galloway royal infirmary.

We are in discussions with colleagues in the Scottish Government on how the budget exchange mechanism could further support that approach.

Within the £12 billion that we spend, it would give further flexibility centrally and more weight to the movement away from having to deliver on 31 March each year. It works well at Scottish Government level, so we are discussing with colleagues giving that flexibility to the health and social care directorate.

Willie Coffey: Overall, on a year-by-year basis, the boards still have to broadly stay within their allocations. If all the boards reported an overspend next year, the alarm bells might ring in this committee. In the context of the flexibility that you are talking about, how would we get the sense that that was not an issue and that the measures had been approved and agreed? If something like that happened, how would we get the sense that an alarm bell should not ring?

10:45

Alex Neil: We monitor the situation throughout the year, and John Matheson and his team are in regular touch with the finance people in each of the health boards. We look not only at the money that is already committed but at the balance that is available for the rest of the year, to ensure that they stay within budget.

If there is a challenge, such as arose at Larbert or at the new Victoria hospital in Fife, or with the Greater Glasgow NHS Board's project, which is the largest health building project in the entirety of Europe—£842 million is a lot of money even for Greater Glasgow—we manage that challenge in conjunction with the health boards to ensure that the cash flow and commitments are in tune with the plan.

As John Matheson said, if we need to brokerage a bit of funding, particularly towards the end of the financial year, we have the flexibility to do that.

Willie Coffey: Turning to waiting times, there has been discussion around the table about the 98 per cent compliance with the guarantee. I only ever achieved a 98 per cent exam mark in my first year at university and I was absolutely delighted with that, but I have never achieved such a mark since then. That is a fantastic performance, but some of today's discussion seems to suggest that it is a problem. I do not think that it is a problem, if health boards are genuinely pursuing the 100 per cent target, as they are legally required to do. The 98 per cent compliance rate that has been achieved is a fantastic performance by the NHS.

You referred to times gone past when people would wait months or even years before getting treatment. I would like to ask a more general question about the impact on the nation's health. What has the introduction of targets such as 18 weeks or 12 weeks done in terms of benefit to the health of the nation and driving forward improvement?

Alex Neil: For individuals, the result has been enhanced health outcomes. One thing for which we do not have a specific target, but where we are keen to make progress, is reducing the amount of time that people need to spend in hospital for any procedure. The longer someone spends in hospital, the worse their health outcomes will be compared with what could be expected if they spent less time in hospital. That seems ironic, but that is the truth of the matter, not just in Scotland but internationally.

The first benefit of improvements in meeting the targets is enhanced health outcomes, particularly for those with life-threatening conditions such as cancer. We still have a long way to go to be as good as the best in Europe on survival rates for lung cancer, for example, but we are in a far better position than we have ever been with lung, bowel, breast and other main cancers.

Secondly, there is a huge benefit to the economy because if somebody is on a waiting list for months before they can get a procedure and they have to be off work during that period, they lose income and they may have to go on long-term sick pay, at a cost to the exchequer, and their health will deteriorate until the procedure is done.

There can be a significant financial loss to the individual in such circumstances, but there is also a big financial loss to the state, so the quicker we can get people into hospital and get their procedures done, and the quicker those who are in work can get back to work, the more everybody benefits. Companies benefit, the economy benefits and the individual benefits financially; the financial benefit is huge.

Willie Coffey: You said that there are clinical reasons behind the 12-week target. I do not understand why it is 12 rather than 10, 11 or 13. I previously asked how quickly we pick up people after 12 weeks if they have not been seen within that period. Sometimes when we set a target, we forget to collect information at the tail end.

I know that Mr Gray responded to the question in his letter, but as a member of the Public Audit Committee I am keen to keep a close eye on the issue. If something is medically important about 12 weeks, I would be keen to see some response about how we pick up those for whom the target is not met and how we perform in treating them.

Alex Neil: I can give you that statistic. I am looking for it now, but I am sure that John Connaghan will have it. What is the percentage of people who are treated within 15 weeks?

John Connaghan: The answer was in Mr Gray's letter. I think that it was over 99 per cent.

Willie Coffey: So nearly all the people were seen within 15 weeks.

Alex Neil: Absolutely.

John Connaghan: One of the hidden benefits of having a relatively tight performance regime on waiting times is encapsulated in the reference to transforming the patient pathway in the document "18 weeks: The Referral to Treatment Standard". One benefit has been a transformation in the amount of day-case surgery, which has benefited patients and is making the NHS a little more efficient and productive. There are hidden benefits from transforming the system, making the entire journey a little slicker and pushing the boundaries of clinical practice.

Alex Neil: Professor Leitch has not had a chance to speak. He can say a word or two about the health benefits of the targets.

Professor Jason Leitch (Scottish Government): Apart from the benefits that have been mentioned, we know for sure that healthy life expectancy is increasing and that in-patient hospital mortality is reducing. That is partly the result of the increased work on healthcare-associated infections, the Scottish patient safety programme and other things that we have done in the healthcare system, but it is also partly the result of treating people earlier.

Someone who waits two years for a hip replacement is likely to get comorbidities in those two years—their heart disease or lung disease might get worse, for example. If we treat the initial cause more quickly, people get out of hospital more quickly and they are healthier when they are out as they can undertake their normal activities. Early treatment of acute disease is better for the individual and for the population's health.

John Connaghan is correct to say that such an approach is more efficient. If someone is treated earlier for their hip replacement, their wisdom teeth or whatever they are waiting for treatment for, they are healthier when they have the treatment, which is much better than waiting longer, when the person will be sicker. If they are sicker, they are in hospital for longer. That is bad for the patient and their family and for the system, because it is less efficient and less productive. More efficiency means that we can use the hospital service for the correct people—the people who need that care—at the time when they require it.

The surgical mortality rate in Scotland has fallen by a quarter in the past three years. I am not aware of such a reduction anywhere else in the world. That is partly the result of what we have done on safety and quality, but I have no doubt that it is also a response to the fact that we are treating people more quickly.

Willie Coffey: I am hearing that the health service is performing well and is delivering positive health outcomes for the population. How far can we push that? Should we worry about the health of a person whose treatment has not met the 12-week target? How far can we push the improvement in performance? I know that budgets are not infinite and that some degree of sense must be applied. One day in the future, could we bring down the 12-week limit?

Alex Neil: The profile is one of rising demand and increasing complexity. The ageing population has two consequences for health policy. The first is a significant increase in comorbidity, because people are living long enough to develop more ailments. The second is an increase in long-term conditions.

I will give you an idea of the volume that we are dealing with. We reckon that, at any one time, half Scotland's population is engaged with the national health service. That might be for a repeat prescription or for something terminal. Of the adult population in Scotland, 46 per cent have a long-term condition. We are dealing with about 1.75 million A and E presentations a year. Every year, somebody sees a doctor more than 30 million times—I should add that that is not the same person. Last year, for the first time in the history of the national health service in Scotland, more than 1 million admissions to hospital—some were repeat admissions—were made. That is a record.

I have a very interesting graph, which we would be happy to supply to the committee, showing what is happening elsewhere in the UK on waiting times. The graph, which is produced by the Office for National Statistics and is not based on Scottish Government statistics, sets out the "90th Percentile waits (unadjusted) for ONS's 11 key procedures" for Scotland, England, Wales and Northern Ireland. For hip replacement, we are the best in the UK, England is second, Wales is third and Northern Ireland is fourth; patients in Wales are waiting twice as long as patients in Scotland. The same is true for knee replacement procedures, while the position on cataract operations is much the same. Wales and Northern Ireland face deep problems in angioplasty waiting times. In the graph, Scotland has shorter waiting times for almost every single one of the 11 procedures. The only exception is endoscope of bladder, for which our waiting times are slightly behind those in England, but in every other case, Scotland is ahead of the rest of the United Kingdom. In the case of varicose surgery, if I hold the graph up, you can see Scotland's waiting time in blue, with England's in red—perhaps those colours should be the other way around—Wales's is in green and Northern Ireland's is in grey. By any standard, the service that we are providing in

Scotland is far superior to anywhere else in the United Kingdom.

Willie Coffey: I would like to see that graph at some stage.

Alex Neil: We are happy to provide this information to the committee and let members see how well we are doing.

Willie Coffey: I have a final question. To return to the 12-week waiting time guarantee, when we achieve that target in 100 per cent of cases Public Audit Committee members will inevitably ask whether we can get any better and where the scope is to improve the guarantee. For example, if a medical intervention is needed, should we ask you to reduce the guarantee to 11 or 10 weeks? What happens after we reach the guarantee in 100 per cent of cases? How do we improve the situation?

Alex Neil: I would rephrase your question to ask how, at a strategic level, we improve further the health outcomes of the Scottish population, rather than to ask for a discussion on the targets. At the end of the day, the strategic objective is to improve the health outcomes of the Scottish population. We are doing loads of things in that regard. The whole patient flow is changing right across the system and turnaround times are improving dramatically in A and E and elsewhere. We could give you a list—it would be endless—of all the initiatives that we are taking, including improvements to the use of theatres, providing a 24/7 service in many areas and so on and so forth.

In addition, many of the leading developments in the life sciences sector will have a revolutionary impact on healthcare in Scotland. We are at the cutting edge of those developments. For example, the Glasgow Southern general hospital campus will not just include a new £842 million hospital, which will be the largest in Europe and where 10,000 patients and employees will be based at any one time, but include a new centre for what the European Union has renamed precision medicine. That will initially focus on better ways to treat cancer.

I will give you an indication of what precision medicine refers to, although I will ask Jason Leitch to give you more information. Precision medicine will treat a person based on their DNA and their genetic make-up. We are getting so precise with treatment that if, for example, you have a tumour, your treatment will eventually be tailored not just to your DNA make-up but to the genetic composition of the tumour. The new centre puts Scotland at the cutting edge; indeed, we are the world leader in that field. Similarly, we will be investing even more heavily in imaging technology.

We are very keen to pursue those new technologies as soon as possible because their impacts are transformational on how we will treat people in the future. Therefore, we should not just think in terms of getting a target down from 12 to 11 and a half or 11 weeks; we must think far bigger than that. I will let Jason Leitch add to that.

The Convener: A number of members want to come in, so if Professor Leitch wishes to send us a note on the issue, that would be fine.

Alex Neil: Okay.

11:00

Mary Scanlon (Highlands and Islands) (Con): I echo the convener's comments and thank you for being here, which is helpful to this committee in the Scottish Parliament—not the United Kingdom Parliament—in looking at value for money and scrutinising. I have certainly found it helpful so far.

First, I want to ask about the national resource allocation committee allocation formula, which used to be the Arbuthnott formula. You have mentioned the Grampian and Lothian health boards quite a few times today. The report that we have in front of us states that the NRAC underfunding to five health boards is £517 million. In fact, Lothian's payment—or lack of—was such that it got £54 million less than expected in 2012-13. Lothian and Grampian are probably the two main health boards of the five. Could the problems and difficulties faced by Lothian and Grampian in meeting the targets—I hear everything that you have said about the new theatres—be as a result of their underfunding through the NRAC formula? I know that you have a timetable to ensure that all boards are given the recommended funding. When will they receive the recommended funding for their populations?

Alex Neil: First, as you probably saw in the statement that we put out last week, Grampian is getting an increase of 4 per cent next year compared with a Scottish average for territorial boards of 2.9 per cent. We have a long-term plan up to 2016-17 and we are determined that, by the end of that period, no health board will be more than 1 per cent outwith NRAC. In other words, within the next two years every board will be within 1 per cent of their NRAC allocation. I think that that is substantial progress from where we started a number of years ago. The announcement last week that Grampian will get a 4 per cent rise compared with an average rise of 2.9 per cent shows our commitment in that respect.

I do not think that the capacity issues in Grampian and Lothian are primarily related to NRAC. I think that they are related to other issues. I will deal with Lothian, as I have spent a lot of time on Grampian. One of the major problems in Lothian is that Edinburgh royal infirmary was planned on too small a scale in terms of its bed

capacity, which is roughly 20 per cent below what is required. There was probably a 10-year planning phase between the initial proposal to build a new Edinburgh royal infirmary and the opening of the new hospital. Some people warned about the capacity issue at the time. For example, I remember Margo MacDonald saying in her first election literature in 1999 to get elected to the Scottish Parliament as a Scottish National Party candidate that the planned bed capacity for the new Edinburgh royal infirmary was too low. It was too low because the population of Edinburgh had expanded so dramatically during the planning phase.

One of the challenges that we have in Lothian is that, although we have a fantastic new hospital facility in the royal infirmary, it has undercapacity because its planned capacity underestimated the population growth in the Edinburgh area. As a result of that, we have a 20 per cent shortfall in the number of beds that we need at the ERI; and as a result of that, we have had to reopen additional bed capacity elsewhere in Edinburgh. That is nothing to do with NRAC; it is just pure bad planning, quite frankly.

Mary Scanlon: I am sure that £54 million a year would help a wee bit towards addressing the problems.

Alex Neil: In terms of solving the problems, Lothian of course got a very substantial increase over a period. In terms of implementing NRAC, one of the reasons why we have been able to make so much progress in the past two years and why we will be able to make so much progress in the next two years is that we can bring the likes of Grampian and Lothian up to their NRAC allocation without penalising the other boards. People would argue that, by definition, Glasgow has more than its fair share at the current time. However, given the deprivation and poverty profile of the area that is covered by NHS Greater Glasgow and Clyde, which includes the convener's constituency, I think that the convener would be down my throat if I did not give that health board a real-terms increase in its budget over that period.

We are trying to ensure that everybody gets to NRAC, but we are doing it over a period of time so that areas that have reached that point already are not penalised, because they need the money as well. Of course, we could not do that if we were not getting the Barnett consequentials dedicated to the health service in Scotland. That is one of the reasons why we took the decision to ring fence the health consequentials for health in Scotland.

Mary Scanlon: I know that time is moving on, so I want to be brief.

I know that you are going to remind me that I was on the Health and Sport Committee when much of this happened—

Alex Neil: I wouldnae blame you for anything, Mary.

Mary Scanlon: I am sure.

The position is that no patient should wait more than 12 weeks for their first appointment and that, once they have seen a consultant, they will not wait more than 12 weeks after their treatment has been agreed. That is 24 weeks.

We know that 13 out of 14 boards met the 90 per cent referral-to-treatment target, which is 18 weeks. Are you saying that, if it takes 12 weeks for someone to see a consultant, they are guaranteed to have their treatment within six weeks?

John Connaghan was helpful last time in relation to questions about standards and so on. When you are doing your uncluttering exercise and making the process easier to understand, will you think about the fact that the process that I have just set out is a bit confusing, to say the least?

Alex Neil: I will say a couple of things and then I will get John to explain the patient flow, in terms of the targets.

Mary Scanlon: But the 12, the 12 and the 18—

Alex Neil: We will get into that.

We have HEAT targets and HEAT standards. Our HEAT target for A and E at the moment is 95 per cent by September this year. However, we aspire to a HEAT standard of 98 per cent. What is the difference? The difference is that the target is something that we are not achieving but which we want to get to. However, once that target becomes the norm, it then becomes a standard. In other words, everybody should be doing it in a run-of-the-mill way. However, having said that, I have said on more than one occasion—to my officials, in the chamber and out in the world—that it is not always easy to describe the difference between a target and a standard. We are, therefore, reviewing the terminology—

Mary Scanlon: Thank you.

Alex Neil: —and we will come back to you with terminology that is easier for me to understand as well as for MSPs and the public to understand. We would be happy to take any input from the committee with regard to suggestions in that regard.

Mary Scanlon: It is important that the public understand what is being talked about.

John Connaghan: I cannot add much to that explanation. The cabinet secretary is absolutely

right. HEAT targets have been with us for 10 years and, before that, we had waiting time targets, so quite a legacy has built up over the years. We have tried to make the best sense that we could of that, in terms of engagement with the service, but I fully recognise that things can be difficult for the man in the street to understand.

Alex Neil: And the woman in the street.

John Connaghan: Sorry, it is difficult for the man or the woman in the street to understand all of this.

We should note that, in 2014, we have embarked with partners in the health service, local authorities and some professional bodies to review where we are. A consultation process will be conducted over the summer period, and the results will help to inform what we do in 2015-16 and subsequent years.

Mary Scanlon: You have not addressed one of my points. The two periods of 12 weeks come to 24 weeks, but there is an 18-week treatment time guarantee.

John Connaghan: I am happy to explain that. I could describe it as an overlapping target. Even though we expect that for 90 per cent of patients it will take 18 weeks from first referral to treatment—in other words, there is a 10 per cent tolerance attached to that—the in-patient and out-patient elements sit within that. In essence, you are absolutely right. If a patient is not seen until week 12, there will be rather less time for the treatment element.

Mary Scanlon: So if a patient is seen in week 12, they should be guaranteed treatment within six weeks.

John Connaghan: They cannot be guaranteed their treatment within six weeks because a 10 per cent tolerance is attached to it. Boards will bend their best efforts towards ensuring that they are seen as quickly as possible within that 18 weeks, but not all patients will be seen within that remaining time.

Mary Scanlon: But we are talking about 90 per cent.

John Connaghan: Yes.

Mary Scanlon: In April 2011, the 12-week wait for new out-patient appointments became a standard rather than a target. The Audit Scotland report makes it clear that although all out-patients should be seen within 12 weeks, that situation has been deteriorating. In September 2012, 5,993 people were waiting more than 12 weeks for an out-patient appointment but, a year later, the figure was 11,544. In other words, the percentage went up from 2.7 to 4.6 per cent. The Auditor General's significant point is that the out-patient target is being missed and the situation has been deteriorating. Has that got anything to do with the fact that it is no longer a target but a standard? Does moving from a target to a standard mean that things can slip, which is what has happened here?

Alex Neil: I will deal with the final point and John Connaghan can go into the detail on it.

My answer to your final question is absolutely not. Once it becomes a standard or norm—which could also be called a target in normal English but not under the terms of this definition—everyone is expected to continue to meet it.

John Connaghan: We recognise those figures. We fully understand that there is a risk if we continue to drift from performance and we are continuing to work with boards on the matter.

However, if we look behind the headline figure at individual boards, we will find that two boards—Forth Valley and Lothian—stick out as having the greatest challenge with regard to out-patients. I think that we have said enough about where Lothian has been but, in considering why there has been such a significant rise in the Forth Valley figures, we should understand that, over that time period, two old hospitals closed and the move to the new hospital in Larbert began.

Sometimes there are understandable reasons why we get pressures inside what I might describe as a health economy, but I advise the committee that we are working with Forth Valley and Lothian on plans to redress some of that backlog in 2014-15.

Mary Scanlon: My final question has already been touched on by Colin Beattie and Tavish Scott. In response to Mr Beattie, who is always very good at asking for robust information, you mentioned that you have very cleverly managed to come up with hospital cleaning costs per square metre, which is something that I welcome.

Tavish Scott mentioned ISD information. The Audit Scotland audit update report says that NHS boards

"have not been able to provide"

detailed

"inpatient data since October 2012. Instead, they have been providing limited, summarised inpatient data ... ISD Scotland has been receiving less detailed information ... and is not able to carry out the same level of analysis and reporting".

There have been two years in which NHS boards have been unable to provide the data that I presume you and your officials need but which we, too, require to do our job properly. As you know, when the Patient Rights (Scotland) Bill was passed three years ago, I was a member of the

committee that looked at the bill. We were promised that all of that would be done but we will not have all the information until August 2014.

The bill became an act in, I think, March 2011, so why have we had to wait for three years with basically limited information—if any? We have less detailed information than we had before, and health boards have been unable to give information. Do you acknowledge that that makes our job difficult and that it makes the Auditor General's job difficult, as she has highlighted? Why has the information not been provided when it was promised during the passage of the bill?

Alex Neil: I will let John Connaghan explain the history.

11:15

John Connaghan: When the treatment time guarantee was planned for, the information that was available nationally was deemed to be acceptable. In fact, Audit Scotland, in its 2010 report on the new ways system, commended the NHS for having done well to implement it. We are all aware that, subsequent to the NHS Lothian audits, there is a requirement on NHS boards to provide much more detailed information, principally on the reasons for unavailability. Prior to that, the information was supplied on an aggregate basis. Over the past year or so, boards have been making big changes to their systems so that they can get that level of detail reported nationally and have it statistically validated. That is the new information that will come on stream from boards from 1 April, after the system changes are implemented.

The short answer is that, when the treatment time guarantee was planned for, the level of aggregate data that was available in the system was deemed to be appropriate. We understand that, from an audit point of view, we need more detailed information at this stage, and that is precisely what will be supplied. As the cabinet secretary intimated, that information will be published in August of this year.

Alex Neil: On the methodology, under the old system, information was collected on a census basis at the end of each month, whereas now the process is far more robust, in that we measure what happens to every patient. The new approach is not to have a census at the end of the month; instead, every single patient is included in the measurement of the guarantee. Although the new approach has taken more time than was anticipated to set up, the statistics on the treatment time guarantee will be far more robust than those under the previous system.

Mary Scanlon: It has taken two years. Obviously, good data is critical for Audit Scotland and the committee to do their job.

In paragraph 52, there is a list of the gaps in in-patient information. I will not go through them all; the critical point is that ISD does not have information on those areas. The gaps include

"the number of patients removed from the waiting list"

and

"the number of patients who did not attend or could not attend".

However, the one that really upsets me is

"the actual time patients waited compared to the wait recorded against the waiting time target".

We do not have that. We have been patient enough, and two years is long enough. In fact, it is three years since the bill was passed, but we are still struggling. I acknowledge your point that good data is coming, and the sun will shine in the month of March, but we have had two years without the information, which would make the job of any audit committee very difficult.

Alex Neil: I will just say that, from April onwards, all that information will be available. As John Connaghan said, the NHS Lothian case threw up the fact that the systems were not as robust as they needed to be. Obviously, the Auditor General has done a lot of work on the issue—as have we, in implementing fully her recommendations.

James Dornan (Glasgow Cathcart) (SNP): I welcome the cabinet secretary, as it is important that he and the other witnesses are here to take questions from members. I do not really want a response on this, but I wonder whether the cabinet secretary agrees that it would be a better use of our time and the witnesses' time if, when one committee member has 27 very detailed questions on one issue that could not possibly be answered here, the witnesses had prior notice of those questions. The cabinet secretary should be asked questions and he should not know what we are going to ask him, but when the questions are so detailed, I suggest that they would be much better dealt with by correspondence.

The Convener: I do not think that that is for the cabinet secretary.

James Dornan: I completely agree and—

The Convener: Mr Dornan, it is a matter for committee members to determine what questions they wish to ask and for me to determine their relevance. The cabinet secretary is here to answer the questions. He is not here to determine how the committee operates.

James Dornan: I am glad that you have put that on the record, convener.

I move on to the point that I want to raise, cabinet secretary. In discussing the previous Audit Scotland report on NHS financial performance, we talked about clearing the maintenance backlog by 2016. Can you give me an update on that? You have said that the high-risk and significant-risk items will be gone by that time.

Alex Neil: Absolutely. We published a detailed report on the matter last week, which will obviously be available to the committee. Some 60 per cent of the high-risk maintenance backlog has now been cleared and we expect to clear the other 40 per cent over the next two years or so.

This relates not to the high-risk maintenance backlog but to the general, global figure. Some of the maintenance backlog relates to property that will be declared surplus to requirements, even though it may not be declared as such at the moment. I will give an example from your patch, James. Next year, the patients at the old Victoria infirmary will be relocated to the new Glasgow Southern general hospital. At that time, the Victoria building will be declared surplus to requirements, and I think that NHS Greater Glasgow and Clyde's intention is to put it on the market. It will make a good development opportunity for somebody.

Obviously, the building has to be maintained in a clean and safe state but, as an example, I do not think that anybody would suggest that we should spend a lot of money on any structural backlog or whatever when we are just about to vacate the entire building.

James Dornan: The figures show how much of the backlog is high risk and how much is significant risk. If we use that building as an example, would maintenance on a building that is going to become surplus to requirements be included even though you know that it is going to be—

Alex Neil: No, that would not be included in the high-risk category. I will give a further example. Some asbestos was discovered in one part of Monklands hospital in my constituency, and that was classified as high risk. It needed to be sorted, and it has been and is being sorted.

James Dornan: Okay, and you are confident that the high-risk and significant-risk items will be dealt with by 2016.

Alex Neil: Absolutely. We are determined to do that. In looking at the profile of the estate, we should consider not just hospital provision but the number of clinics. In North Lanarkshire alone, we are building two new clinics, at Kilsyth and East Kilbride, and a couple of years ago we opened the new Airdrie health centre. There is a lot of investment in new property and new estate right across the country.

One of the areas in which I would like to do more, now that, I hope, we are out of the post-crash recession, is to dispose of surplus land and buildings and realise as much as we possibly can from the capital receipts because they can be reinvested in the national health service. The security costs for disused sites—either buildings or land—such as Hartwood hospital in Lanarkshire can be significant, even over only one year. We are actively pursuing a proactive disposal programme to try to realise such capital receipts as soon as we possibly can, but that often depends on the state of local property markets. Law hospital has been on the market for at least eight years and it has still not been sold because of the lack of robustness in the local property market.

James Dornan: I can assure you that the Victoria will not be on the market for long.

Alex Neil: I would not have thought so.

James Dornan: It is going to be flats. Thank you.

The Convener: I have a couple of final questions. The first is for Mr Gray, whose letter to the committee about the guarantee states:

> "I have ... asked for follow up work to provide ... assurance on actions taken to track and treat all patients who are taking longer than 12 weeks to receive treatment. This will take the form of an exception report provided to Scottish Government indicating the reason for any patient breach, providing confirmation that the patient has been contacted, and confirming the anticipated treatment date."

Can you tell us when that will happen?

Paul Gray: Mr Connaghan has been in touch with the boards about that.

John Connaghan: We need to give the boards a little bit of time to implement that as it requires additional administrative resources. My plan is that we will implement it from the end of June 2014 onwards, which gives boards about four months to prepare for it.

The Convener: When will that information be available for Audit Scotland to include in its next report?

John Connaghan: We would probably want to make that information available quarterly, so the first information would be for the quarter up to the end of September, but Audit Scotland can begin to look at the information as soon as we have it. If we have data for the first month—July—we will be quite happy to send it to Audit Scotland.

The Convener: Okay, thank you.

On treatment and outcomes, we heard previously from one of the NHS staff that there was some suggestion from international research that the more treatments that consultants and staff carry out, the more successful the performance outcomes, when those are compared with outcomes for consultants and staff who carry out fewer treatments. I do not know where that work is being carried out and when it will be concluded, but is there any evidence to suggest that, for A and E departments, the outcomes in larger centres are more successful than those in smaller ones?

Alex Neil: The figures obviously vary between medical disciplines but it is true that the general principle is that throughput is very important to maintaining skills and upskilling consultants. For example, up here we can only really afford one centre for paediatric cardiology for reasons of clinical safety. We do not have the throughput in terms of the number of children who require paediatric cardiology provision to justify more than one centre in Scotland. It would not be safe to have more than one centre because there would not be enough throughput to ensure that the consultants had the skills.

Some disciplines have figures for the minimum throughput that is thought to be safe if consultants are to maintain skills. A and E is an area where a minimum throughput is required. I ask Jason Leitch, as the medic on the panel, to give you more detail on that, but you are absolutely right about the general principle—all the international research shows that we get far better outcomes and far greater safety in certain disciplines if there is a minimum throughput.

Professor Leitch: Mr Neil is correct. It varies by specialty and by procedure within the specialty. In my specialty, we only have two cleft lip and palate centres in Scotland because it makes perfect sense to have only two such centres, but you can have your wisdom teeth taken out in every health board area in Scotland because there are perfectly competent people to do that in every health board in Scotland.

A and E is interesting because it deals with a huge range of procedures and illnesses. You would want the top end of major road traffic trauma—head trauma or neurosurgical trauma—seen in probably only three centres in Scotland. That is what happens for neurosurgical trauma, which in a sense comes through A and E but then goes to Southern general, and for head trauma, which goes to the Western general. However, someone with a broken arm could walk into any A and E in the country and be treated perfectly adequately and competently.

We take account of numbers, skill sets and staff mix when we make decisions about what centres are going to treat—and not treat—so the answer to the convener's general question is yes, it varies according to specialty but also, within those specialties, it varies by diagnosis.

The Convener: Okay—thank you for that.

Cabinet secretary, I thank you and your colleagues for contributing to the committee's work. It has been fascinating and informative, and it is useful to hear from you directly on some of the issues. I look forward to that happening again in the future. Thank you very much..

Alex Neil: Thank you. It has been very helpful from our point of view and, as I say, we aim to please at all times.

Mary Scanlon: Is that your target?

Alex Neil: It is a standard.

The Convener: We will take a break for a few minutes to allow for a changeover.

11:29

Meeting suspended.

11:35

On resuming—

"Reshaping care for older people"

The Convener: Agenda item 3 is to take evidence on the section 23 report, "Reshaping care for older people". Committee members have the report, and the Auditor General is here with her colleagues Fraser McKinlay, Claire Sweeney and Rebecca Smallwood. I invite the Auditor General to brief the committee on the report.

Caroline Gardner (Auditor General for Scotland): Thank you, convener.

In 2010, the Scottish Government and the Convention of Scottish Local Authorities launched a 10-year change programme on reshaping care for older people. The programme aims to improve the quality and outcomes of care, and to meet the needs of an ageing population. People in Scotland, as in most European countries, are living longer and, by 2035, a quarter of us will be aged 65 or over, up from 17 per cent in 2010. Many older people are in good health and, in many instances, they provide care and support to other people. However, older people are more likely than younger people are to be admitted to hospital in an emergency and to have multiple and more complex health problems.

The report before you today assesses progress with the programme of reshaping care for older people three years into the 10-year programme and considers the impact of the change fund that has been in place for two of its four years. We also

hope that the report will inform the planned integration of health and social care services.

We found that reshaping care for older people is an ambitious programme that affects most health and social care services. Implementing the programme is challenging for the organisations involved, which need to change services for the future while meeting people's current care needs and managing the pressure on existing services—you heard a fair bit about that earlier. Given the scale of the changes, strong leadership is needed at a national and a local level to take the agenda forward.

In 2011-12, NHS boards and councils spent approximately £4.5 billion on care for older people. I have commented in previous reports on the slow progress that has been made in moving money to community-based services, even though that has been a policy focus for a number of years. Locally, organisations need to do more to target resources on preventing or delaying ill health and supporting people to live independently in their own homes; they also need to make better use of data to focus on reducing unnecessary variation, and to monitor and spread successful projects.

The change fund amounts to £300 million over a four-year period, and it represented 1.5 per cent of all spending on older people in 2011-12. The fund has helped to improve partnership working by bringing together NHS boards, councils and the voluntary and private sectors to improve care and support for older people. The fund has also led to a number of small-scale initiatives across Scotland. Given the scale of the challenge in reshaping care for older people, though, we think that NHS boards and councils need to have clearer plans to ensure that successful projects are sustained and expanded to change mainstream services over time.

The core principles of supporting older people to live independently and improving partnership working have been a policy focus in Scotland for a number of years, but progress has been slow. National performance measures have not kept pace with policy changes and a greater focus on outcomes is needed. National monitoring is not sufficient to show whether NHS boards, councils and their partners are successfully implementing the policy and, in particular, what impact it is having on older people.

The report makes a number of recommendations to help the Scottish Government, NHS boards and councils increase the pace of change. In particular, we think that the Scottish Government needs to set out clear measures of success when it introduces such new policies in future, and then regularly monitor and publicly report on performance against the measures. NHS boards, councils and their partners need better information to support improvements in services for older people. There are particular gaps in information on community-based services. Given the scale of the challenge involved in reshaping services and the growth of the elderly population in Scotland, it is very important that the recommendations are addressed in a timely fashion.

The Convener: Thank you, Auditor General.

We are sitting on a time bomb here. The biggest challenge facing Scotland today is how to deal with the massive increase in the number of older people and the attendant health demands and care needs. Is there any evidence that the current system is sustainable?

Caroline Gardner: The Government's own evidence suggests that, in its current form, the system is not sustainable, which is why the reshaping care for older people programme was put in place in 2010. As you have suggested, the population is ageing very fast, and that is much more apparent in some parts of Scotland than it is in others.

The change is a very difficult one to make, because we need to keep providing services now while developing services for the future. Moreover, as people get older, they tend to have more co-existing medical conditions that make it more difficult to maintain them at home. That is absolutely why we think that it is time for the programme to really pick up pace and for progress to be seen.

The Convener: But if, as the Government has accepted, the current system is not sustainable and if, as you have outlined and again the Government has accepted, services need to be reshaped but, as you have indicated, the pace of progress needs to be stepped up, because we are clearly not meeting the requirements or matching demand, what will the consequences be if services are not reshaped in time and the current system proves not to be sustainable?

Caroline Gardner: The short-term consequence is likely to be the increasing pressure on acute hospitals that we have set out in a number of reports and which committee members will be aware of with regard to A and E waiting times, increasing emergency admissions to hospital and difficulties in discharging people to their own homes or better environments after their treatment. When reshaping care for older people was launched in 2010, the Government's own estimate was that, without change, the amount of money spent on older people's services was likely to rise from £4.5 billion a year to around £8 billion a year, which is a huge increase at what will be for the foreseeable future a time of very tight resources for public services.

That pattern is not in anyone's best interest. It will mean that the health service will spend more time treating older people in acute hospitals where many of them do not need to be and where, as the cabinet secretary made clear in the earlier evidence session, their health might actually deteriorate rather than improve. It will also make it harder for other people who need acute hospital care to access it in a timely fashion. That is absolutely why the investment in developing community-based services and ensuring that individual older people get the care and support that they need to live healthy independent lives in their own homes for as long as possible needs to happen now.

The Convener: In preparing the report, you have obviously spoken to different departments or sections of the Scottish Government and certain key officials, and I presume that you have also looked at what councils are doing at a local level. My understanding is that, under the legislation, anyone with a community care need should be offered a community care plan, the identification of which helps the local authority in aggregate to determine what resources are required, what gaps there might be and how services might be reshaped. Do you have any evidence that local authorities are preparing community care plans for those who require them?

Caroline Gardner: I will ask Claire Sweeney to pick up the specific point about community care plans but, in response to your question, I think that any approach needs to happen at two levels. First of all, there needs to be planning for individual people's needs, not only through the community care plan but as a result of older people contacting their GP for all sorts of reasons, which should indicate that they might need more support to stay at home more safely for longer.

We also found and have described in the report some really good examples in Perth and Kinross and Lothian of health and social work services working closely together to use data about the services that older people are using to identify variation that is not explained by obvious factors and to explore what sorts of services would be a better solution to meeting individual needs as well as reducing the pressure on acute services.

11:45

Claire Sweeney (Audit Scotland): We did not look in great detail at what is happening in each local authority area as part of the work for the report, but we are carrying out work to look at self-directed support and the raft of changes that that will bring for social work services in the next short while. In the report, we highlighted in case study 3 gaps in understanding about people's needs locally. The position was difficult to determine from the national information that is available.

Members will see that we highlighted at various points in the report that, although we have information on activity and the number of people who get certain levels of home care, there is a big gap in national information on needs and the appropriateness of services. That was a big problem for us in pulling together the information about what good care looks like and seeing whether the trend information in national data shows good and bad practice.

There is definitely a gap in the national information on needs. We did not look at that in every local authority area, but we will pick it up through the work on self-directed support.

The Convener: One of the problems that we have is that older people's care is like a jigsaw—every piece fits with another piece and is integral to getting the bigger picture. Our local authorities are struggling to cope with demand and are stretched. Many skilled and experienced people have left under voluntary redundancy schemes because councils have struggled to stay within their budgets. Councils now have no flexibility to raise local funding, so many have had to resort to looking at increased charges and reduced service levels. That must be part of the bigger picture.

I am not necessarily criticising local authorities. I do not know the situation in other members' areas, but I know from dealing with my constituents that few people are offered a care plan as a matter of course, although they and their families should have one, because it helps them to assess whether the requisite level of service is being provided. I suspect that that is partly because council staff are under enormous pressure. That takes us back to the discussion about treatment time guarantees. We pass legislation, but it seems to have no effect.

If care plans are not being provided—although I understand that they are required by law—how do individuals know what they are entitled to and how do councils assess the aggregate demand and negotiate with health boards on reshaping services in the way that is necessary to sustain people at home?

Caroline Gardner: You are absolutely right that the issue needs to be looked at across the system. It cannot be considered in relation to just social work services or just acute services. As Claire Sweeney said, the work that we are doing on self-directed support is looking—from the individual up—at what is happening to assess each individual's needs and to have a proper discussion, with the individual in the driving seat, about how they would like those needs to be met,

against a backdrop of tight resources in social work services and the NHS.

It is interesting that the self-directed support policy that the Parliament has introduced has the potential to turn the system on its head so that it starts with the individual, in the way that has been described. In the report on older people's care, we are looking at the challenge of shifting resources, in line with Government policy, from acute services into the right range of services on the ground to meet needs so that, when people say that they would like help with getting to the shops and using community facilities, services can help them to do that. We are coming at the issue from both ends, which are both important.

Mary Scanlon: Exhibit 11 on page 28 provides quite a good summary of the progress that has been made on reshaping care for older people. As an ex-teacher, I looked at the marks, which show improvement in three out of eight commitments—the commitments on third sector capacity, respite care and reducing emergency admissions.

When I look at the other commitments, I see serious cause for concern. In particular, the first commitment states that

"We will double the proportion of the ... health and social care budget that is spent on care at home",

and yet the proportion has in fact fallen from 9.2 to 8.7 per cent.

On commitment 3, which relates to the change fund, it appears that there is no difference. The progress report on commitment 5 states:

"The Scottish Government has not defined what it means by 'waste' and 'unnecessary variation'."

If there is no definition, how can progress be measured?

On commitment 7, the report states:

"National data is not available".

How can an audit committee or an Auditor General measure anything when there is no data? Finally, on commitment 8, the report states:

"There is no centrally available information".

We have made progress on three of these eight commitments, which should be our framework for looking at progress across the board, but in one there has been no change and as for the other four there are no definitions and no information. Am I right to be concerned?

Caroline Gardner: That is one of our findings in the report. There are eight commitments under the reshaping care for older people policy, which we have set out in our report. On three of them, things are moving in the right direction, but on another three there is simply not enough information to know what is happening—

Mary Scanlon: I am sorry to interrupt, but there is not even a definition.

Caroline Gardner: A definition of the way in which the commitment will be measured?

Mary Scanlon: That is right.

Caroline Gardner: You are absolutely right. A lot of work has been going on in Government, particularly with the joint improvement team, to come up with measures that would allow all those commitments to be monitored and progressed, and we have recommended that it needs to pick up steam. I ask Claire Sweeney to talk you through the progress that is being made of which we are aware, and where that should leave us in the future.

Claire Sweeney: We note specifically that on commitments 7 and 8 there is just no information to enable us to form a judgment. The same is true of commitment 5. Although it is fairly clear, there is no definition of what is meant by "waste" and "unnecessary variation".

Mary Scanlon: How can you measure the information if there is no definition? You do not know what you are measuring.

Claire Sweeney: The terms need to be defined before we can start to measure the information and reach a judgment on how the Government is performing.

On commitment 7, one issue that lies behind the reason why the information, which relates to older people not being admitted directly to long-term institutional care from acute hospitals, is not there is the lack of a link between NHS data and local authority data on care. That comes through in a number of areas of the report. As the two data sets are very different, there is an issue.

We know that people are making efforts to address that at a local level and that in some areas people are sitting down and looking at what services their local population is using in the round. However, we simply could not measure that at a national level.

Similarly, on commitment 8, although we can give you a certain amount of information on the use of telecare, which we have included in the progress column, we do not know whether that use is in line with the people who are assessed as needing those services. There are big gaps in some of the indicators.

Mary Scanlon: If we come back to the commitments in a year's time, will we have a definition for commitment 5? Will the NHS know where patients are being discharged to under commitment 7? Is the information being gathered on commitment 8? Is a commitment not set in the knowledge that there is a way and a means to

measure progress and decide whether the commitment is being met?

Caroline Gardner: We certainly think that it should be; that is one of the report's main messages. The reshaping care programme is good and detailed but where there are clear commitments the Government should be setting out how it will monitor and report on progress against them.

Mary Scanlon: You say that the Government should be doing that, and that there should be a means of measurement, but we are saying that there are no means of measurement in the report.

Caroline Gardner: We say at paragraph 51 that NHS Health Scotland is currently developing a series of outcomes to measure progress on reshaping care for older people, and that is due to be available in spring of this year. We will be keeping that area under review and will report back. The committee may wish to explore that area with the Government to see what progress is being made in that regard.

Mary Scanlon: Forgive me, but we are constantly being told that more robust information will be coming forward on that. I appreciate that your problem is the same as mine.

My final question is on exhibit 1. The increase in the percentage of the population aged 65 and over up to 2035 ranges from 13.6 per cent in West Lothian to more than 22 per cent in Dumfries and Galloway. I was a bit disappointed to see that there are so few diagrams to illustrate the trends. Between 1999 and 2003, the convener and I were on the Health and Community Care Committee, which considered the Community Care and Health (Scotland) Act 2002. I still remember clearly the intentions and principles behind that act, and I would have found some diagrams about the trends helpful.

Exhibit 6 illustrates the trend in spending on "Care Homes", "Homecare" and "Other", and shows that spending in all those areas has been falling from 2009-10 to 2011-12. Why do we not have more up-to-date information on that issue? We are now in 2014, and I would have hoped that we would at least have had figures for 2012-13 so that we could look at the trend. Nonetheless, the resource for care homes, home care and other care for the elderly has been falling since 2009-10.

Caroline Gardner: I will ask Claire Sweeney and Rebecca Smallwood to comment on how up-to-date the data is. On the broader point about the trend in local authority spending, that goes back to the convener's earlier point about the pressures on council budgets in particular.

We make the point in the report that although council spend on home care had been rising in real terms it has now started to fall. We know that there are pressures, and a key part of what the new health and care partnerships will do when they come into being should be to ensure that it is possible to look at the whole budget—in other words, all the resources that are being spent on all the people in an area—and to make the best decisions about how money should be moved to deliver the services that older people need.

Mary Scanlon: A falling budget and a 20 per cent projected increase in demand have to be a significant concern.

Caroline Gardner: That is at the nub of why we think that progress in this particular policy area needs to pick up. We are all getting older by the day and we know that the challenges are there. The money needs to shift to ensure that the services are in place. Fraser McKinlay might want to pick up the point on council budgets in general.

Fraser McKinlay (Audit Scotland): As Mary Scanlon has set out, the pressure that exists with declining budgets and increasing demand makes the agenda in using the full resource that is available to the public sector partners in an area very important. Community planning must be a key part of that. Specifically, as Caroline Gardner mentioned, it will have to be an enormously important part of the agenda for the new integrated health and adult social care bodies that will come into being next year.

The point that we repeatedly make is that we should gather information not for its own sake or as an end in itself but to enable people locally to make the right decisions and invest the money—the scarce resource—that they have at their disposal in the most effective way.

Information gathering is not just about making our lives easier as auditors by making it easy to get information—much as we would like it to be easy to get—but about how we can be confident that the public pound that is spent in the local area is spent in the most effective and efficient way, given the scale of the challenge that lies ahead.

Caroline Gardner: I think that Rebecca Smallwood can answer the question on how up-to-date the data is.

Rebecca Smallwood (Audit Scotland): Exhibit 6 is based on published information that uses the local financial returns. At the time of the report's publication, the 2011-12 data was the most recent that we could get, as the data for 2012-13 was not yet available.

Mary Scanlon: Do you have any information to suggest that the downward trend is continuing?

Rebecca Smallwood: We will not have anything on 2012-13 until the data is published.

Mary Scanlon: Nothing at all. Okay.

The Convener: Before I bring in James Dornan, I would like the witnesses to clarify something. Commitment 7 states:

"We will ensure older people are not admitted directly to long-term institutional care from an acute hospital."

When an older person is ready for discharge from an acute hospital but they do not have a home to go back to, where will they be discharged to, if they are not to be discharged to long-term institutional care?

Claire Sweeney: That commitment is about preventing older people from going directly into care homes when they are discharged from hospital if there are alternatives that better meet their needs. For example, someone could receive rehabilitation services or additional support at home to try to enable them to live independently in their home. The aim is to prevent the situation in which people are automatically referred to a care home or institution, even though alternative services could be put in place.

12:00

The Convener: Because no national data is available, you just do not know where they are going.

Claire Sweeney: Yes.

James Dornan: I seek clarification on commitment 5. We are looking for definitions. Are the discussions that are taking place on, say, bed blocking and trying to get people back into their homes happening only between the Scottish Government and the health boards or are other partners involved?

Caroline Gardner: Our understanding is that a lot of that discussion is going on through the joint improvement team, with all the partners that are involved. One of the strengths of the change fund is that it has brought those partners together. That is important, because the problems are not ones that a health board, a council or a voluntary organisation can solve alone.

James Dornan: The issue is that many of the partners define things such as waste slightly differently, and you are trying to get a definitive description.

Caroline Gardner: As we show earlier in the report in an example on NHS Lothian, the challenge is that, not just across Scotland but even within health board areas, there can be real variations in the types of services that are provided. Some of that variation might be proper and might reflect the fact that people are sicker, poorer or older in a particular area, but the challenge is that we do not know how much of the variation reflects people's needs and how much of it reflects issues such as there simply being no other services that could support people or there being a GP practice that is not good at thinking about alternatives to referring people to hospital when a crisis occurs. The challenge is to understand what necessary variation is and what "unnecessary variation" and "waste" are and then to drill into that and tackle it.

James Dornan: Do you have any idea of the timetable for the partners coming to some sort of conclusion?

Caroline Gardner: That is a good question. Rightly, the programme is a 10-year one, and the change fund is a four-year fund that we are two years through. One reason why we think that the monitoring information is important is that it is important to be able to track what is happening across those 10 years rather than wait until the end and look at the difference that the programme has made. So the answer is that it is a 10-year programme but we cannot leave it until 2020 to see what is different.

Bob Doris: I commend the Auditor General and her team for pulling together information on what is a hugely complex and changing landscape. I have a couple of brief points to make before I go on to my substantive question.

Ms Scanlon referred to exhibit 6; she is absolutely right that spending on care homes and home-care provision has reduced in the past couple of years. However, I see that reduction as being fairly minimal and would not gauge it as a long-term trend. I am being honest about that—I genuinely do not agree with Mary Scanlon that it is a long-term trend. I have a reason for saying that. I agree with her that the yellow line in exhibit 6, which is for "Other" provision, has completely flatlined, although I would say that the long-term trend is that budgets for care homes and home care are up.

The biggest thing that I pick up from exhibit 6 is that the traditional methods of working with older people in the community are pretty much still what are used. If that was not the case, the "Other" line would be starting to increase. I acknowledge that—as Ms Scanlon said—in the past couple of years the money for care homes and home care has slightly dipped, but the big thing is that the "Other" line has pretty much flatlined. What is your analysis of that?

Caroline Gardner: Claire Sweeney and Rebecca Smallwood will keep me right on this. I think that you are broadly right, but in the "Other" line we are seeing a much smaller focus on things such as day centres and other more traditional types of care that are perhaps less valued by older people and are of less help in enabling them to

stay healthy and independent at home for longer. Claire Sweeney will amplify that for me.

Claire Sweeney: In paragraph 32, we describe in a little more detail what is in exhibit 6 and we highlight what is included in "Other", which I think is helpful.

There are two issues around council resources for social care services. The first is the intention in respect of reshaping care of older people. Integration of health and social care is, to a degree, about supporting people so that they do not access acute services, hospital services and social care services unless it is absolutely necessary, and so that they can live independently. It is also about communities working with people to support them at home as long as possible. The changing focus over time has led to much greater focus on community support and helping people to stay at home through, for example, improved access to telecare.

The second issue is the change to self-directed support, which will be a big change for social care services and on which we are doing more detailed work that will change the focus of those services over time. We are already starting to see signs that that is having a big impact in some areas on how social work services, and social care services more broadly, are being planned and considered in relation to future provision. We will see that change over time because of the policy change.

Bob Doris: That fleshes out what exhibit 6 is saying.

I am sorry to be a bit of an anorak about this—I have a much larger question that I want to ask—but I would like to ask next about exhibit 11. I share Ms Scanlon's frustration about whether we are able to collect the information for auditing purposes. However, I also think that the situation is fairly understandable.

Commitment 5 says:

"We will improve quality and productivity through reducing waste and unnecessary variation in practice and performance with regard to emergency admissions and bed days across Scotland."

I look at that commitment and ask how we can quantify that. Then, I look at one of the key recommendations at the start, which says that we must

"do more to understand the reasons why activity and spending on services for older people vary across Scotland"

and goes on to mention things such as benchmarking activities and costs, identifying areas for improvement and ways of identifying and rolling out good practice.

If each local authority and health board is currently looking at service reform, and each area is doing that differently because the Government has made it clear that the approach is about locally led solutions, including the involvement of the voluntary sector via a kind of co-production process, it becomes quite difficult for the centre to monitor and audit what is going on. In saying that, am I giving the Government a "Get out of jail free" card? I do not want to do that. Alternatively, is what I am saying reasonable? If it is, how could the Government capture that information more systematically?

Caroline Gardner: That is a reasonable thing to say. In case study 4, on page 42, we talk about what NHS Lothian and the Lothians councils are doing. We think that they have started doing good work using data to explore what is happening in quite small parts of the health board area—down to the level of individual people—in terms of emergency admissions, use of social care services and so on. As you suggest, that information can be used to find out whether anything is missing in Edinburgh, East Lothian or wherever that would help to avoid emergency admissions, or to keep people safer at home for longer. We have identified two areas where that is happening well: the Lothians and the Perth and Kinross Council area, with NHS Tayside. We did not find evidence that it is happening as well as that consistently across Scotland. We think that that needs to happen.

It is also true that, at national level, it is hard to monitor or understand such variations, and the gaps between information systems make it hard to track overall progress on the policy. If there is a particularly high level of emergency admissions for people over 65 in a part of Scotland, we cannot link that to whether, for example, the level of home care is less than the national average; we cannot say whether it is the people who are getting home care who are being admitted to hospital or those who are not. There is a bit of both, I think. That is why the Government has to clarify what it means by "unnecessary variation" and say how it will monitor progress on the policy so that the areas that are lagging behind can be given the support that they need in order to catch up, given the scale of the challenges.

Bob Doris: That is a much more nuanced view.

I always wear two caps when I sit in this committee. In wearing not just my Public Audit Committee cap, but my Health and Sport Committee cap, I come to an issue that can and should be audited: the change fund.

I will return in a second to the fact that the change fund represents 1.5 per cent of the overall budget, but there have been misinterpretations about what the £300 million that will be spent over four years on older people is for. Those are not additional moneys that will then disappear; rather,

those moneys provide short-term funding for local authorities, health boards and the third sector to get round the table and change provision in each health board area so that, when the change fund ends, that new service provision is embedded in the core budgets in each area. In other words, I would not expect the new health and social care corporate body models that are to roll into town with the Public Bodies (Joint Working) (Scotland) Bill to turn around in a couple of years and say, "Well, we were given £300 million, but we haven't got that now, so what do you expect us to do?" That is not what the change fund is for.

How and when do you expect to audit it? I guess that it would be in two years, when the change fund has run its course, before a successor committee would be in a position to look into the matter. Will there be an interim monitoring process? How can you guide this committee and the Health and Sport Committee to follow the process?

Caroline Gardner: You are exactly right: the change fund's purpose is not short-term funding; rather, it is to leverage the £4.5 billion that is spent on the services across Scotland. Fraser McKinlay will pick up your questions.

Fraser McKinlay: I will make a very similar point. The clue is in the name: the change fund is designed to change how services are delivered. Inevitably, you want to start small and test out and pilot things. As Mr Doris says, given that we are two years through a four-year programme, our concern would be the extent to which the bodies are able over the next couple of years to "embed"—to use Mr Doris's word—the changes and make them a core part of their work, so that that just becomes how business is done and how the service is run.

Claire Sweeney will say a little about what the joint improvement team and others are doing on monitoring because that—as we say in the report—is definitely an issue. We see some good examples of local working, but the challenge is about scale and pace, which is about making the changes more quickly and everywhere. It is also about—as Mr Doris said—whether in two years, when we assess the change fund's impact, we will be able to see that there has been a fundamental shift in how services are being delivered, or whether we will be looking at a series of relatively small-scale projects that have delivered good things for a relatively small number of people. That will be the big test over the next couple of years.

Bob Doris: That is helpful.

Claire Sweeney: Some of the things that we were looking for are directly related to that. In looking at what the change fund was being used for, rather than just look at small-scale projects and where new things were being tried out, we tried to see a connection between how much a service cost and its impact on people and the rest of the system.

In the change fund's first two years we saw greater focus on the testing side. The joint improvement team has more recently tried to focus on the evidence base and how spreadable are the initiatives. The team has asked for all areas to give details about the extent to which tried projects have spread. Therefore, more information is available about the extent to which some of the initiatives will stick, and which shows that they are not just expensive initiatives that will not be replicated in other ways. In addition, the impact on people who need access to those services is being a bit more clearly tracked than it was at the start of the change fund process.

The Convener: I do not mean to cut across Bob Doris, but a number of members have pointed out to me that Parliament convenes at half past one today. I have at least four members who wish to ask questions, so I ask Bob Doris to make a very short contribution, after which I will move on.

Bob Doris: In that case, I may just have to make a comment, so that I can put the matter on the record, rather than have an exchange with the witnesses. My final question was about how the issue fits with the Public Bodies (Joint Working) (Scotland) Bill. I have in front of me the stage 1 report that went to Parliament. It mentions COSLA's desire to top slice some of the acute hospitals' budget for reform of health and social care at local level through health and social care integration.

I know that that is something that the Government has ruled out and will not set minimums on, but there was silence from local authority partners about how much of their budgets they were willing to put into the pot. There was a great demand for the NHS to put money into the pot, but we do not know what local authorities would bring to the table or, just as important, how the voluntary sector would fit in and be part of the co-production process. Is that something that you and your team would want to follow through in the years ahead? That £4.5 billion now goes on to the table for radically reforming health and social care for older people.

12:15

Caroline Gardner: The spirit of the Public Bodies (Joint Working) (Scotland) Bill, and of the policy, is about being more transparent about how money is spent; you can see that in the examples that we have used from Perth and Kinross and from Lothian. What is working there is the health board, the council, the third sector and private

sector providers sitting down and asking what is happening to older people, where there is room to improve care, what is likely to improve the situation and how they can try that and track what happens. That is the way forward. There is a need for monitoring at national level as well, and if we can join that up through all the policy initiatives it should be possible to make a step change in the quality of services for older people and their ability to stay at home for longer.

Tavish Scott: Point 4 of exhibit 11 on page 28 states:

"The Change Fund has provided about £35 million to help unpaid carers, directly and indirectly."

Is that the scale of the spend on the small initiatives that was described earlier?

Caroline Gardner: No. I think that that money is specifically for carers. Claire Sweeney will talk you through that.

Claire Sweeney: There is a little more detail in paragraph 61 on page 34 about the focus of the change fund resource on carers. The report highlights the fact that there was a lot of attention on that because it was seen as being one of the potential solutions for supporting people for longer in their own homes.

Tavish Scott: Am I right that the change fund was worth £70 million in 2011-12, and £300 million over the four-year period, of which £35 million per annum is being spent—or has been spent in the first couple of years—in that area? I am trying to understand the split and how the money is being spent.

Claire Sweeney: Paragraph 61 sets out that at least 20 per cent of the overall change fund was to be spent on supporting carers, with £50 million being allocated for that purpose between 2012 and 2015. However, in reviewing the change fund plans, the joint improvement team has identified that in some areas more than that was being spent on carers, so it has been identified as a particular priority for the change fund plan. More attention has been paid to how that money is being used than is being paid to some other areas of the change fund plan, because it was seen as such a significant issue.

Tavish Scott: You also say, in paragraph 54, that 30 per cent of the fund is underspent. There are a lot of different things going on.

Claire Sweeney: That is right.

Tavish Scott: Is Fraser McKinlay's point that some initiatives are going on, but that it is difficult to quantify them? I cannot find any assessment in the report of how much is being spent on local initiatives; I take the point that they have got to be local to drive the process. We know that £35 million is already being spent on respite care, which is entirely fair and as it should be, but what is the rest being spent on?

Caroline Gardner: Paragraphs 54 and 55 summarise what we know from the joint improvement team's evaluation of the change fund. The short answer is that there is not a complete picture. We say that the returns that come back to the joint improvement team do not account for the whole allocation in 2011-12 and, as you said, there was in the first year an underspend, which partnerships were allowed to carry forward into the following year.

There is a plan to evaluate the change fund in 2015. We think that it is important that how it is being used is well understood now, so that we can build on success and stop spending money on things that are not having the desired impact.

Tavish Scott: If I understood Bob Doris's point, the fund is to ensure that £4.5 billion is being spent in the right way, and you have only two years of the change fund left to achieve that. It sounds as though we are not very far down that road.

Caroline Gardner: We think that there is not enough clarity about how the change fund is being used, although we say that it has done some good things. It has genuinely improved partnership working, in particular by involving the voluntary and private sectors more in the discussion, and there are some good examples of local projects. What we have not seen is the information that would let people spot those good projects and think about how to spread them.

It is worth saying that the health service in particular has some great experience of doing that in relation to the patient safety strategy and the early years collaborative, and has developed a very strong method for saying, "We want to change this aspect of services. Here's how we expect it to happen, here's how we will monitor it, after which we'll review the situation and reinvest." That sort of approach could make a real difference to the change fund, and to reshaping care for older people more generally.

Tavish Scott: That seems to be very fair.

You say at the very start of the report something that I think is said in all Audit Scotland reports about the need for strong national and local leadership. Ten years equates to two and a half Governments, but most ministers and MSPs can hardly look ahead to next week, never mind to 10 years from now. How strong is the drive to achieve the change, given that we are halfway through the change fund period and a long way from the eight years by which time the whole thing is supposed to be done and dusted?

Caroline Gardner: In a sense, that goes back to the convener's opening questions about the scale of the challenge. In exhibit 3, we track the policies in this area back to 2000. In truth, such policies did not start in 2000; there has actually been a formal policy in place for as long as the Parliament has existed. What is different now is not only the speed at which the size of the ageing population is increasing, but the fact that after 10 years of growing resources we are now in a period of tight resources. That means that the problem of sustainability is much tighter, and that the need to focus on what is working and to ensure that we are learning from that right across Scotland has never been more important.

Tavish Scott: Thank you.

Colin Beattie: Given the time, I will restrict myself to one question of clarification. In paragraph 23 on page 16 of the report, you carefully state that the "figures are ... real terms". Is the fairly dramatic move from £4.5 billion to £8 billion that is outlined in paragraph 22 also in real terms?

Caroline Gardner: I am pretty sure that it is, but Rebecca Smallwood will keep me straight on this. The £4.5 billion to £8 billion increase is the Scottish Government's estimate, and I would have expected the figures to be bigger if they had to account for inflation.

Claire Sweeney: I think that we will need to come back to you on that.

Caroline Gardner: We will double check and come back to you, but I think that those are real-terms figures.

Colin Beattie: The point is important, given the dramatic nature of the increase. We need to know the basis of it.

I have another question that brings us back to the issue of the data not quite giving us what we want. In the final couple of sentences of paragraph 38 on page 23 of the report, you say that the

"percentage of homecare clients receiving intensive homecare has increased from 24 per cent in 2005 to 32 per cent in 2013"

while the overall number receiving home care has fallen. Is that a result of councils raising the bar and only accepting people who have greater needs? In other words, they are looking to accommodate people with the greatest needs, with the result that those at the other end are dropping out. Is that borne out by the figures?

Caroline Gardner: It is. It has been the case over quite a long period that eligibility criteria have been increased to focus on those with the most intense needs instead of giving people one, two or three hours of home care across the week. There is a debate over whether that is the right approach and whether there is value in providing lower levels of care that can help to keep people more independent. Of course that debate will become all the more intense when, as the report in general shows, resources are tighter.

Colin Beattie: The same paragraph says:

"Information on the number of hours of care people receive at home is often used as a proxy for need (with more than ten hours of homecare being considered 'intensive homecare')."

Is such analysis valid? I suppose that, crudely speaking, the number of hours could determine the intensiveness of the home care but surely the type of home care should also be taken into consideration.

Caroline Gardner: You are absolutely right, and I ask Claire Sweeney to pick up the issue.

Claire Sweeney: You have drawn out one of our biggest challenges in this report, which was to use information that gave us an in to the issue of need and the appropriateness of treatment and care. There is actually not much information that tells us very much beyond counting units of provision for social care services. The issue is, I think, nicely highlighted in the report with the comment that it is not really possible to tell whether people use more than one kind of service, whether levels of service provision are low or high or, indeed, whether that is a good or bad thing. Throughout the report, we were trying to pinpoint what a good service might look like in the reshaped model of older people's services, and we found it quite difficult to pin that down because the information at national level is either not joined up or not collected in a way that would help us to do that. There is definitely an issue about not having good enough information about appropriateness of treatment and levels of need, and that is reflected in that particular paragraph.

Colin Beattie: Clearly, the information will lie at council level, but it is not gathered at the national level at all.

Caroline Gardner: In case study 3, we talk about the index of relative need, which is a tool that is used to measure dependency. Most councils in Scotland use it when they assess an older person's needs and the services that they require, but in 2012 only 8 per cent of the records that came back from councils to the Scottish Government included that information. That is an example of the data that we think could be useful both in helping to plan the way in which services are developed in future and in thinking about the sustainability of the model of care that we have and how to make best use of the money that is spent.

Colin Beattie: Convener, in view of the time, I will leave my questions there.

The Convener: Thank you. I call Ken Macintosh, to be followed by Willie Coffey.

Ken Macintosh: I want to return to a subject that everyone has pursued. You state that

"There is little evidence of progress in moving money"

from health

"to community-based services".

Do you have any evidence or good examples of where that has been done successfully?

Caroline Gardner: In overall terms, it is clear that money is not transferring. The figures in the report demonstrate that things are pretty steady, and actually the overall level of local authority spend fell between 2011-12 and 2012-13. That is not to say that it is not shifting in some localities and some council and health board areas, but across the country the Government's commitment to shifting that relative spend is going in the wrong direction rather than the right one. That is happening for reasons that we all completely understand to do with the difficulty of making the shift at a time when finances are reducing, the number of older people is increasing and we need to keep on running the acute hospital service. However, the shift is not happening just now.

Ken Macintosh: You have summed up the dilemma. You point to weak leadership, but could a different conclusion be drawn? I can see how we could put more resources into community-based care and expand that sector, but I cannot quite see how we could ever decrease investment in acute care. That is a different conclusion altogether, is it not? Do you tend to the view that, no matter how hard we try to shift resources away from acute care, that will not happen, and all that we can ever do is to maintain the level there while we increase preventative care?

Caroline Gardner: It is certainly very challenging to make the shift, but I am not sure that anybody has the evidence to say that it is impossible. There are different drivers. As you heard this morning, we have seen a dramatic reduction in average lengths of stay, which is due to people being treated as day cases or outside hospital. There are technological advances that mean that people who would have been treated in hospital can now be treated at home with drugs. Some of the challenges go the other way, because we can do new things that cost more, so an awful lot is changing.

We focused on the first commitment under the reshaping care of older people policy, which is to double the proportion of the total health and social care budget for older people that is spent on care at home over the 10 years of the policy. There is something important there about understanding the different factors that are going on from the top, but also from the bottom up. It is important to understand what the variation is and how it can be reduced. Some of it may be entirely appropriate, as we discussed earlier, but some of it almost certainly is not. Tackling the places that could do much more to treat people out of hospital—and to give them a better quality of life in doing that—has to be the way to unlock this.

Ken Macintosh: In paragraphs 62 and 63, you mention the role of the third sector, particularly in care, and the difficulties that you have in that area. Can you make any assessment of the role or value of the third sector in promoting community-based care? Many of us as MSPs see things such as lunch clubs, befriending, volunteer drivers and so on as both cost effective and important because they provide a culture and a supportive community that increase older people's independence, but you do not seem to be able to make any assessment of such work in an auditable way.

Caroline Gardner: I think that the consensus is that, as you say, those voluntary services can be both effective and highly valued by older people. However, it is also true that we do not have evidence of that at present. The stitch in time project, which we mention in paragraph 63, is intended to gather that evidence in order to strengthen the voluntary sector's hand in discussions about where money should be spent in future. To a great extent, having the evidence makes it much easier to make the case for the shift.

Ken Macintosh: Will that be published in time to influence the Public Bodies (Joint Working) (Scotland) Bill? The bill is about integrating health and social care, but it does not really involve the third sector in any meaningful way.

12:30

Claire Sweeney: That is part of the agenda of reshaping care for older people and the changes around the integration of health and social care services. In some areas across Scotland, that relationship has been gained in part through the support of the change fund by bringing together partners to start to think about the way in which resources are used in totality for that local area. That relationship is new; it has not really been done before. We are starting to see a greater focus on that in local areas, which directly involves the third and private sectors in most discussions about provision in the local area.

The example in the report is in Tayside, where the integrated resource framework information is

being shared with GPs. That is interesting because it starts to look at a much lower level of service provision for the population than has happened before, and we start to get into the options that are available to people. Again, there is a clear link to the self-directed support policy through thinking about the other options that might suit people better, and what might better meet people's needs and improve outcomes for them. All the agendas are therefore quite closely linked.

Ken Macintosh: Thank you. I think that I interrupted Fraser McKinlay earlier.

Fraser McKinlay: Claire Sweeney covered it.

Willie Coffey: Auditor General, I want to pick up on the issue of delayed discharge. The figure that is mentioned in the report is something like 305,000 days all in. From your comments in paragraph 67, it appears that the problem is half the size that it used to be, but it is still quite extensive. You also comment that 837 hospital beds or equivalent are being occupied for a year by patients who are otherwise ready to leave hospital. There must be quite a considerable cost attached to that. Do you know what that cost is?

Caroline Gardner: It is possible to put a cost on it by basing it on the average cost of a hospital bed day. The question is how much that really tells us. As Mr Macintosh said, the problem is that, because of the pressure that we all put on acute hospital beds, if there is not an older person in that bed, it will be filled very quickly by someone else, so that sort of average cost is not particularly useful. That shows why stepping back and looking at the whole system is the only way to tackle the problem.

Willie Coffey: You hint at the issues in paragraph 66, but why are people being brought into hospital? Is there no discharge plan ready? Should people be admitted to hospital when there is no discharge plan for them? What are the main reasons for that?

In your recommendations, I do not see a strong enough recommendation for dealing with that and smoothing people's transition back into the community.

Caroline Gardner: You are right to say that there is no specific recommendation about that. That is partly because the ways in which it can be tackled just by focusing on delayed discharge have already been done. That "easy work"—if I can put that phrase in inverted commas—has already been done, which is why the figures have fallen so significantly during the past few years.

There is scope for people whose admission to hospital is planned to be clearer in advance about what they will need to get out again and, on the whole, that is done for them. If someone is going in for a hip replacement or a knee replacement, it is clear what is needed to get them home as soon as they are able to stand and move about, and those requirements are almost always in place. The problem arises when people are admitted unexpectedly as an emergency and something changes. If they fall and break their hip, it is much harder to get them home quickly because new things need to be put in place.

It is important to look at the situation through the other end of the telescope, too. Services that can prevent someone from falling and breaking their hip and going into hospital are just as important as the services that will help them to get out of hospital once they are in there; they are possibly more important. As Claire Sweeney said, the ability to work with the GP, the district nurse, and the social workers to focus on older people who have had a history of falls and look at what would help to keep them safer can have a bigger impact than the assessment process once someone is in hospital.

Willie Coffey: I will leave it at that, convener. Thank you.

The Convener: Thank you. I thank the Auditor General and her colleagues for their evidence to the committee. With that, we move into private session.

12:34

Meeting continued in private until 12:39.

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