The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 1 October 2014

Session 4

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PUBLIC AUDIT COMMITTEE
15th 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)
*Bruce Crawford (Stirling) (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:

Dr Roelf Dijkhuizen (NHS Grampian)
Professor James Ferguson (NHS Grampian)
Russell Frith (Audit Scotland)
Alan Lawrie (NHS Lanarkshire)
Ian Ross (NHS Lanarkshire)
Owen Smith (Audit Scotland)
Shobhan Thakore (NHS Tayside)
David Torrance (Kirkcaldy) (SNP) (Committee Substitute)
Lorna Wiggin (NHS Tayside)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Public Audit Committee

Wednesday 1 October 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 15th meeting in 2014 of the Public Audit Committee. I have apologies from Colin Keir—David Torrance is substituting for Colin this morning. I ask everyone to ensure that all electronic devices are switched off, or at least to silent, in order to avoid any interference.

Under agenda item 1, do we agree to take items 5 and 6 in private?

Members *indicated agreement.*

Section 23 Report

"Accident and Emergency: Performance update"

09:30

The Convener: Item 2 is on a section 23 report entitled "Accident and Emergency: Performance update". We have agreed to take evidence from a number of health boards, and I welcome the witnesses to the committee. Dr Roelf Dijkhuizen is the medical director at NHS Grampian, and Professor James Ferguson is a consultant in emergency medicine there. From NHS Lanarkshire we have Ian Ross, chief executive, and Alan Lawrie, the board's director of acute services. From NHS Tayside we have Lorna Wiggin, director of acute services, and Shobhan Thakore, consultant in accident and emergency.

I understand that no one wishes to make any opening comments. I will first ask a general question, which could apply to any one of the health boards represented here. When ambulances arrive at accident and emergency, is a waiting time generally recorded for how long patients have to wait before there is a discharge or acceptance into A and E? Does the target time in accident and emergency start only when the patient is taken in from the ambulance?

Professor James Ferguson (NHS Grampian): I will speak on behalf of NHS Grampian, but this is probably true for most places in Scotland. In Scotland, we do not have a big problem with patients being held in ambulances, certainly not in Aberdeen. They are downloaded off the ambulance immediately and are then taken into an initial assessment area. I know that it is similar for Tayside, and probably for most other areas. The time starts as soon as they hit the door.

The Convener: It starts as soon as the ambulance arrives.

Professor Ferguson: There is usually a bit of a delay to get the patient out of the ambulance and let us know that they are there, but there is no holding the patient in the ambulance before they come out.

The Convener: It does not happen across Scotland at all that patients are held in ambulances before going into accident and emergency.

Shobhan Thakore (NHS Tayside): I would reflect what Professor Ferguson has said. Our experience in NHS Tayside is that the ambulance arrives and the patient is brought in on to a trolley and registered in the department. That is when the clock starts.

The Convener: Issues of recruitment keep coming up. That is generally an issue across Scotland. There was a report in the papers recently from Grampian about flying in a consultant for weekend work. I do not know whether the figure that was quoted is accurate, but the total cost was reported to be £7,000 for a weekend. Is that accurate?

Dr Roelf Dijkhuizen (NHS Grampian): It is accurate in the way that you have described it. It must be said, however, that the consultant was not a locum in the sense that we did not know him. The consultant had been working with us in the department since August. He was a well-known doctor who was trusted by his colleagues and by the nursing staff in the department, who was fully qualified and who had been working in Grampian for two months. He was not just a locum; he was somebody we knew and trusted.

People have their own lifestyle choices. That locum works two weeks on and two weeks off. In the two weeks off, the locum returns to India, where his family lives. As it happened, in the weekend in between, we asked him to come in, because of the unexpected illness of one of our consultants.

The Convener: Was there no one else who could do that work?

Dr Dijkhuizen: No. It is the more general aspect of your first question. We struggled with senior staff in the accident and emergency department in NHS Grampian during August and September, which caused us to rely on people from elsewhere. In our ideal rota, we need nine senior people on any one day to contribute to the department; there are other people in the department, such as junior doctors. When we were at our worst, we had 16 people from which to deliver that. We are coming out of that situation now—we now have 20 people—and we are looking for further recruitment. When we had that small pool of people to make a contribution every day, our consultant colleagues, such as Professor Ferguson, would have worked five out of six weekends. We felt that that was unnecessary.

The other thing that we took into account was the cost. The total cost of this arrangement was no more than we would have had to pay our own staff. According to our terms and conditions, if you have special rates the rate goes up very quickly, so economically it was neutral. For the staff, it was the best thing to do. On the quality of the individual who was hired to come over, we knew him—he was trusted by the department.

There have been some stories about tiredness. There was no such thing, in the sense that he flew in the day before, and had 16 hours before starting a shift in the department and six hours sleep between the Saturday and the Sunday—that was guaranteed, because we had somebody sleeping in from the intensive treatment unit at that point, to back up if need be. It was not needed, but he had sufficient sleep. Overall, the arrangement was very satisfactory from our point of view, although we understand how bad it looked in the press, with people making more of the situation than was the case.

The Convener: Is the total of £7,000 accurate?

Dr Dijkhuizen: That is the reality of providing 46 hours of cover for an A and E department.

The Convener: That is what I wanted to ask you. You said that it was no more expensive than hiring somebody locally. That is the cost of providing consultant cover for—how many hours on duty?

Dr Dijkhuizen: The total number of hours was 46—

The Convener: Not continuously, surely.

Dr Dijkhuizen: No. I was just explaining how it worked. The consultant is on standby for some of the time, but they are in their bed. That is no different from what a normal consultant does. What I am trying to say is that if we had had to ask our own staff to do it, according to the terms and conditions we would give triple pay for an extraordinary shift like that, and we would come to the same cost arrangement as we had in this instance.

The Convener: Is the difficulty that you face in recruiting consultants a general difficulty across the health board or is it just in accident and emergency?

Dr Dijkhuizen: There is no doubt that we have problems across the health board in recruiting medical staff. I have been a medical director in this board for 12 years and the situation has exacerbated in the past few years. Increasingly, doctors are making choices that are financially motivated—their choices are motivated by the cost of living in a certain area. Housing in Aberdeen is very pricey—I think that it is the highest in Scotland, although I am not an expert. We get stories about people saying that they can get so much more out of their pay packet if they take a post in Glasgow or elsewhere as supposed to Aberdeen. It is an enormous problem for us.

The Convener: Is NHS Grampian's recruitment difficulty greater than that in any other health board in Scotland? Is there a particular problem in Grampian?

Dr Dijkhuizen: Well, I would say that, wouldn't I, but I genuinely believe that there are reasons why recruitment in Grampian is more complicated than it is in other boards. It could be argued that

although Edinburgh, for example, is expensive to live in, the fact that it is the capital of Scotland attracts people. There is a difference between Edinburgh and Aberdeen.

The Convener: What problems does that give Grampian in meeting the four-hour target?

Dr Dijkhuizen: To meet the four-hour target, we have to put together a very complex jigsaw that involves not only the A and E department but services both in the community and in the hospital. It is a very long story, but I would say that, as far as recruitment in emergency departments is concerned, the earlier you get a senior clinical opinion of the patient when they present at hospital, the more likely you are to make the right decision early in the journey and get the patient to the right doctor and facility. Having a senior opinion early on in the pathway is very important in reaching the four-hour target, and if you are finding it difficult to recruit people who can give a senior opinion, you will be at risk of delaying the assessment.

Mary Scanlon (Highlands and Islands) (Con): As a supplementary, I note that, according to statistics issued by the Scottish Government's Information Services Division, there were as of 30 June 347 vacant whole-time-equivalent consultant posts, with a high vacancy rate—23 per cent—in intensive care. There are a lot of vacant consultant posts across Scotland, but I just wanted to highlight that 23 per cent vacancy rate in intensive care. I am sure that you have had a look at the report that we are discussing this morning, but I am concerned that, although on paper there are more consultant posts, vacancy rates are higher and the number of doctors in training is falling. This is a problem not just for today, and I am finding it difficult to see how it will be fixed in the years ahead.

Dr Dijkhuizen: Was that for me?

Mary Scanlon: Well—

The Convener: It might be that others will want to answer it.

Mary Scanlon: My question is this: why is it that 23 per cent of the 347 vacant posts are in intensive care? The figure for paediatric cardiology and paediatric dentistry is 20 per cent, but no other figures are mentioned in the Government statistics. Why is this such a concern? You have talked about doctors' choices, but are they choosing not to go into intensive care or accident and emergency? Moreover, why are the training rates falling?

Dr Dijkhuizen: I am sure that other people will want to give their own perspective, but my perspective from NHS Grampian is that consultants' choices are not only determined by the attractiveness of a particular specialty at a particular time but very much influenced by the place and the team that they will work in. Scotland has fallen a little bit behind with the incentives that it offers medical practitioners; I am not saying that the English system is better—I am actually a very strong supporter of the Scottish system, because its set-up is much healthier than the English one—but English trusts are able to provide recruitment incentives that our healthcare organisations quite simply cannot. We have national terms and conditions, national agreements and national pay rates that we cannot deviate from.

As for the number of clinicians in the budget, I point out that the consultant rate in Grampian is lower per 100,000 population in almost all specialties and that, within that, we are still running vacancies. That is because, financially, NHS Grampian has had to live in a different way from many of the other boards.

09:45

Members will know about what was originally called the Arbuthnott formula and is now the NHS Scotland resource allocation committee formula. We have lived with 10 per cent less than the average for a decade—all the time that I have been a medical director. That totals £1 billion over the 10 years, which is a massive amount of money. Over the years, we have constantly innovated and done things differently. We have done things with less senior staff and have tried to have a safe and high-quality service with a different staffing profile.

We in Grampian do not have medical difficulties in intensive care but, as for any board, such things always fluctuate—one service is in trouble, then another is. For us, intensive care looks good medically. However, we have a problem in nursing in intensive care, which means that we cannot always open all the beds in intensive care that we would like to open.

Mary Scanlon: You did not say which of the incentives that are available in England and are not available in Scotland are attracting our best consultants there, as we have national pay and conditions.

Dr Dijkhuizen: At the specialty doctor grade—that is the non-training grade and the non-consultant grade—people can put their own package together in England, whereas people would have to ask for a variation order to do that in Scotland, which would set an awkward precedent in a system that is otherwise in equilibrium.

The Convener: Can I ask about a comment that you just made? You said that you have tried a number of innovative ways of dealing with the

problem, which included using fewer senior staff to deliver the service.

Dr Dijkhuizen: I would not have said that, but it is right to refer to a different equivalent of substantive-grade doctors. We are trying to get a safe service in the A and E department by using not just emergency department consultant staff but staff from other departments—particularly general medicine and medicine for the elderly.

The Convener: How successful has that been?

Dr Dijkhuizen: We believe that we have provided a high-quality and safe service, but it would be remiss of me to say that we have cracked the issues and are in a stable and sustainable situation, because we are not—it is hard work.

The Convener: I asked the question to find out what works well, which my colleagues will also ask others about. If that approach works well, makes a contribution and helps you to have more for your budget, should you seek to consolidate it? Should others copy it? Perhaps they are already doing that.

Dr Dijkhuizen: I would not like to say that we have cracked it. However, Professor Ferguson and I have travelled the country and been outside the country to share Grampian's good practice, particularly on decision support and the use of telemedicine for the pre-hospital phase of the acute care episode. We support clinicians in the community to reach the right decision about a patient and to back that up with resource for the patient. That model works well, but the issue is always how to scale up a measure to make it the way in which we do things and to make the difference. We are still working hard on that, but Professor Ferguson can say more.

Professor Ferguson: Roelf Dijkhuizen is hiding his light under a bushel. Under his direction, we have introduced physician assistants in Aberdeen. A lot of the day-to-day care of patients in the ED was delivered by junior doctors in training, but their numbers are reducing, so we now have a programme that uses physician assistants, who are superb and are cheaper. They are motivated and they like being there.

That is one example of an innovation that has allowed us to adjust. That does not fill in for senior decision making, but it allows us to have manpower in the department so that we can get patients through.

Ian Ross (NHS Lanarkshire): I want to add something about vacancies. In Lanarkshire, about 10 per cent of our consultant posts are vacant at the moment and we cannot recruit to them. Even above that 10 per cent, we have locums either from elsewhere in the health service or from agencies. In certain specialties, such as emergency medicine, vacancy rates are 20 per cent. We have 35 funded posts, but our vacancy rate at the moment is 20 per cent for certain posts. We have just advertised for nine posts and I hope that we will be successful in filling some of them.

As my colleagues have said, staff in the accident and emergency departments are extremely committed and will work extra hours, but we need to ensure that they are not working beyond the safe working hours limit. They will sleep in the department and will take extra shifts to provide cover, because sometimes it is difficult to get locums, either from agencies or from the national health service. It is a problem that we all face.

The Convener: I will come on to ask about vacancies.

You have just said that staff sleep in the departments. I know that the issue does not affect only Lanarkshire, but if you are asking staff—particularly young and inexperienced staff—to do all those hours, it must put stress and strain on them. Does it impact on their ability to exercise proper judgment in some cases if they have been working extraordinary lengths of time?

Ian Ross: I was talking about senior staff staying in the departments to support junior staff. There is an issue with junior doctors' hours, but this is about senior decision makers who have clinical competence and who are there to support the junior staff in A and E departments.

The Convener: How many vacancies do you have for middle-grade doctors?

Ian Ross: I am not sure of the exact number, but we have vacancies.

The Convener: Is it higher than 20 per cent?

Ian Ross: We do not have middle-grade vacancies in A and E at the moment, but there is a skills mix issue. Alan Lawrie may be able to give you more detail on that.

Tavish Scott (Shetland Islands) (LD): Thank you for being so commendably open. It is incredibly helpful to have people coming along to the committee who are open about what is happening.

How do you think we can best tackle the recruitment challenges? Are you arguing that the NHS across Scotland needs to be able to reward in different ways? We now provide golden hellos for general practitioners in particular areas of deprivation and in areas of rurality. Do you think that other incentives need to be built in?

You may also be aware that MSPs and health ministers face some pressure around public perception, given the pay rates in that area. We

are under that pressure at the same time that you are faced with pretty ghastly choices and recruitment challenges.

Ian Ross: It is a difficult area, because if you focus on accident and emergency and give incentives to those consultants, there could be a shift from other areas. I remember that, many years ago, there was a great shortage of radiologists, and when trusts started paying a higher rate for consultants, there was a movement of consultants, with parts of the system getting into a bidding war to attract them. It is not as simple as saying that we need more incentives for a certain group of consultants; we have to look across the system and find a balance.

Dr Dijkhuizen: People have different motivators. Going into a specialty is a motivator, and that influences whether people choose a career in general practice, so we should consider how attractive a specialty is. Accident and emergency has a specific issue because the fill rate for senior trainees in accident and emergency across the United Kingdom is 29 per cent.

Tavish Scott: What does that mean?

Dr Dijkhuizen: It refers to the available training posts that are filled. The majority of the posts that are designed to be training posts are occupied by other grades of staff.

I mention it because it is an indicator of how unpopular accident and emergency currently is as a specialty across the United Kingdom, which is to do with the way in which accident and emergency units across the United Kingdom act as the safety net for anything that falls between the healthcare cracks in the region concerned. Doctors who are trained to treat patients with immediate ailments—to provide resuscitation and to treat trauma—are in fact confronted with a very wide range of diseases that do not answer that description. When people are trained for something that is different from what they see in front of them, that can have an effect on the popularity of the specialty.

Shobhan Thakore: Emergency medicine training is where we have seen the big problem in recent years, with a reduction in training numbers. The problem is not so much recruitment into the beginning of training but attrition rates during training. The training programme lasts six years, but before people get to the fourth, fifth and sixth years, when they are considered to be experienced trainees, some of them will have resigned from the rotation.

Tavish Scott: Why does that happen?

Shobhan Thakore: There are a number of reasons. People are being asked to make decisions about their careers at a fairly early stage these days. I was probably part of what was called the lost tribe of senior house officers, back in the day when people spent five years trying different specialties and then found something that suited them. People almost have to make their decision at medical school; when they come out, they head towards a specialty at a very early stage. Sometimes, they just make the wrong decision, they go into the wrong specialty and they then move to a different one.

Tavish Scott: If you wanted to change the system, is that the part that you would target?

Shobhan Thakore: That would be one area.

The Convener: Who determines that?

Shobhan Thakore: It comes through the modernising medical careers programme.

The Convener: Is that a Government initiative, or is it led by the colleges?

Lorna Wiggin (NHS Tayside): It has been the direction of travel now for some time.

Professor Ferguson: It started in 2007.

Shobhan Thakore: That is one aspect. People come into A and E as a junior trainee. They work fairly intense rotas, with lots of out-of-hours shifts and night shifts. As part of their initial training, they then go on to other specialties, which are slightly less intense. They might think that they have seen the middle graders and consultants in A and E working quite hard, and they might not be sure that that is how they want to work.

The environment in which people work, with crowding an increasing problem in emergency departments, is not always the best. People will consider that, they will consider their career and they will reflect on whether they want to work in that way.

Managing to get on top of the four-hour target, achieving a flow through departments, reducing crowding and making a better environment to work in would improve our chances of keeping people in the specialty.

Tavish Scott: In your different health board areas, are you all being asked to make these observations—and indeed suggestions—to the NHS at the centre? In fairness, the Cabinet Secretary for Health and Wellbeing has made observations at question time on many occasions about how difficult recruitment is. I just wonder who is driving the process of recognising the challenges that you have all—very fairly—identified. How, therefore, do we tackle them?

Professor Ferguson: We raise them repeatedly. I was there right at the start of the MMC programme. The idea was that we were going to reduce the number of middle-grade and

junior doctors delivering the service. In 2007, we had a huge bulge of EM trainees, and we wondered at the time whether there would be enough jobs to employ them at the end. We were told, "Don't worry about that. At the end we will have more consultants in the department." The problem is that posts have not expanded as rapidly as we wanted, and there has been an attrition rate.

The acute problem in Grampian is that, in August, we happened to lose a whole lot of our middle graders, and we did not increase the consultant jobs in line with that. Suddenly, we have an acute problem. We knew that it was coming, but we did not appreciate that there was such an attrition rate.

There are other things to consider, including the retention of staff. Senior decision makers are guys of my age—53 or 54—whose kids are leaving school and all the rest of it. We froze the merit award system two years ago. A large number of senior clinicians are now being attracted to work overseas once their children grow up.

Suddenly, not only are we failing to recruit but the guys we have, who traditionally would have worked till 60 or 65, are going. There are pension changes, and people are saying, "I'm going at 60 because the pension changes mean that it's not worth my while staying on till I'm 65."

There is a whole culture associated with retaining staff, and we are putting a lot of money into it.

10:00

The final thing is variation orders. I am clinical lead for telehealth and we just ran a paediatric unscheduled care pilot to see whether we could redesign healthcare, with consultants at home who would be available by videoconference to remote and general hospitals. We had absolutely fantastic, positive results. Could we pay, in a different way, the consultants who did that? No. When we went for the variation, we were told that we must pay them in exactly the way that we paid them before. Basically, our entire system is guaranteed to ensure that we cannot redesign the system. We had to come up with a really inventive way of paying them, through Tayside. The whole system is inert at the moment and we are just seeing the pressure. That is why we are falling over, to a large extent.

Shobhan Thakore: The consultant contract does not reflect current changes in working conditions for newly qualified consultants. Newly qualified consultants are often asked to do night shifts as part of their job plan. They look at the working times and conditions in the job plans and they think, "I'm doing night shifts and I'm working a lot of weekends and a lot of out of hours. Am I being remunerated any differently from someone who is just on call from home?"

Colin Beattie (Midlothian North and Musselburgh) (SNP): We have heard quite a lot about retention and recruitment issues. The thrust seems to be all about money. Is it only money that motivates? We have heard about the pension pot, which has come down from £1.5 million to £1.2 million, which presumably affects people's decisions about whether to carry on. Although a few other things have been mentioned, is it fundamentally all about money?

Lorna Wiggin: No.

Professor Ferguson: I think that it has become about money. When I started my career, I wanted to work in the NHS until I retired and all the rest of it. The NHS looked after you. The problem is that we are now in a marketplace. I get offers daily to go abroad for ridiculous sums of money that are far in excess of what we get here. The thing is, what is keeping me here now? There is really nothing much. My wife works in the oil industry. We could go next week.

We went to try and recruit at the international conference on emergency medicine in Hong Kong in June, and I got five job offers at lunchtime. We handed out cards suggesting, "Why don't you come to Scotland?", and they said, "Why don't you come and work here, and we'll give you £250,000 a year?" We were like, "Wow."

I came through the NHS. I want to work in the NHS. I do it because I enjoy it but it is getting increasingly difficult. We are paying locum rates because we are struggling. In the past we would never have paid those sorts of rates. At the end of the day, though, the market is dictating that. I would much rather have expanded the consultant numbers so that we did not need locums. When I was a boy, we did not use locums very often, but at the moment, if you want to run your service, that is the going rate.

Dr Dijkhuizen: Money is about value and there are other things that determine value. Shobhan Thakore has referred to that. If you are in a busy and high-intensity specialty such as accident and emergency, and you work very differently from other people but you are treated the same, you do not feel valued. You could say that it is because of money or anything else. We could make special arrangements for our professionals. It is an unpopular specialty because of other things and not just money. It is about how you are valued in comparison to other specialties and what type of work-life balance you have. Are you doing what you are trained to do, or are you trying to be the stop-gap for everything and everybody?

As I said, you are trained to deliver a certain type of medical and surgical specialist treatment, but you are actually involved in a lot of other conditions, because the health system as a whole delivers these patients—these citizens—to the A and E department if anything goes wrong.

Lorna Wiggin: I respect what Professor Ferguson said, but people look for other things in their work, such as when they want to work. In Tayside, it is much more about the experience. In the specialties where the flow is working appropriately, where we have increased our consultant numbers, where patients' experience is good and where we are getting fewer complaints, people want to work there, and we get good feedback from trainees.

What matters is much more than just money. We could put as much money as we wanted into some areas, but we still would not recruit in them, because the experience of working there is probably not good.

It is too simple to say that just one thing is the solution, because the situation is much more complex than that. People look for a lot more than just a financial reward.

Shobhan Thakore: People look for job satisfaction.

Colin Beattie: To follow up what has been said, given that on-going budget constraints are likely, are there ways of making the job more attractive by enhancing aspects that do not cost as much?

Shobhan Thakore: I honestly believe that enhancing the service and the flows, taking crowding out of the department and making trainees see that they will deliver the care that they were trained to deliver and have the time to make the decisions that they were trained to make will hugely increase job satisfaction. Looking at processes to improve flow should not cost a lot of money, and increasing job satisfaction should help with retaining staff.

Obviously, money plays a bit of a role, and I have mentioned the consultant contract. When staff work in a crowded department where they are surrounded by patients who probably should not be there or who should have gone quickly through it, that is demoralising.

Colin Beattie: Who is responsible for that? Surely it is the responsibility of the hospital and the NHS board to ensure an efficient flow.

Lorna Wiggin: It is. The situation is complex, because it does not involve just accident and emergency. We must get the flow right pre-hospital, in hospital and out of hospital.

Colin Beattie: Who is working on that now?

Lorna Wiggin: That is a whole-system issue. We have had good results in Tayside because we have managed to get some parts of our system to work very well. We have looked at processes and systems in our emergency department and in our acute medical unit, which takes patients who do not need to go to the emergency department and who can go elsewhere for an assessment of whether they need to be admitted or can receive their care in an alternative way. Everybody is on the same journey, but perhaps we are at different stages. We are further forward in our whole-system work than some other boards are.

The Convener: I will stick with that point. You said that you move people from accident and emergency to other departments, and I presume that they go to a clinical assessment or decision-making unit. Do you record the number of patients whom you move from accident and emergency to other departments? Is that published as part of your accident and emergency figures?

Lorna Wiggin: Yes.

The Convener: Do the patients who come into accident and emergency and are moved to another section count against your accident and emergency statistics, or are they counted elsewhere in the system?

Shobhan Thakore: I will explain the system. We have direct admissions. If a GP feels that a patient needs to be admitted to a specialty, the patient goes directly to that specialty's admitting ward and does not touch the ground in A and E.

The Convener: We are not talking about such admissions—this is something different.

Shobhan Thakore: People who come into A and E are stopped and fully assessed—they are not stopped and then moved on. They are seen by a senior doctor and they are counted in the statistics all the way through to getting into a bed in an admissions unit.

The Convener: So they are counted as part of accident and emergency statistics.

Shobhan Thakore: Yes.

The Convener: At what point are they no longer counted as part of accident and emergency statistics?

Lorna Wiggin: Once they are assessed to be admitted, that is when the time stops.

The Convener: Is that system used elsewhere?

Lorna Wiggin: Yes, it is the same system. The ISD determines how we measure, and the same measurements are used across all the boards.

Professor Ferguson: The other important point to remember is that the four-hour target in no way

measures the clinical appropriateness of those patients being in hospital. I have worked for the collaborative performance team since its inception and some of the work shows that, at any given time, anything between 25 and 33 per cent of patients in our hospitals are not getting any benefit from being there. The four-hour target just tells us how fast the hamster wheel is going; it does not tell you whether you should be on the hamster wheel to start with.

It is a blunt tool, and we do not really know everything, so that hampers us a little bit. We are now doing some work on trying to turn round patients in the acute medical receiving unit on a day-case basis, and that is working well. However, the clinical appropriateness of that work is not reflected in the numbers—it is a complex issue.

The Convener: Colin, did you want to come back in?

Colin Beattie: Only to say that I am surprised that NHS boards are not further ahead with managing patient flow. Surely that is a basic efficiency that should be there and which NHS boards should be maximising. I am astonished that we are talking about being on a journey towards that sort of efficiency and that some boards are further ahead than others. Surely it is not something new.

Ian Ross: We are trying to get across the complexity of the issue in terms of preventing admissions to hospital in the first place. I am sure that you will have heard of the age specialist service emergency team and the integrated community support team in Lanarkshire that aim to do that. When people come into hospital through the A and E door, we need that flow through, and then we move them into an in-patient bed. The in-patient beds are in the same part of the system where we are trying to meet the cancer treatment targets, the waiting times targets and the referral-to-treatment target, so we are trying to balance the whole system to provide services, whether in relation to waiting times in A and E or other waiting times targets. Boards constantly have to balance the system.

Then there are the discharge arrangements, which give rise to the issue of whether there is enough capacity outside of hospital to give support in the community, part of which involves local authorities. Last week, we had 219 patients in beds in Lanarkshire who were considered no longer to require clinical care, but they could not go out that day. It is not as simple as looking at the front door of the A and E department. It is complex and there are lots of levers; we are trying.

On the four-hour waits in A and E, Lanarkshire is not proud of its record—we are not the best, although we are getting better—but when it comes to services such as stroke and waiting times in other areas, we are very good. It is necessary to take a balanced view of the system when considering how the board provides health services instead of looking at just one specific area.

The Convener: You mentioned the 219 patients still in hospital. Is that due to bed blocking?

Ian Ross: We tell those patients that they are ready to go home, but we have to work with the local authority and the community support team to provide services in the home.

The Convener: Is it the case that, during that week, there were 219 people who should have been discharged but who could not be because the services were not available in the community?

Ian Ross: Or because the processes had not been put in place quickly enough to allow them to be discharged into the community.

The Convener: Whose responsibility would that be?

Ian Ross: We work closely with the local authorities. Home care support is the responsibility of the local authority.

The Convener: I realise that, but if the processes are not being put in place quickly enough, which is different from the facilities or services not being available, who is responsible for not processing quickly enough?

Ian Ross: We work together on that. The services are provided in the community by the local authority, but the local authority needs to work closely with the team in the hospital—whether you call it a discharge team or a discharge hub—to ensure that the services will be provided in the community to meet the needs of the patient.

The Convener: Was the week with 219 such patients a particularly bad week, or was it a typical week?

Ian Ross: It has probably been typical over the past few weeks.

Alan Lawrie (NHS Lanarkshire): That has certainly been typical over the past few months.

To add to what Ian Ross has said, we have established in each of our hospitals an integrated discharge hub so that the discharge process is not just either a social work event or a health event. The process is jointly managed, so there is buy-in from both the health service and the local authority in trying to fix problems, which can be complex at times. There is joint effort around that.

The Convener: Has the problem been getting worse recently?

10:15

Lorna Wiggin: Certainly in Tayside, we have always had an issue. At any given point in our health system, we will probably have anywhere from 90 to around 110 patients in four local authority areas across Tayside who are clinically fit to be discharged, but who are awaiting a complex care package, home care or adaptation to housing. That delays their discharge into the community. Likewise, we have integrated discharge teams and enhanced recovery to try to accelerate some of those arrangements, but it often comes down to the availability of specific staff in quite small locations to provide the care.

The Convener: To go back to A and E and the process of people coming through, is that after they have been discharged from A and E and have been put into the general hospital system?

Lorna Wiggin: Those patients will probably have been in the hospital system as in-patients and had care. In general, they probably tend to be patients who have come in, their health status will have changed in the period in which they have been in hospital, and they require support.

The Convener: Does that blockage in the use of resources impact on what you can do in A and E?

Lorna Wiggin: It could do. I expect that, if the other systems and processes are not in balance, the impact of that will be felt more significantly than if the systems and processes are in balance in other areas.

The Convener: So it feeds all the way back.

Lorna Wiggin: Yes.

Professor Ferguson: If you put a dam across a river, the river backs up; it has to continually flow. The minute you have any blockage at any point in the system, you are stuck. It all comes to A and E; we are the barometer of how the system is working. If there is a blockage downstream, we start to feel it.

Dr Dijkhuizen: The issue is fundamental. It is also one of the reasons why Scotland is currently better off than England. In Scotland, we work as a single system between primary and secondary care. Although we struggle with that, we do it, and there is genuine integration.

In Scotland, strategically with local authorities, we are on absolutely the right path in integrating services. The service in England is much more fragmented than that in Scotland. That is one of the reasons why our ambulances are not backed up outside the A and E department. We should all be very proud of that.

That also indicates that the issue is not simple and why hospitals do not sort it and show a degree of impatience to do so. When I try to explain the problem to people, I say, "If you want to know about the region where you want to live or work, go to the A and E department and walk round it. If you get a feeling of control, that is a good area as far as the health service is concerned. If you feel a sense of backing up, people running around and a loss of control, that tells you something about the A and E department and it tells you a little bit more about the hospital as a whole but, most of all, it tells you about how well the system works in an integrated way."

Many issues that manifest themselves in the A and E department are related to a lack of clinical capacity not in the hospital, but in the community—to general practices' ability to see patients timeously, long closures, four-day weekends and so on. That tells us about how the system is working as a whole. That is insufficiently recognised.

The other thing that I would like to make a plea for in my dying days—I am retiring—relates to organisational focus. As NHS Scotland, we do not have enough organisational focus on unscheduled care or on the front door of our services. The front door of our services is every GP practice in our community, the GP out-of-hours services—the GMED service in Grampian—all the way up to the high dependency unit. Our organisational focus is on waiting times and on elective care—the other side of the health service. There is huge public demand for that—understandably so—but we must be careful, because the most vulnerable people in our society are dependent on access to unscheduled care services and we have not really managed to focus our energy on that.

In NHS Grampian, we are visited by the senior civil servants frequently about our performance and breaches of the 12-hour target, which is law, but people do not come round our organisation so often to check the quality of the unscheduled care services that we provide. I make a plea for a change of organisational focus more towards unscheduled care.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): I find it moving to hear you say that, Dr Dijkhuizen. Thank you very much for bringing that information to the committee's attention.

I will open up a little more discussion on the four-hour waiting time target, which has been the subject of considerable discussion at the committee over recent months. One of the interesting comments that the Auditor General made in her report was:

"Discharges from hospital generally take place in the afternoon"

and

"fewer inpatients are discharged at weekends"

but a high number of people come to A and E on Mondays and Tuesdays. That seems a trivial set of circumstances for us to struggle with, but are such dynamics behind the reasons why we do not generally meet the 95 per cent target? What can we do to ensure that we achieve the target?

Professor Ferguson: It is partly because unscheduled care is often more predictable than elective care because we know that Mondays will be busy. It is all related to seven-day working and such matters.

We still operate the way that we have always operated. We know that people are more likely to die if they go into hospital at the weekend—there is good evidence to suggest that—but, on a Sunday, we are busy with minor cases because everybody wants to be seen before they go back to work on Monday and, on Monday, everybody who has waited the weekend starts piling in. The GP service is up, so people are admitted.

Those are not the people who are collapsing with a stroke or a heart attack; they are the background numbers. They are the folk who are gradually getting iller. We basically get batches of moderately ill people being moved into hospital for investigation because that is the way that we have designed the system to perform.

Willie Coffey: We know about that—it has probably been the case for years—so why would there be fewer discharges at the weekends? It sounds as though we are creating the potential for back-up. Why would we do that? Is it all to do with the integration of health and social care?

Professor Ferguson: It is partly that we do not have the facilities at the weekend. Hospitals tend to power down at the weekend, so we are in a holding pattern. We might not have imaging services, so if someone is waiting for a CT or an ultrasound scan, they will not get it done until the Monday.

It comes down to the fact that we are still working a five-day week but people get ill seven days a week. That raises a big question about running our hospitals hot, as they would say in the States, and using our facilities all the time to get patients through. In Europe, we still traditionally do things Monday to Friday.

The Convener: I understand what you say about people being more likely to die at weekends. I have raised such issues about the Royal Alexandra hospital in Paisley and had a variety of responses on them. Are you suggesting that the fact that you work a 9-to-5 pattern Monday to Friday contributes to the greater mortality rates at the weekend because the service is not fully staffed? If the service ran seven days a week, 24 hours a day, would that lessen the number of deaths at weekends?

Professor Ferguson: There is good evidence that shows that the longer the wait in an ED, the greater the mortality rate. It is a marker of how effective the system is. That is why we worry about 12-hour waits, because some of the data suggests that that leads to an increase in mortality of up to 20 per cent.

All these things are well documented, but they are not particularly well known. I spend most of my time pointing them out in the talks that I give. It is probably unethical to send somebody into a hospital with a crowded system if they do not need to be there and it would be better to treat them in the community.

How to change the entire way that a health service works is a big question. You cannot do it overnight. That is not to defend the situation; it is just how we have always worked. As our workload grows, with more elderly patients spending time in hospital and all the rest of it, we see greater mortality and morbidity when we are not efficient.

Willie Coffey: Could we perhaps hear from Tayside and Lanarkshire on that? I think that Tayside's performance results showed that it was meeting the target. I would like to try to understand what differences in approach have enabled the target to be met, as they could be shared with other boards.

Lorna Wiggin: It is a whole-system approach, although Shobhan Thakore will be able to pick out the things that have worked in accident and emergency. We have looked at having our senior decision makers—not just those in A and E—available for extended periods, seven days a week, in our acute medical assessment unit, our surgical receiving unit and our paediatric receiving unit. That lets us know that there are good decisions and timely treatment, and patient outcomes should improve as a result.

We have invested a significant amount of time in an enhanced model in the community, whereby multidisciplinary teams look at patients in their locality who might be at risk. Those patients might be known to social work, police or health. The teams are coming together to look at those patients and to predict who might need more support before they deteriorate and need a hospital admission.

We have done significant work on our medical floor. We have looked at all our specialty wards, how we stream those wards, how they are staffed and what the consultant cover is. We have made a variety of improvements across the whole system, but some of the things that have been done in A and E have significantly improved flow through the department and helped to make sure that the right patients come to the right place.

Willie Coffey: Does that kind of approach flatten out the blockages that happen at weekends and on Mondays and Tuesdays throughout the system?

Lorna Wiggin: It does, although that is not to say that we have totally flattened out the blockages. We still have issues with not always having access to all the diagnostic support. We have it for emergencies, but not for the patients who are deemed to be able to wait. We are still looking to see how we might provide a model that gives us services more of the time—probably not 24/7, because we do not need all services 24/7, but certainly some services are needed for some periods over seven days. We are working on what that model needs to be—in other words, the next steps.

Alan Lawrie: Our performance has not been as good over the past couple of years, and we certainly recognise that. We have probably talked about a bit of that, in terms of the three dimensions. We need to get it right by having senior decision makers in the emergency department and the receiving areas, we need to make sure that the internal processes are right—we need to have the right time of day for discharge and to move people through the system quickly when we can—and there is the flow issue that we have just looked at.

We did a risk assessment in April of what was in our medical and surgical receiving areas. As a result of that, the board is investing in an additional nine physicians across our three hospitals, so that we can have a consultant presence in our hospitals for a much longer period in the day—up to 11 o'clock at night. We will also have an enhanced presence in our receiving areas of senior decision makers at weekends so that we do not get into the problem of immediately having a negative number of beds on a Monday morning.

How successful will we be in recruiting? The early part of that is key for us. Ensuring that we can attract people because we have a model that we think will work is really important. We are taking that forward.

The Convener: Is recruitment the key thing for all these problems?

10:30

Alan Lawrie: It is one of the key things, certainly given the level of vacancies in emergency medicine. We also have vacancies among our physician body across the piece. Recruitment is important.

We have done reasonably well over the past couple of years in recruiting into posts. As I was saying in relation to Tayside, it is a matter of ensuring that what people see looks like somewhere where they want to work—a calm and controlled environment that is operating in an effective way. Where we see things operating in that way, we get very good recruitment.

Bruce Crawford (Stirling) (SNP): I thank you all for helping us to understand the scale and complexity of what you are dealing with and for taking a very wide perspective, going way beyond A and E. That has helped with our knowledge considerably.

I want to bring the discussion back down a bit. First, I wish to establish a baseline for the recruitment issue. I have heard different boards discussing different numbers, using slightly different terminology. Could you help me with that, just to let me know how many A and E consultants you have funding for in your establishment? How many do you have currently? How many vacancies do you have? That will give us a baseline as regards where everybody is, which would help me.

Shobhan Thakore: We have funding for 17 consultants—16.2 whole-time equivalents—and we are full.

Alan Lawrie: We have funding for 35 consultants across our three hospitals, and we currently have 28 in post, so we have seven vacancies.

Dr Dijkhuizen: We have funding for 16 consultants in NHS Grampian, and we are looking for three or four more.

Professor Ferguson: I think that it is a bit more than that, in fact—it is five. We have 11 in post—8.8 full-time equivalents.

Bruce Crawford: What is your funding establishment? What are you allowed to fund?

Professor Ferguson: We are aiming for 16.

We need to put this in context. Different parts of the country have gone through the process at different stages. Grampian is a bit behind, as we had a disproportionate number of middle graders. We have agreed that we are aiming for 16 consultants. That is the minimum level that we currently need to run a big ED. We are behind the game—but we have been compensating with middle graders.

Bruce Crawford: Could you repeat how many you have now?

Professor Ferguson: At the moment, there are 11 people physically in post, which I think equates to 8.8 full-time equivalents.

Bruce Crawford: Okay—we now know exactly what is happening in every area.

The Convener: Sorry, but I want to ask this before Bruce Crawford continues: how have you managed in Tayside?

Bruce Crawford: I was going to ask that.

The Convener: Sorry.

Lorna Wiggin: I will let Shobhan answer that question.

The Convener: Sorry—I will let you develop the question, Bruce.

Bruce Crawford: The convener has just asked it—so, on you go.

Shobhan Thakore: People want to come and work there. People have been trained in the system within Tayside, and they want to stay.

Bruce Crawford: I am sorry to interrupt, but is that because there is a teaching hospital? Has that helped?

Shobhan Thakore: It is not just that. It comes back to the environment in which people are working—the feel of the department.

In general terms, there are three main things that we have done. This sounds really basic, but one is to define our service: to say what A and E or emergency medicine is actually there to do, and what we are not there to do. That means having a view of where our skills lie and where we can add benefit to patients and to the organisation.

The second aspect is staffing. We have done a couple of different things. One is to model our staffing against demand: we have doctors on duty when the patients actually arrive, as opposed to when doctors like to work, and for that we model demand within the department. Another relates to senior decision makers. It has involved making the argument to management, and providing data and evidence to suggest that having a senior doctor within the emergency department making a decision early on in a patient's journey prevents admissions—and, more importantly, unsafe discharges. It also prevents a lot of referrals. When we studied the system, we found that we were effectively reducing referrals from the unit for medical admission by 25 per cent. That has a huge impact for the organisation and a positive impact for the patient.

Making that argument to management has led to a collaboration where we have supported the model that we have. Our trainees see that we have a jointly owned model, in that our executive team buy into what we do and recognise that the four-hour target is a measurement of the system, not just of the department. The doctors see that, and they want to come and work there.

Thirdly, we have a number of different processes in place to improve flow and to ensure that we are seeing the right type of patient: patients in the right place being seen by the right doctor. That has effectively led to departments that are not crowded, and the nursing and other medical staff enjoy coming to work. They are not surrounded by patients on trolleys thinking that they have nothing else to add for them, and they are not seeing patients whose problems they are not trained to deal with because a GP should be managing them.

We have a number of processes in place that have led to that efficient flow and a feeling of job satisfaction.

Bruce Crawford: Other boards have told us that they are on a similar trajectory towards getting to where Tayside is. What is the next improvement that you need to make to continue the journey? You have reached the stage you are at but we never stop learning, so where are you going next? I am interested in sharing good practice throughout Scotland, so we know what the next part of the journey will be for others.

Shobhan Thakore: Some of the improvements will be downstream changes as opposed to changes in the emergency department. We have tried to focus on our specific processes that have added value and made us the department that we are and to share that with other boards through networking events or visits to our department.

I will let Lorna Wiggin speak about improving our service. There has been a lot of investment in downstream areas—admission areas—to improve the patient experience and flow.

Lorna Wiggin: Our next steps will be to define our seven-day model for all-over services, which is what we are heavily involved in at the moment. A lot of our time and effort is going into our work on integrated teams, so that patients can be identified earlier in order to prevent admission or provide care at home. Given our demographics and the increasing number of over-65s, that is a significant issue and challenge for every board area.

We are testing out with GP practices the enhanced multidisciplinary team model and using an electronic tool to help us to look at risk and to share information between health and social care so that everyone has access to the right information at the right time to support people. We are spreading that practice. That is probably where our biggest gains will come in helping to maintain our improvements in A and E.

Bruce Crawford: I have one last question. Various partners are involved in the structure that you have described, including local government, social work departments and Government. What could those partners do to help you to complete the journey so that it is as good as it can be? What

changes do they need to make to help you to get better?

Lorna Wiggin: That would be to do the same—provide a seven-day service. It is difficult to discharge over the weekend because local authorities do not run a full set of services over the weekend. That is our biggest challenge. People do not get ill Monday through Friday; they get ill or need to be discharged over weekends, so we all need to be able to support that model.

Bruce Crawford: We will be having discussions with various local authorities, including Angus, Dundee and Perth and Kinross. What response is NHS Tayside getting to that request to its local authorities?

Lorna Wiggin: People want to work in that way; indeed, we are beginning to see that with the new integrated arrangements. Operationally that happens, but the issue is about how we support the work on the scale required to meet the challenges ahead. We have good relationships with our partners—we work together in order to tackle the issues that we have with patients who are delayed in getting into the community for those reasons.

Bruce Crawford: What can the Government do to help you?

Lorna Wiggin: How we manage the whole system is an issue. There is pressure in managing all our targets, as well as all the elective demand and the unscheduled care, with the resources that we have, especially if we want to stretch the services over seven days. There is probably a bit of work that we could do together to better understand what needs to be delivered and when. That work would be helpful for the future.

Bruce Crawford: Thank you. Does anyone else want to reflect on that?

Ian Ross: Work has already commenced with the Scottish Government and health boards to look at seven-day working, what it means, and how we can do it. Obviously there are issues with resources and staffing. That is being worked on at the present time with the Scottish Government and health boards.

The Convener: I want to clarify something for the record. Tayside has 17 consultant posts and there are no vacancies. Grampian has 16 posts and 8.8 full-time equivalents. Lanarkshire has 35 posts and how many full-time equivalents?

Alan Lawrie: Twenty-eight.

The Convener: I will ask the committee clerks to get information from the other health boards so that we can see how the three boards that are here today fit into the wider pattern.

I have one other question. How many units are we talking about in Tayside? There are 17 posts so is it just the one unit?

Shobhan Thakore: There are two emergency departments.

The Convener: In Lanarkshire?

Alan Lawrie: Three.

The Convener: And for Grampian?

Dr Dijkhuizen: Can I make a correction? The figure that you have been given is for Aberdeen royal infirmary only. We have two further consultants. There are four on the senior rota in Dr Gray's in Elgin. The WTE figure is always difficult, as it depends on how much of someone's full time they work on accident and emergency, which is why I got confused in the first place. That would take us to, let us say, 12 WTEs but 15 people actually in post.

The Convener: How many posts do you have funded across the health board area? Is it still 16?

Dr Dijkhuizen: Sorry. That figure is 20.

The Convener: Twenty.

Dr Dijkhuizen: We still have our five vacancies.

The Convener: Okay—thank you.

Ken Macintosh (Eastwood) (Lab): I want to pick up something that Professor Ferguson said on the theme of seven-day working. In March, I asked the health secretary the question

"whether there is a difference in mortality and readmission rates in hospitals at the weekend compared to weekdays."

His answer was:

"A recent study of the mortality data provided by national health service boards to the information services division of NHS National Services Scotland in response to a freedom of information request suggested no evidence of significant differences between the mortality rates in hospitals in Scotland at the weekend and those on weekdays."

I asked him a supplementary and he expanded by saying:

"I have to say that I am surprised and disappointed that he is not aware of the number of studies that have been carried out over many years"—

no, sorry, that is me. [*Laughter.*] I thought they were wise words!

Mr Neil replied:

"I am very familiar with the international figures, but I am also familiar with the fact that the Scottish health service is the safest in the world as a result of the patient safety programme. Indeed, the programme is probably a major contributing factor to why the mortality rate at weekends is no higher than it is during the week."—[*Official Report*, 12 March 2014; c 28810-11.]

Do you recognise that description, Professor Ferguson?

Professor Ferguson: The answer is that I do not know what the Scottish data is because I do not think that that has been studied specifically. I am reporting on international data, and I have to say that it is like everything else: you can read one paper from one place, and then a paper from another place will come up with different answers. The basic message is that, if you are busier and more overloaded, morbidity and mortality go up. How much they go up is variable and depends on the local circumstances.

I go back to the statement that I made earlier. We measure flow; we do not measure clinical appropriateness. It is difficult to get that level of detail in the Scottish morbidity record data that we collect at the moment. I hope that we do not have an increased rate of mortality in our department. I am not aware of it, but I suspect that there are issues when our hospital is busy.

I stress that I am not talking about the person who has come in from a road traffic accident, because we have great systems in place to take care of them; I am talking about the elderly patients who have multiple morbidities and mortalities and who do not fit the pathways of a hospital but are probably treated there because there is not sufficient capacity to treat them in the community. They are then boarded out, and we have data from Scotland that shows that boarding increases morbidity and mortality. That information came from Dr Daniel Beckett at NHS Forth Valley about two years ago.

The answer is yes, but not in the sense of a headline that says, “People are dropping over.” An overworked system performs more poorly, and it is inevitable that there will be higher morbidity and mortality rates, but it is difficult to measure that in simple terms.

10:45

Ken Macintosh: As Ms Wiggin mentioned, there is not a seven-day system in Scotland, is there?

Lorna Wiggin: No, there is not at present in every part of the system. However, as part of the patient safety programme that was mentioned, a significant amount of work has been done on looking at mortality, and mortality rates have significantly reduced in Tayside.

I do not have any information about rates on weekdays versus rates at weekends at this point in time, but I am sure that we could provide that. I know that most systems will have mortality reviews in place. Our medical colleagues in anaesthetics and in the intensive care unit have a process through the patient safety programme to enable them to look at the issues and see whether they can learn anything or whether there have been any changes.

The patient safety programme has been instrumental in enabling people to look at the issue and in ensuring that they are aware of what is happening in their system and taking action to understand that and to make improvements.

Dr Dijkhuizen: The studies to which Professor Ferguson referred are international, and they would have been designed to demonstrate relationships with crowding to show an effect. We do not measure that in Scotland, so we would not know.

I agree with Ken Mackintosh that, because those studies show such a relationship, we should assume that the effects are the same in our country and our organisations. That is why we do studies: to learn in order to know what to focus on.

I agree that the patient safety programme will have reduced patient mortality in hospital even in a non-seven-day set-up. The programme works with SEWS—the Scottish early warning system—scores with regard to knowing when a patient is going to deteriorate so that a more senior person can be involved in that patient’s care.

Those systems have been worked on very hard in Scotland, and they will have had an effect on mortality rates, certainly in our organisation and, we believe, in most healthcare organisations.

Ken Macintosh: That is good to hear.

I have a question for NHS Lanarkshire. A recent report suggested that there is a substantial funding gap in the NHS in Scotland. The leak pointed in particular to some of the difficulties that were experienced by NHS Lanarkshire. Is a resource gap part of the issue that is leading to such poor A and E figures in your board?

Ian Ross: We could always do with more money—if it was available, we would certainly take it—but we work within our resource and we have balanced our budget and achieved our efficiency savings every year so far. We are undertaking some work this afternoon to look at our efficiency savings for next year. Resource is a constant challenge for boards, but I cannot say that that has had an impact on A and E services.

We have put a considerable amount of money into A and E consultant posts—we have increased the number of posts in the past couple of years. As we have said, however, the issue is not just A and E consultant posts for which we cannot recruit—it concerns the whole system and how it balances and flows.

Rather than just asking whether there is a money issue in meeting the four-hour target, we

need to look constantly at how we use our resources.

Ken Macintosh: I suppose the difficulty is that the Auditor General did not just pick out the four-hour target—she said that, as well as missing the four-hour target in virtually every year, the number of patients who waited longer than 12 hours has also increased. She also suggested that the median wait in A and E has increased—in other words, the average number of people waiting are waiting longer to be treated. Finally, she pointed out that about 11 per cent of all admissions to hospital occur within the last 10 minutes of the four-hour period.

On top of that—I am sorry for picking on Lanarkshire, but the board has been the subject of scrutiny—a number of recent reports have raised issues. For example, one paper—I think it was the *Express*—reported that there were issues in A and E in Lanarkshire relating to "unexpected or avoidable" incidents. There were also reports on excess deaths at Monklands hospital.

As you can imagine, that picture worries residents of Lanarkshire and their representatives. I see that staffing and bed blocking are issues, as has been suggested. Is the service sustainable at present? Do you have the resources to sustain it?

Ian Ross: I will ask Alan Lawrie to come in on the point about waits. We have the resources available in terms of finance; the issue is getting the resources—the staff—to provide the services.

I will pick up the two latter points. The first concerned the incidents at Hairmyres hospital. The great bulk of those reports were made by staff who felt that staffing levels were not correct at that time. We are seeing investment: the board took the decision last year to invest £3.1 million across our sites plus an extra £1 million in the A and E departments. We recognised that there was an issue, and we have identified the resources. It was not a matter of money—it goes back to the issue of recruitment and getting staff in post. We should have all the staff in post across all the sites by the end of this year.

The term "excess deaths" was used in the media, which I think was unfair. Monklands was highlighted as having "excess deaths", but it never did. If you look at the crude mortality rate in Lanarkshire, it is no higher than other boards—in fact, it is lower than the rates in a number of boards. The report indicated that the hospital standard mortality ratio was not coming down fast enough at Monklands in comparison with the national average. However, Wishaw hospital was improving better than the national average, as was Hairmyres hospital.

The latest figures that came out about four weeks ago indicated that all three of our hospitals are improving and are better than the national average HSMR. The phrase "excess deaths" was used in particular by STV and by some of the press. There were not "excess deaths"—the rate is complex, and there is a debate in the medical field over whether it is the right measure to use. I am sure that the debate will go on, but the HSMR is the measure that we currently use in Scotland, and our performance in Lanarkshire is well above that of other boards.

Ken Macintosh: I just want to check one thing that you said. Are you saying that A and E departments in hospitals in Lanarkshire are performing better than the national average, or are you suggesting that they are actually performing worse and are improving at a faster rate only because they were performing worse in the first place?

Ian Ross: No—the HSMR rate is based on the whole hospital rather than just A and E, so—

Ken Macintosh: So how are A and E departments in NHS Lanarkshire doing?

Ian Ross: In terms of deaths?

Ken Macintosh: In terms of four-hour waits, patients waiting longer than 12 hours and the median wait for patients.

Ian Ross: We are still not at the 95 per cent position, but we will continue to work on that with our staff. As I said, it is not just a matter of looking at A and E; we need to look at the balance right across the system. If you look at our stroke bundle and the stroke care that we provide for patients that come in to hospital, you will see that we are better than other boards—

Ken Macintosh: That is not what we are looking at today.

Ian Ross: I know that, but I am trying to say that we are taking a whole-system approach rather than looking at just the A and E department. We try to balance planned care with unplanned care. Do we give the bed to a cancer patient, under the guarantee, or to an emergency admission? It is very difficult for staff to look at those situations and decide on priorities.

Ken Macintosh: I think that we all accept that. I am not trying to be particularly unfair. I think that we are still trying to get to the bottom of why some areas, with the same targets and criteria, are struggling more than others. Are you looking at service redesign in Lanarkshire? Do you feel trapped in the service that you have? Are you looking at other solutions?

Ian Ross: We know that there is no silver bullet. If there was an easy silver-bullet solution, that would be fine. However, we are looking at every aspect of our flow. We have had excellent support

from Scottish Government officials and support from someone from Birmingham who has an expertise in flow. We have expertise from someone who is based in London, I think, and we have also used Professor Derek Bell, a UK leading light who used to work in Scotland, in terms of flow. They recognise that there is no silver bullet and that it is a matter of changing nuances here and making improvements there; it is about getting the system into balance rather than just looking at flow.

Ken Macintosh: So, to summarise, you are getting excellent support from the Scottish Government and you do not have a resource problem. Are you therefore suggesting that there is something else behind the situation? I cannot quite work out what you are saying.

Alan Lawrie: I think that it probably goes back to the fact that to achieve a sustainable performance we need to get sufficient senior decision makers at the front door, and not just in the emergency department. It is about getting our internal processes right.

We are perhaps alluding to things like the time or day of discharge. If discharge happens late in the day, the beds do not come up quickly enough and we therefore get bed waits. However, we can actually do something about that: it is down to us to get it sorted.

That is the last element that is associated with the flow. When we get the three elements aligned, we get good performance. We can demonstrate that, hospital by hospital and week by week. However, we are not getting that regularly enough. The issue for us is therefore trying to get those three elements in alignment. We believe that we have the resources to do that, but we must make sure that they are all working in equilibrium.

Ken Macintosh: Thank you.

The Convener: Before I bring in Mary Scanlon and then James Dornan, I have a question for Professor Ferguson. In your exchange with Ken Macintosh, the issue of weekend mortality was touched on. You were quite clear in your earlier evidence that there were higher mortality rates at weekends than there were during the week. In a subsequent exchange with Ken Macintosh you said that there were no Scottish studies on that—or at least no Grampian studies.

Professor Ferguson: I am not aware of any Scottish studies. I think that I am correct in saying that studies were published at the end of last year and I think that Derek Bell was involved in those. We all remember the press coverage of that from London. I am not aware of any specific studies on the issue. Again, though, there are lots of papers that say that, if you work five days instead of seven days, it makes a difference.

The Convener: But you believe that, because it would be no different in Grampian and probably in other health board areas, mortality rates at weekends would be higher than those during the week.

Professor Ferguson: I have no reason to believe that that would be any different. Just as Roelf Dijkhuizen said—

The Convener: But it would be the case that mortality rates at weekends would be higher than those during the week.

Professor Ferguson: Yes. At best, the situation at weekends is inconvenient; at worst, it could be causing damage.

The Convener: But Ken Macintosh quoted the Cabinet Secretary for Health and Wellbeing, who I think said that there was no difference between the situation at the weekends and that during the week.

Professor Ferguson: Yes, but I think that this comes back to the point that I made earlier, which is that the four-hour target is a very blunt tool. Looking at mortality ratios for a hospital in general, we may not pick up the numbers sensitively enough. If there is not a very big mortality figure, 20 per cent of increased mortality will be difficult to identify.

The Convener: Sure, but there is inconsistency between the cabinet secretary's statement that there is no difference and your statement, which is that you believe there is a difference.

Professor Ferguson: Right. The simple answer is that the cabinet secretary is talking about Scotland, but I am talking about evidence in the literature.

The Convener: No, no. We can check the *Official Report* for your original comments, because you were talking about Scotland and then you referred to the international evidence.

Professor Ferguson: What I am saying is that there is international evidence that backs up that that happens. I would surmise from that that we have the same problem in Scotland—otherwise, why would we need the safety programme?

The Convener: Sure, but how then can a statement be made that there is no difference, if there is no Scottish evidence?

Professor Ferguson: I do not know. Do you want to ask the person who made the statement?

Ken Macintosh: Convener, the cabinet secretary did not just say that—he actually said that the safety programme is the reason why there is no difference. He attributed cause and effect in the reverse order.

The Convener: We can pursue that with the Scottish Government next week.

Ken Macintosh: I have tried.

11:00

Mary Scanlon: The witnesses have alluded to this, but my concern is that the service is no longer mainly an accident and emergency service. To me, that is at the heart of the problem. Exhibit 5 on page 14 of the report shows that self-referrals are at 66 per cent, so two out of three patients who turn up at accident and emergency are self-referrals.

I do not want to go through all the figures, but I will use two. At Ninewells hospital, the figure for self-referrals is 50 per cent, so one out of two patients self-refer; whereas in Aberdeen royal infirmary, the figure is 75 per cent, which is 25 percentage points more. In Aberdeen, only 7 per cent of patients come in through 999 calls and the ambulance service, whereas in Dundee the figure is 27 per cent.

Are patients who should actually be going to their GP self-referring? A family member of mine has used A and E in recent years; they did so because, after four times at the GP, they did not get a proper diagnosis. I told them to wait until the weekend and go to Dr Gray's. Within 5 minutes, they were on a blue-light service to Aberdeen. On top of that, the report states that 50,000 more patients attended A and E in 2013 compared with in 2009.

Therefore, recruitment is not really the answer. You are there to provide accident and emergency services, but given that two out of three of your patients are self-referring, it appears from the figures that we need to ask more questions about why people are not going to the doctor. Can they not see the doctor? Is the ambulance service working differently in different areas? In five, 10 or 20 years, we might find that thousands and thousands more patients are going to A and E, but no one is holding the ambulance service, the GPs or, I would say, NHS 24 to account. Are you getting the right patients?

Professor Ferguson: Shobhan Thakore has lots of data on that, but before we get into that issue, we have to determine the safe minimum level of cover for our big EDs, and I do not think that we have reached that yet, as the figures that are coming out—

The Convener: Sorry, but I did not hear that. A safe level for what?

Professor Ferguson: We need a minimum level. To an extent, Mary Scanlon is saying that our workload in A and E is going up and up and asking whether that is appropriate. We have to differentiate that issue from that of deciding what a fully staffed ED is and what we need to deal with true accident and emergency issues, because the temptation is to put more resource into the wrong part of the system.

Mary Scanlon: The true rate of emergency is one out of three patients.

Professor Ferguson: Shobhan Thakore will tell you about inappropriate attendances.

Shobhan Thakore: Our experience is that we need a certain level of staffing to provide the senior decision makers. Earlier, when I talked about our systems in Tayside, I mentioned that one area that we focus on is what we call input pressures. The recording and categorisation of whether someone has come through self-referral or a 999 call is different in different areas and comes down to the particular receptionist who happens to be on duty at the time, who might think that if somebody dialled 999, they have referred themselves. However, should we call that a 999 or a self-referral? There is a little inconsistency in how the numbers are recorded.

I agree, however, with the main point that we need to control the input into A and E departments so that we see emergency cases rather than non-urgent cases. In Tayside, we have had a redirection policy since 1998. At the first point of triage, we identify patients who would possibly be better served by seeing a GP, pharmacist or optician. A senior decision maker has a conversation with the patient and, if necessary, redirects them to the correct place. Over 16 years, that has touched a number of people within our catchment area. That sends out a message to the public that we are an emergency department and that we are there for emergencies rather than non-urgent cases.

Since the HEAT—health improvement, efficiency and governance, access and treatment—T10 target has been in place, we have seen a reduction in attendances of about 4 per cent. We have done a fair amount of social marketing work with that group of redirection cases, and the feedback that we get is that there is confusion about how people can get to their GP out of hours and whether a GP is available out of hours. Do people want to use NHS 24 to get to a GP? Are people put in queues waiting for a call back from NHS 24? Is there too much of a block? Basically, are we the only open door and are there too many hurdles to get to a GP, particularly out of hours? That is one of the themes that comes back from that group of patients.

Mary Scanlon: What is your conclusion? Are there too many hurdles to see a GP out of hours—it is just too difficult—which is why you are seeing more patients in A and E?

Shobhan Thakore: If we are going to learn from speaking to people in the community, we need to accept what they are saying to us. They have a lack of knowledge of what is available, particularly out of hours. The system seems complex to them. Having a 111 number might help, but when people get through and then have to wait for a call back, after which they have to go through 101 questions to get through to a nurse—

Mary Scanlon: It is easier to turn up somewhere.

Shobhan Thakore: It is easier to turn up somewhere.

Mary Scanlon: So the real problem is managing the increase in patients who are self-referring, for which the figure is 66 per cent.

Shobhan Thakore: That is one of the areas—

Mary Scanlon: Apart from the issue about basic cover.

Dr Dijkhuizen: I fully agree with that, which is why I tried to say that the problems that we have with clinical capacity in the community manifest themselves partially in the A and E departments across our country. One of the major reasons why it is so difficult to fill A and E posts is that people do not want to be the point of last resort in society—that is not why they studied emergency medicine in the first place.

We will learn from the way in which Tayside has been so explicit in defining what accident and emergency is and is not for. The figures to which Mary Scanlon referred show the difference between Tayside and Grampian. In Grampian, we have a recruitment problem, whereas Tayside does not at present. In the coming months, we will build an arrangement so that we can learn how we can define our A and E departments better than we have done to date to encourage people to work according to their skills rather than trying to be everything to everybody.

The big societal challenge, which relates to my earlier plea, is about the front door of our services as a whole and not just the A and E departments and hospitals. How do people get access to healthcare in an emergency? We have spent an enormous amount of time and effort on how people get access to healthcare electively, when they need an operation, but in my view we have not really looked seriously at how people access healthcare in an emergency. All that we have done is look at A and E departments, which are only the symptom of a wider illness.

We should not take the situation the wrong way and say that we are the worst in the world, because we are not. We are a very good health service and possibly the Cabinet Secretary for Health and Wellbeing is right. Certainly, the Institute for Healthcare Improvement in Boston has said that we are the safest health service in the world. I do not believe that that is the case, but we are certainly not bad. Through our integration, we have fewer A and E problems than NHS England has. Nevertheless, the lessons that are learned from international studies apply to us and we need to heed them and learn from them.

Mary Scanlon: I want to make it clear that I did not imply for one second that there is any problem here; I am actually looking behind the problem. My suggestion was that the fact that 66 per cent of patients coming through A and E are self-referring means that you are no longer an accident and emergency service but have become almost a service that should be provided at GP level. I do not know the patients, obviously, but that is my impression.

Dr Dijkhuizen: I agree. That is the core of the problem.

Professor Ferguson: We are now co-located with our after-hours service—we are literally next door—so we just re-direct people, which is a lot easier. We completed an audit just after we moved into the new building and found that we had sent something like 600 patients through to it.

That comes back to the issue of clinical appropriateness. Once we had done the audit, we audited the patients that we had sent through to GMED and found that about 60 per cent of them did not need to be seen within 16 hours; they could be seen the next day. As Shobhan Thakore was saying, a lot of this involves people practising convenience medicine—that is, saying, "I don't want to wait until Monday, or phone NHS 24 and wait a couple of days to see my GP, so I will go to A and E." We are trying to change our protocols so that we turn those people away at the door. The hamster wheel was going because, instead of sending away people who came to A and E who should not be there, we would pass them on to GMED, because they had presented out of hours, and GMED would send them out the door—

Mary Scanlon: People practising convenience medicine has a severe impact on your ability to meet your targets, through no fault of your own, and it also impacts on the patients because, regardless of clinical need, a patient needs to be seen within four hours.

Professor Ferguson: We are about to publish a paper on people presenting with minor ailments in Grampian. If they are seen by a chemist, it costs £29. If they are seen by a GP, it is £82. If they are seen by an A and E department, it is £149. They are spending taxpayers' money—their own money—inappropriately when they go to A and E with something minor.

Mary Scanlon: So really, we should also be speaking to someone from the Scottish Ambulance Service and a representative of GPs, rather than laying the full blame at your door.

Professor Ferguson: If the message is about a whole-system approach, you have just outlined the situation perfectly.

Lorna Wiggin: There are some good things happening with the Scottish Ambulance Service through the see-and-treat approach, which involves treating patients in their own home, which prevents admission. There are some new models that could work across Scotland.

The Convener: How would those patients then be classified? Are they classified as having been seen by part of the accident and emergency department?

Lorna Wiggin: No, because they have not come into the A and E department.

The Convener: Where do they fit in the system? Are they recorded as having been treated by the Scottish Ambulance Service?

Lorna Wiggin: Yes.

James Dornan (Glasgow Cathcart) (SNP): I agree with my colleagues that this has been a useful session. I will come out of it knowing much more than I expected to know when I went into it.

I was delighted to hear Dr Dijkhuizen's comments about the work in Tayside because I was slightly concerned by Mr Ross's comments about experts coming from Birmingham and London to help with the flow. It appears that there was someone pretty much next door who could have been spoken to, and I was worried that that meant that best practice was not being spread across the country. I hope that that is not the case. If it has been the case, I am sure that, after this session, it will no longer be.

Grampian and Lanarkshire have the same issue, although for different reasons, but Tayside does not have that issue. Does anyone have an explanation of why that is the case?

The Convener: Apart from the housing issue in Grampian and Aberdeen that was mentioned earlier.

Professor Ferguson: It is a good question.

11:15

Dr Dijkhuizen: The reasons will be different, yes. There are some things that one does well and other things that one does not do so well. With regard to the things that one does not do so well, one can learn from colleagues in other boards. We have all taken slightly different approaches to the issues. Certainly, we in Grampian have examined closely clinical capacity in the community. We even started new training courses to support that. We have successful courses for emergency nurse practitioners and emergency medical practitioners, and we have set up a course, almost independently, for physician associates, with clinical capacity in the community in mind.

However, on the timeline, we have been overtaken by attrition and by the difficulties of filling A and E posts because the specialty was not seen as attractive. NHS Tayside—I apologise for speaking for it but I hope that it will clarify things a little bit—has looked at different things and has defined what the A and E is for and what it is not for very carefully. We have learned that we could or should have done that earlier. Basically, we have been overtaken by the fact that it is increasingly difficult to get specialists in A and E unless we define that department and protect those professionals from being the safety net for any service in the region.

We all have a slightly different approach and that is why we are in different places. I do not believe that we are on different phases of an improvement line because I do not think that such a line exists in real life—certainly not in the complex area of health systems. It is just that we have approached the issues that we saw coming in a different way so we have different results and different difficulties. Also, arguably, we have different potential for the years to come. Personally, I believe that our investment in training grades and getting different skills on to the market will pay us back at some point. It is difficult to say who has done the best, but we can learn from each other about what works well.

Alan Lawrie: A couple of years ago in NHS Lanarkshire, we knew that we were going to be losing a number of our middle grades and therefore the board made an investment in consultant posts and there was an increase of about 10 consultant posts. We have recruited seven over the past two years and lost three.

The three we lost probably left to be able to work close to where their families are, but when they were asked, as they were going, "What things could we be doing differently?" the answers were around ensuring that we had the right resources in the department, having different sorts of practitioner, such as the physician assistants that Professor Ferguson talked about, and training up some of our advanced nurse practitioners to take on some of the workload. It was about having departments that the consultants saw as functioning—that was one of the things that they thought would make the posts more attractive if they were ever to apply again.

We have put nine posts out to advert over the past month and the closing date was yesterday, so

we are hopeful that we get a return around that. I do not have a result yet, unfortunately, but I am hopeful that we will get one. We advertised nationally and internationally and it will put us back into a better place. When we have proper substantive posts in place as opposed to a number of locums, morale in the department will improve and the attractiveness of the department will improve.

James Dornan: It would certainly be nice if, when we discuss this again, everybody has that closure between the cost of the post and the post in place.

On the other point that I raised, is best practice being shared across health boards just now?

Lorna Wiggin: The Scottish Government has a programme and through the quality and efficiency support team—QuEST—clinicians and managers are encouraged to come together and learn from each other about unscheduled and scheduled care. The department does a huge amount of work around going and sharing its knowledge and experience with all boards. If we are requested and people specifically want us to go and work with them, we are more than happy to do that. Is there anything else that you can think of on that point, Shobhan?

Shobhan Thakore: I think that covers it. We have hosted visits from other board areas and we have gone to national networking events to share practice. We are obviously a few years ahead and sometimes I wonder how achievable it is for other board areas to get to our position in a short timescale.

James Dornan: That takes me on to my last point. How long has it taken you from deciding that you had to change the way things were being done to get to the point that you are at just now?

Lorna Wiggin: Our A and E performance has been stable for quite some years.

Shobhan Thakore: Since the target has come in, performance has always been relatively sustained, but we have had a constant level of design review and redesign of the system, with the group of consultants that we have, to bring in policies to improve the system. It is a constant process that has gone on as long as there has been a consultant in post. It is our own paranoia that drives us to keep what we have.

James Dornan: It can be useful to be paranoid.

Alan Lawrie: To add to what Ian Ross said, I can say that we recognised a year ago that although our performance had been okay and plateauing, it was starting to dip, so we asked for support from the Scottish Government. It came in with expertise—it picks up on everything that is happening nationally, such as the models in Tayside, Grampian and the Borders—and the first port of call was to see how some of those measures would fit in the Lanarkshire context.

The Scottish Government had worked with people such as Professor Derek Bell, who was part of the unscheduled care team and, because of his expertise, we had him in, particularly in relation to Hairmyres hospital, to ensure that we were doing all the things that we needed to do and to guide us.

James Dornan: My comment was not about where the people came from but about the fact that Tayside is close at hand. I just wondered whether its best practice was being shared.

The Convener: My last question is about making decisions to meet the four-hour target. If someone with a sprained ankle is sitting in accident and emergency at 3 hours and 50 minutes and someone else comes in with a more serious but not life-threatening problem, such as a broken leg, is the person with the less serious injury treated first, so that the four-hour target is met?

Lorna Wiggin: No.

Shobhan Thakore: Certainly not in our case.

Professor Ferguson: Two weeks ago, it was 20 years since I became a consultant. Twenty years ago, someone with a sprained ankle just waited and waited. Since the four-hour target was introduced, we have had a different flow for ankles.

The Convener: I was just using one example of a less serious condition.

Professor Ferguson: Minor injuries are hived off. For all other patients, there are robust, well-defined and well-tested triage processes, which all of us in emergency medicine use. Patients are treated according to the severity of their illness when they come in. If the target is breached, it is breached.

The Convener: So no one with a more serious injury is delayed to allow the treatment of someone with a less serious injury in order to meet the four-hour target.

Professor Ferguson: I do not think that such a delay would happen.

Dr Dijkhuizen: I have spent the past four weeks in our ED—I could afford to do that because my successor is taking over my medical director roles. I confirm that people in our department look at how seriously ill a patient is and what they need, and the target comes second to that. That is how it should be, I am afraid. Although it makes performance look not so good at times, it is crucial that the people with the highest clinical priority are

seen first. I can say that that is what happens in NHS Grampian and I am proud of that.

The Convener: I let the session run for longer than expected because the quality of the evidence was first class. We might have—[*Interruption*.] There is a technical issue with the microphones. I do not want our witnesses to be delayed, so I record our gratitude for their evidence and suspend the meeting.

11:25

Meeting suspended.

11:32

On resuming—

The Convener: I reconvene the meeting and ask for members' forbearance, as there is a slight technical issue; you will have to be particular about pressing the speak button when you wish to contribute to the discussion.

I deliberately allowed the session on the accident and emergency report to run on for longer than we anticipated because it was probably one of the best evidence sessions that I have been involved in as a convener over a number of years. What was very evident from it was the passion and the commitment of staff in the NHS to provide care and to make things better, and their determination to improve. On behalf of the committee, I thank everyone who has contributed to that process for everything that they are doing; I am not referring only to those who gave evidence to the committee today. I also wish Dr Dijkhuizen all the best in his retirement.

"The National Fraud Initiative in Scotland"

11:34

The Convener: Agenda item 3 is on the Audit Scotland report on the national fraud initiative. I welcome the assistant Auditor General, Russell Frith, and Owen Smith, senior manager at Audit Scotland. I invite Mr Frith to brief the committee.

Russell Frith (Audit Scotland): Thank you, convener.

I think that this is the fourth time that I have come to a Public Audit Committee meeting to talk about the national fraud initiative, which you may recall is a biennial data-matching exercise, for which Audit Scotland acts as the co-ordinator. It involves matching various data sets from across the public sector, with the objective of trying to identify matches that may indicate the presence of fraud or error.

Public spending systems are quite complicated and there are high volumes of transactions. Using computer-based techniques is a very efficient way of looking through large volumes of data to identify matches that may indicate fraud or error, but the computer systems cannot be definitive about that because they do not know all the circumstances of the cases. For every match that is reported back to a body, we expect that body to do further work to identify whether it really is an indicator of fraud.

Since we last reported in May 2012, further outcomes with a value of about £16 million have been identified. That takes the total from the NFI in Scotland to around £94 million over the past eight to 10 years and the total in the UK as a whole to just over £1 billion. In the exercise, we work very closely with the Audit Commission and the other audit agencies so that we can get across geographic boundaries. Fraud does not recognise organisational or geographic boundaries, and data matching on a co-ordinated basis across the UK is one of the ways in which we can combat it.

This time round, 127 Scottish bodies took part, which is more than ever before. In particular, we brought in a significant number of central Government bodies and one of the new, larger further education colleges. Just under 600 data sets were used, and they generated about 380,000 matches. We do not expect the bodies to investigate all of those. We provide them with tools to filter those matches to identify the ones that are most likely to yield a result.

This time, we also tried to identify matches in cases in which the outcome was of benefit to the sector as a whole rather than to the body that was submitting the data. One of the issues that we

have had in previous exercises is that some bodies have found that they have not got much out of the process, but their data has been extremely helpful to other bodies. For example, if it was discovered that an NHS employee was claiming housing benefit unduly, the NHS would not see the result of that but the local authority would. Therefore, we encouraged those bodies that might not benefit directly to recognise the wider benefit of the exercise.

As members may know, the Audit Commission, which has been co-ordinating the NFI since it started, is to be abolished from 1 April next year. Its data-matching powers are being transferred to the Cabinet Office, so the exercise that is just starting—the 2014 exercise—will continue pretty much as is. There will then be further reviews of how the NFI will continue. One of the big issues for us is that when universal credit finally comes in, housing benefit will be taken out of the NFI remit. As housing benefit is one of the areas with the biggest impact, that will challenge us to look at the value of the rest of the exercise. Having said that, depending on what happens with the final agreement on further devolution to Scotland, it may be that other data sets will come within our remit, which might make continuing the NFI an extremely worthwhile exercise.

I will be very happy to answer committee members' questions.

Colin Beattie: Before I ask a couple of specific questions, I will ask one overarching question. I see in the report the figures for the savings achieved and so on, but there is a huge cost to the national fraud initiative, is there not? The operation is not cheap; it extends through a chunk of the public sector. Is it cost effective, other than as a deterrent?

Russell Frith: We think that it is at the moment, hence my references to the future of housing benefit. In pure cash costs, it costs us just under £250,000 for the matching exercise to take place. There is then an element of staff cost in Audit Scotland—particularly Owen Smith's time—but, probably, the biggest resource cost is the cost of the various public bodies investigating the matches. I could not tell you the actual cost of that, but as long as we get outcomes in the sort of range that we get, the initiative certainly more than pays for itself. In fact, it pays for itself many times over.

Colin Beattie: Does that £250,000 come from Audit Scotland?

Russell Frith: Yes. It comes out of our overall budget.

Colin Beattie: I refer you to key message 8 on page 6, in which you say that some organisations

"could act more promptly to investigate matches".

What sort of delays are we talking about?

Russell Frith: We are talking about delays from a number of months to anything up to a year. That is one of the reasons why we have the recommendation to bring that to the attention of bodies. It is also why we have the appendix at the back with the checklist for people to complete. We are bringing forward by at least six months the reporting that we expect to get from the local auditors so that we can identify much more quickly than we have done in previous exercises when bodies are taking longer than we think they should. That will enable us to prompt them more readily than we have done in the past.

Colin Beattie: In paragraph 7 on page 9 you say that you have

"increased the number of bodies involved to 127".

What is the significance of that? How many were there before? Are any significant bodies now being captured?

You talk about a

"further education college and a greater number of central government bodies."

How does that affect the college trusts that were set up? Will they be captured by the initiative or do they remain outside it?

Russell Frith: I will answer on the last point and then ask Owen Smith to comment on the rest.

As far as I understand it, most of the college trusts do not have employees of their own. They mainly rely at the moment on college staff, who would be picked up for the colleges that we include. Therefore, at the moment, the trusts would be outside the scope of the initiative.

Owen Smith (Audit Scotland): In the previous exercise, 89 bodies took part. By far the majority of the new bodies are central Government bodies. In Scotland, we are in the unique position that we can bring in many Scottish bodies because Audit Scotland audits them. That is not so much the case in England, but the move to the Cabinet Office will, we hope, bring in more central Government bodies from Westminster.

There are two data sets that apply to central Government bodies: payroll and creditors. We reviewed the bodies that we were not including on a materiality level to ensure that it was worth while bringing in the data sets. That was our process to bring in the additional 30 or 40 bodies.

I cannot see many more bodies or data sets that we could bring in, because we are almost full with what is worth bringing in. Whatever comes with the new devolved powers will be a new area to consider. The colleges are merged. They are

getting a bit bigger, are being made more weighty and have bigger payrolls, which is why we are trying to bring them in.

We do not have any direct powers to mandate other areas. For instance, we cannot mandate data from registered social landlords; they would have to volunteer it. We will try and work with them in the next two years to determine whether we can bring in some of their data sets to match against our existing ones.

11:45

Colin Beattie: Paragraph 106 on page 32 refers to that very point about social landlords. I realise that the provision is voluntary, but do you think that you will make progress on that? It is clear that that is a large area. It is a big piece of database.

Russell Frith: Indeed it is. As Owen Smith said, the provision will be entirely voluntary. We have the legal power to accept data from bodies that are outside the public sector, but we do not have the power to mandate it. If social landlords start to see potential benefits for themselves, that will encourage some of them to take part.

Colin Beattie: Are you in discussion with any social landlords? Are there any hints that they might be amenable to the approach?

Owen Smith: We will be planning for the next exercise, so I hope that discussions will take place in the next year. There is a two-year reporting programme, but trying to identify new data sets to bring in is a continual exercise. I will meet the English, Welsh and Irish audit agencies next Tuesday to discuss what we will bring in for the next two-year exercise in the future. Things are evolving, and the registered social landlords are one of the big areas that we think we could get something from, but we will have to make contact and discuss the matter with them. We cannot make them do it; there has to be a voluntary arrangement.

Colin Beattie: Finally, paragraph 11 on page 10 says:

"two councils, Angus and Perth and Kinross, decided not to upload data".

Why was that?

Russell Frith: Those councils had internal legal advice that the provisions of the Representation of the People Act 2000 that restrict the extent to which electoral roll information can be shared took precedence over the legislation that we are working under. We are not entirely convinced about that, and it is clear that neither are the other bodies that take part.

For me, the most important thing is that something is done to look at the types of fraud that could be happening. In the case of the electoral roll, in essence we are looking at single person discount frauds, and there are other ways in which local authorities can tackle that. I am more interested to know that local authorities are using techniques to tackle that area rather than necessarily using the NFI. We have therefore looked at those councils to see that they are doing something alternative to the NFI to look at that area.

Owen Smith: And they are. They have just tendered for other people to use data matching to identify issues with their council tax single person discounts against the electoral register. They are therefore using data to try to identify efficiencies and errors or fraud. We do not want to make them use the NFI if they have another way of doing things. As long as they use the data efficiently and effectively to try to stop errors or fraud, we are quite happy with that. It is a fact that they did not do that two years ago, but they are doing it now. We have engaged with the local auditors to try to push the issue to members in the councils, and they have taken cognisance of the matter and are now data matching on those data sets, but not within the NFI.

Colin Beattie: Surely we should clarify that particular legal point. If two councils are not participating because they believe that, legally, they should not share the data, either they are right or all the other councils and bodies that are involved are right. How can we clarify that?

Russell Frith: We have not moved to do that. That would involve our incurring legal costs. The two councils are the only ones in Scotland, England and Wales that are not taking part on that data set, although they take part on all the other data sets. As I have said, my priority is that they do something to prevent fraud, not necessarily that they use the NFI for each individual type of data.

Colin Beattie: My gut feeling is that there is still an issue. Those councils are out of step with everyone else, and they create a gap. You say that they work around that in other ways, but that is not readily evident—certainly not to the Public Audit Committee.

Russell Frith: That is correct. Yes.

The Convener: Are the arm's-length trusts that are established by local authorities covered by the initiative?

Russell Frith: In most cases, I do not think that they are, unless the employees of those trusts are already on the main council payroll system, in which case they may be.

Mary Scanlon: Colin Beattie took one of my questions so I will ask a supplementary to it.

Paragraph 11 says that Angus Council and Perth and Kinross Council did not participate in data matching. There was 97 per cent voter registration for the referendum, which I think we all welcome. I have heard recently in the media that high voter registration is leading to council tax payments from the past being pursued. Will Angus and Perth and Kinross be less able to pursue those payments from the past than other councils that we have heard about in recent days? Are those councils at a disadvantage?

Russell Frith: I do not think so. From what I have heard in the media, the intention was that the councils would use the data from their own electoral registers to pursue people directly. Angus and Perth and Kinross will have exactly the same data available to them as the other councils.

Mary Scanlon: Okay.

The report says that 832 cases of housing benefit fraud have been identified, yet there have been only 92 housing benefit prosecutions. If we are talking about a deterrent, that is a very low level of prosecutions. Why is that?

Russell Frith: The main reason is that local authorities working under Department for Work and Pensions rules have a whole host of sanctions available to them, from administrative penalties to purely stopping the benefit. There are various levels of administrative penalty short of prosecution. In many cases, particularly the smaller ones, or when there is some doubt about people's motivation—in other words, about how deliberate the fraud was—local authorities will use the other sanctions that are available to them. Those sanctions are used quite widely.

Mary Scanlon: So the number of prosecutions does not reflect the full action that is taken once cases of fraud have been identified.

In paragraph 91, you say:

"The biggest change from the last exercise is that central government bodies have, overall, weakened arrangements in comparison with NHS (improved) and local government (stayed the same) sectors".

If the initiative is to be successful, I would have hoped that central Government would lead the way. However, you state clearly that it has weakened its arrangements. Will you explain that further? What can be done about it? In what way have central Government bodies weakened their fraud initiative arrangements?

Owen Smith: I have read that again and it comes back to an earlier point. The biggest new bodies were central Government bodies. If I could rewrite that now, I would strip out the new bodies, leaving the existing ones that were in the previous exercise. The biggest problem has been that the new bodies take a lot of time to get up to speed with what is asked of them. It is quite daunting getting 1,000, 2,000 or 10,000 data matches back to investigate. We provide self-assessment guidance and checklists to help people through the process. This time, because we have kept the number of bodies constant apart from the new further education college, I expect that the central Government bodies will do better because they have had experience from the previous exercise. I hope that that answers your question.

Mary Scanlon: There must be a significant lack of attention to the fraud initiative by new bodies if the older ones are up to scratch on the issue and the newer ones are pulling them down. Can you identify some of the newer bodies that have, overall, led to the weakening of arrangements for central Government?

Russell Frith: I do not have a list of those bodies with me. However, in general, I suspect that some of them are the smaller, simpler bodies for which fraud is not such a significant issue as it is for local authorities and health bodies.

A number of the smaller central Government bodies that have been taking part generally just have payrolls and administrative expenses. We brought them in largely to see whether they could contribute to the results for councils—particularly around housing benefit, because payroll to housing benefit matches are probably the most productive of all the matches. In a way, I am not entirely surprised by their slower reaction to taking part in the exercise because counter fraud is not a significant activity or risk in those more straightforward bodies.

Mary Scanlon: We did not expect fraud at the National Library of Scotland and Bob Black, the previous Auditor General, did well in bringing that issue to us. When new bodies are being set up, is it not as important to ensure that they are adhering to all the principles rather than just doing that with existing bodies?

Russell Frith: Indeed it is.

Bruce Crawford: This whole area is incredibly important—I ask my questions in that context.

Some individuals and organisations will be concerned about the security of the transfer of their data and information to other sources. I have looked at your "Code of data matching practice 2010"—that shows how sad I can be—because I was genuinely concerned about security issues.

On page 11, under part 2, the code refers to

"Audit Scotland, the Audit Commission (including any successor body) and any firm undertaking matching as its agent".

Are any firms in Scotland involved in the process?

Owen Smith: Yes. We employ seven private firms to undertake audit work. With the exception of three of those firms, which do only a very little amount of work in the further education sector, we have all their payroll data—and Audit Scotland's data—as part of the NFI data washing or processing. The big firms that take part in the NFI and Audit Scotland submit their payroll data.

Bruce Crawford: Will you give me a flavour of which firms are involved?

Owen Smith: The big firms are PricewaterhouseCoopers, Deloitte, KPMG and Scott-Moncrieff.

Bruce Crawford: What checks and validation are undertaken by you with regard to the security of their facilities?

Russell Frith: I am sorry, but we may have gone down a cul de sac. If I recall your question correctly, you were referring to the Audit Commission and firms that are—

Bruce Crawford: Firms that are "undertaking matching", effectively as your agents.

Russell Frith: That particular paragraph refers, I think, to the private sector company that is used by all the agencies collectively to undertake the matching. We use our computer auditors to verify its security. Its security levels for the exercise are up to the same levels as those of the banks. In fact, it keeps a separate room for the data matching work. Its security levels are very high indeed; that is one of the primary criteria for employing that company in the first place.

Bruce Crawford: That is good. What is it called?

Russell Frith: The firm is called Synectics Solutions.

Bruce Crawford: Synectis?

Owen Smith: Synectics.

Bruce Crawford: Okay. How do you spell that? Apologies. You do not need to answer that question—it is just that I might want to look at it.

I will move on to a separate area. I know that you have just asked the Scottish Parliament to provide you with data for a data matching exercise—all MSPs have been given a notice from the Scottish Parliament about that. When you are deciding who to bring in, how do you judge the value of the information that you will get, and how much might it cost that organisation to provide the information? I use the Scottish Parliament as an example because that request has just happened, but the same issue will arise for all other organisations.

12:00

Russell Frith: On who should come in, the principal criteria are to do with the value of the data sets, in terms of the potential to detect or prevent fraud. With some data sets, in which I would include our payroll and the Scottish Parliament's payroll, the public assurance of knowing that there are no issues could be an equally valid outcome. Using us an example, it would be unreasonable for us to match other bodies' data, particularly public sector payrolls, if we were not prepared to put our staff through the same level of scrutiny. That gives us the added assurance that when we talk to audited bodies about fraud, we do not have any skeletons in the cupboard in that respect.

The cost of providing the data is very low—it is a computer file of the most recent payroll. It does not take long for information technology departments to put that together.

Bruce Crawford: So you use a quality standard mark of some sort to ensure that people in the Scottish Parliament are not caught in such circumstances. Thank you very much.

Willie Coffey: Mr Frith, you mentioned the transfer of the NFI to the Cabinet Office, and you spoke about some of the issues involved in that. Can you give us an assurance about whether the scope of the activity that Audit Scotland has carried out hitherto will remain? Is there any lack of clarity about that? Do you expect the scope of your interest in data to extend as a result, or is the picture not particularly clear?

Russell Frith: I expect the scope to continue to be, certainly in the short-to-medium term, at least the same as it is now.

The Cabinet Office might be interested in more real-time data matching. The same computer facilities that do this one-off exercise every two years are capable of matching data on a more frequent or indeed real-time basis. There is some thought in Government about encouraging bodies to use the data more routinely, almost to the point of using it before the transaction takes place rather than retrospectively. If that can be done, it will be much more effective in reducing fraud levels, because people will not have to go back and recover amounts; rather, it will stop the fraud at source. However, there are cost and logistical issues with doing that sort of thing.

We have seen some evidence of such an approach already in Scotland. Instead of just using the NFI once every two years to check against deceased persons, some pension funds are now doing that more frequently, of their own volition, as part of their management checks. We entirely encourage that.

Willie Coffey: Because of the transfer of the NFI to the Cabinet Office, do you expect any duplication of what it might wish to do and what you currently do on our behalf?

Russell Frith: No.

The Convener: There are no other questions, so I thank you for your evidence, which we will look at later on.

Section 23 Report

"Police Reform—Progress update 2013"

12:03

The Convener: Item 4 is consideration of a section 23 report, "Police Reform—Progress update 2013". Responses from the Scottish Government and the Scottish Police Authority to the committee's report "Report on Police Reform" have been circulated to members. Do members have any comments?

Mary Scanlon: There seems to be an on-going issue with the information and communication technology system. In the capital plan for 2014-15, which we have discussed previously, there is an approved budget of £25 million for ICT. However, the spending to July is £802,000. Given that full-year forecast of £25 million, will the ICT system be fit for purpose in the near future? That seems to be the main issue.

Ken Macintosh: Are we scheduled to have a follow-up session with the board, the chief constable or the Government on the issue?

The Convener: No, there is nothing scheduled, but we could invite them back if we wished. We can simply note the responses, request further oral or written evidence, refer the matter on to the Justice Sub-Committee on Policing or seek an update on any recommendations in the next Scottish Government progress report, which is due in May 2015. Those are the options that are open to us.

Ken Macintosh: At the very least, we should have an update before May next year, which seems an awfully long time after the initial report was published. Is there an opportunity for us to have an update before then?

The Convener: We could ask for a written response to Mary Scanlon's question and an update on anything that has come out of the recommendations.

Colin Beattie: Is Audit Scotland not going to do a follow-up on police reform early next year?

The Convener: I think that its next major piece of work will be on fire service reform.

Bruce Crawford: We have a choice to make: do we wait until May, or do we ask for a more general update before then, which would embrace Mary Scanlon's point? What would be the sensible and logical way for us to ask for that update, given the work that was undertaken—I was obviously not involved in it—and the process up to May or June last year? What timescale would enable enough progress to have been made for any

evaluation to be of value to us in telling us whether sufficient progress has been made? If we wait until May 2015, that will have been a year. Should we ask, towards the end of the year, for a progress report at the beginning of the year, as a staging post?

The Convener: Mary Scanlon has raised a specific issue. We could ask the Scottish Government or the Scottish Police Authority to get back to us by the end of the year on the detail of any progress that has been made by either of them. I would not want us to generate a series of responses for the sake of it. If we think that there is something for them to get back to us on, we should ask them to do that, but that is a judgment call for committee members.

Mary Scanlon: We have covered the police quite well. We spent a lot of time on the report and took evidence from a lot of witnesses. My main concern is that fire and rescue services merged on the same day, yet we have done nothing on that. I would be happy if I could get an answer on the £25 million budget for ICT and perhaps a forward look at the SPA's plans for next year. However—I know that I am being a bit previous, given the amount of work that the committee has in front of it—I would like to spend a bit of time on the Scottish Fire and Rescue Service when its plans are set out in February.

The Convener: Does the committee agree to seek that specific information and to note the responses?

Members *indicated agreement.*

12:09

Meeting continued in private until 12:30.

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