Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 8 October 2014

Session 4

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PUBLIC AUDIT COMMITTEE

16th 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:

John Connaghan (Scottish Government)
Gemma Diamond (Audit Scotland)
Caroline Gardner (Auditor General for Scotland)
Paul Gray (Scottish Government)
Dr Aileen Keel (Scottish Government)
Professor Jason Leitch (Scottish Government)
John Matheson (Scottish Government)
Mark Taylor (Audit Scotland)
David Torrance (Kirkcaldy) (SNP) (Committee Substitute)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Public Audit Committee

Wednesday 8 October 2014

[The Convener opened the meeting at 09:33]

Decision on Taking Business in Private

The Convener (Hugh Henry): Good morning and welcome to the 16th meeting in 2014 of the Public Audit Committee. I have received apologies from James Dornan—David Torrance is attending in his place—and Tavish Scott. I remind everyone to make sure that electronic devices are switched off or switched to a mode that does not interfere with the recording equipment.

Agenda item 1 is to decide whether to take items 5, 6 and 7 in private. Do members agree to do that?

Members *indicated agreement.*

Section 23 Report

"Accident and Emergency: Performance Update"

09:34

The Convener: Agenda item 2 is the continuation of evidence taking on the section 23 report, "Accident and Emergency: Performance Update". I welcome Paul Gray, who is the director general of health and social care and the chief executive of NHS Scotland; John Connaghan, who is the director for health workforce and performance; John Matheson, who is the director of finance, e-health and pharmaceuticals; Professor Jason Leitch, who is the clinical director of the quality unit; and Dr Aileen Keel, who is the Scottish Government's acting chief medical officer.

I do not know whether Mr Gray or any of his colleagues wishes to make an opening statement.

Paul Gray (Scottish Government): I will make a brief statement, if that is acceptable.

I appreciate being given the opportunity to appear before the committee today. We take accident and emergency performance very seriously, which is why I have asked a number of senior colleagues to accompany me to bring their expertise to bear on different aspects of the issue.

The helpful evidence that the committee has taken from the Auditor General and—last week—from NHS Scotland senior leaders and clinicians has emphasised the complexity of the system within which unscheduled care operates. That complexity is not unique to Scotland. Unscheduled care performance was affected during winter 2012-13 in other parts of the United Kingdom and in similar health systems across the world.

Our approach in Scotland to tackling the issues related to unscheduled care is set within our overall vision that, by 2020, more people will be living longer, healthier lives at home or in a homely setting, so we want to do all that we can to ensure that, when people attend A and E departments, they get the right care, from the right person, within the standards that we set. That already happens in many cases, but we want it to happen consistently.

Sometimes it will be better for people to get the care that they need elsewhere—for example, in a minor injuries unit, via an out-of-hours primary care service or through telephone advice. Again, that is happening in some cases, but there is best practice that we can spread further, which will provide improved outcomes for patients and reduce costs.

I thought that it would be helpful to comment briefly on the phrase "A and E waits". What we are measuring is progress against the target that, by September of this year, 95 per cent of patients will be seen and, as appropriate, treated or discharged within four hours of arrival at A and E. We are not measuring whether patients wait for four hours; we are measuring whether they get out of A and E, with all clinically appropriate actions taken, within four hours.

As I have made clear in earlier correspondence, I welcome the recommendations in Audit Scotland's report, which was published in May of this year. We are progressing those through our unscheduled care action plan, which is supported by the local unscheduled care action plans that the boards prepare annually.

I will briefly mention some of the key actions that have been taken in the first year of the action plan. We have established the flow programme to improve the way in which patients move through the system and to cut out unnecessary delays. We have recruited an additional 18 emergency department consultants, put in additional bed capacity and issued signposting guidance to help direct patients to the most appropriate treatment point. In addition, we have a number of new initiatives to prevent frail elderly patients from going into hospital unnecessarily in NHS Forth Valley and NHS Ayrshire and Arran; we have introduced discharge hubs in NHS Fife, NHS Lothian and NHS Ayrshire and Arran; and we have invested in theatres in NHS Grampian, beds in NHS Lothian and staffing in NHS Lanarkshire.

Over the period November 2013 to March 2014, NHS Scotland recorded a performance level of 93.1 per cent for patients being discharged or admitted within four hours, which compares with 91.4 per cent over the same period in the previous year, and the figure of 94 per cent has been quoted in relation to published data for June. However, I fully accept that we are not at the standard that we have set, and I want to ensure that patients who attend A and E can leave A and E safely within that standard. That is the commitment that we have made and, despite the complexities, it is the one that we are continuing to strive for.

We have also reduced significantly the number of people who wait for more than eight and 12 hours to be discharged or admitted. We want to eliminate that, as far as possible; we do not believe that people should have to wait that long to be admitted or discharged. That should happen only in very few cases. Fewer than 1 per cent of all patients remained in A and E for longer than eight hours, but we owe it to patients to make further improvements, where we can.

I assure the committee that we are well aware that the context in which we are seeking to deliver the commitments is challenging. I am not here to provide a set of emollient statements about how it is all absolutely fine; there are places where it is not.

We have an ageing population, increases in the number of patients presenting with more than one condition—often referred to as multimorbidity—and recruitment pressures. Those issues are not unique to Scotland; nevertheless, we are committed to doing all that we can for the people who are served by NHS Scotland to provide timely treatment so that they experience safe, person-centred and effective care and enjoy good health outcomes.

I am happy to answer the committee's questions. If we do not have the data immediately to hand, we will undertake to provide it as quickly as possible. I know that you have had a lot of detailed information; we want to ensure that any responses that we give in that context are accurate, so if we do not have the data today, we will provide it as soon as we can.

Thank you for allowing me to make a statement.

The Convener: Thank you very much.

You recognised in your opening statement that you are not yet meeting the 98 per cent standard or target. However, you also talked about milestones. Did you reach the 95 per cent performance milestone in September?

Paul Gray: As you will appreciate, convener, the data will not be published until, I think, the end of December. Is that right?

John Connaghan (Scottish Government): No—it is published two months after the period ends.

Paul Gray: Therefore, the data for September will be published in November. Until we have that ratified data, I cannot confirm that we have reached the milestone.

The Convener: Are you confident that you will reach at least 95 per cent?

Paul Gray: On the basis of advice from boards, I think that a number of them will reach 95 per cent. I cannot say that all of them will, and until we have the data I do not want to make a firm statement about that.

The Convener: Okay.

Dr Martin McKechnie, the new chair of the College of Emergency Medicine Scotland, has acknowledged that the additional £50 million that the Scottish Government invested has helped to "curb a crisis"—I am not sure whether those are

his words or the words of the journalist who reported him.

However, Dr McKechnie went on to say:

"We still have unresolved serious issues".

Do you accept that?

Paul Gray: I accept that there is an issue with staffing in emergency medicine, for example, as the committee heard last week in relation to NHS Grampian. I have acknowledged that not everywhere is perfect and I have no difficulty in accepting that in some pockets there are, have been, and will continue to be, difficulties. There was information in the public domain recently about a day when Hairmyres hospital A and E dipped below 70 per cent in relation to the target due to unexpectedly high attendance on that day, which was outwith all the norms. We are not in a situation where every day will be absolutely perfect.

The Convener: You mention Lanarkshire, and last week we heard evidence from a number of boards, including NHS Lanarkshire. One of the interesting things that I suspect the committee will want to look at more closely is how boards share good practice as well as how problems are identified.

We heard from NHS Tayside about its efforts to ensure that people do not attend A and E unnecessarily when they could be treated elsewhere. We also heard from NHS Lanarkshire that it was quite confident that it could sustain the present A and E configuration, but since then I have seen correspondence that suggests that the general practitioner out-of-hours service in Lanarkshire is having problems. I think that there are five units in Lanarkshire and a couple of them had to be closed.

In areas where the GP out-of-hours service is unable to cope, we heard concern that the public would make their own decisions. Mary Scanlon identified a number of areas in the country where it seemed that the public were attending A and E because they felt that that was probably the easiest and quickest way to receive a service. In areas such as Lanarkshire, if the GP out-of-hours service is unable to cope because of a lack of staff, does that not place a huge burden on an already-overstretched A and E service?

09:45

Paul Gray: If a particular aspect of the service in any board stops working for a period of time, the demand goes elsewhere. Ms Scanlon made some important points about the choices that individuals make based on their perception of where they are most likely to get a service.

In the national health service, we never—nor should we—refuse to provide a service. If someone cannot get a service from a GP out of hours, they have the choice of phoning NHS 24, attending accident and emergency or, in extreme cases, phoning an ambulance. Those choices will remain available, and the pressure will displace from the unavailable service to the available services. That is a fact of the way in which the NHS operates in Scotland.

Mary Scanlon (Highlands and Islands) (Con): We are looking at the Audit Scotland report on accident and emergency services today. We could not ask Audit Scotland what was happening with the Scottish Ambulance Service and NHS 24, and why two out of three people presenting at accident and emergency self-refer, but I feel that we can ask you.

The overall increase in the number of patients over the past four years is 50,000. However, if we drill down slightly, we see that at Ninewells hospital the number is down by 46,000, while in Aberdeen it is up by nearly 63,000. The number for Edinburgh is up by 112,000 and for Glasgow it is up by 85,000.

What are you doing to find out why there is a huge increase in self-referral? My point is that we no longer have an accident and emergency service—we have a 24/7 open door to the NHS. Patients are—quite rightly—now saying, "This is where I choose to go", perhaps because they are getting from one service what they are not getting elsewhere.

If that continues at the same rate, we will no longer have an accident and emergency service. It seems that GPs are doing less and less, and patients are voting with their feet to go to A and E. What are you doing about NHS 24, GP referral and the two thirds—66 per cent—of patients in A and E who are self-referring? Is the service really an accident and emergency service any more?

Paul Gray: I have a number of comments, and I will bring in colleagues to speak about some of the wider work that we are doing.

First, I am very reluctant to criticise a patient—I am not suggesting that you are doing so, Ms Scanlon—for making a choice that may not be the best one for them. I will bring in colleagues to discuss the NHS 24 campaign that we will be running over the winter to help people understand what the most appropriate routes to treatment might be. We are seeking to educate the public on what would be best for them. In some cases, going to A and E is not the best option, but people may believe that it is the only option available to them.

I have been speaking to NHS 24 and the Scottish Ambulance Service about what more we

can do to help the public understand where they are most likely to get the best outcomes. They may very well get a good outcome from going to accident and emergency, but they may have got a quicker outcome by going through another route. They may feel that they ought to go to accident and emergency, for the want of quick advice that might have given them sufficient reassurance to enable them to wait until the following day when they could go to a GP.

Those things are all possible. As I discussed with colleagues yesterday, the data flagged up to me that we are not yet very good at collecting information from patients about why they made the choice that they made. We know that they made the choice, but we are not always sure why.

I took the time to go round with the Ambulance Service and to spend time in the NHS 24 control centre. With regard to the Ambulance Service in particular, it was clear to me that some patients called for an ambulance because they were afraid. They had legitimate reasons to be afraid, but if we had provided a different source of assurance and advice, their anxiety levels may well have gone down and we would have been able to provide a service to them in a different way.

The same happens in A and E, but for the want of data, I will not make an absolute judgment on why some people turn up at A and E and why others do not. You are right to say that some presentations to A and E could be dealt with elsewhere. That is why we are doing what we are doing, for example, in minor injuries units, which allow people with a minor injury to get a different source of advice and treatment if necessary.

Aileen Keel might want to say something at this point—

Mary Scanlon: We have the data here in the report. At Ninewells hospital, 50 per cent of patients at A and E self-refer; at Aberdeen royal infirmary, the figure is 74 per cent. For other hospitals, such as Hairmyres, the figure is more than 80 per cent.

Why is it that 50 per cent of patients at Ninewells, which we welcome as a beacon of good practice, are self-referring, whereas at Aberdeen royal infirmary the figure is 75 per cent? I picked out Aberdeen just because its representatives appeared before the committee last week. The number of self-referring presentations at accident and emergency at Aberdeen royal infirmary is 25 per cent higher than at Ninewells. Why is that?

Paul Gray: I am not saying that we do not have the data. What we do not have is the underlying information that tells us why the patient made that choice.

It may be that patients in Aberdeen made the choice because some facilities are not available in Aberdeen, whereas those facilities may be available in Dundee, for example, but we have not asked the patients so we do not know. My point is that I am drawing from the data the fact that we need a better understanding not just of the facilities that are available, but of why patients make the choices that they make. That is what I am keen to pursue as we move forward. Dr Keel may be able to add something on that.

Dr Aileen Keel (Scottish Government): That is right—we do not understand why people make those choices, and we need to get a better understanding of that. There is a graph in the Audit Scotland report—I am struggling to find it just now—that refers to usage of A and E departments and minor injuries units by board. It is very interesting, because it is clear—

Mary Scanlon: Is it exhibit 5 on page 14?

Dr Keel: Thank you, Ms Scanlon.

Mary Scanlon: I do not know whether that is the one that you were referring to—

John Connaghan: It is exhibit 4.

Mary Scanlon: Exhibit 4—okay.

Dr Keel: We were talking yesterday about why there is an enormous variation between boards in use of minor injuries units. Those units are there on a board's territory, but it is clear that patients are choosing more to go to A and E. We need to gather a bit more intelligence on the issue and begin to better understand why those choices are being made.

Mary Scanlon: Okay—well, if you do not understand it, we are not going to get much further on that. I was hoping that we would have a more holistic picture from the health service. It would be wrong to ask Audit Scotland about the Ambulance Service and other areas when it looked only at A and E. The question of what is happening with GPs, NHS 24 and the Ambulance Service underlies the Audit Scotland report, which is why I am keen to understand all of that. Until we understand that, we will not know why two out of three patients self-refer. They are doing that for a reason, and we have to respect that reason.

Paul Gray: Yes, indeed. I will bring in Professor Leitch on that point. However, just to be clear, I accept the point that we need to understand better why patients do what they do. Our approach so far has not been to collect much data on that, but I believe that we ought to do so because that will allow us to modify what we are doing.

Professor Jason Leitch (Scottish Government): Good morning. Ms Scanlon made a couple of points. She referred to exhibit 3 and

exhibit 5. I will deal first with exhibit 3, which covers the differences in attendance between 2008-09 and 2012-13. There are two before/after data points, but we need to see the trend. There are some interesting things about the data—

Mary Scanlon: It is all that we have.

Professor Leitch: Indeed.

In exhibit 3, Glasgow royal infirmary appears to have the second highest increase. That is because Stobhill hospital closed its A and E department during that time and Glasgow royal infirmary absorbed all its patients.

The Victoria infirmary, where I did most of my training and most of my surgery, has the second biggest drop in attendance—it says that it reduced attendance by 61,000. That is because the hospital opened a minor injuries unit, which took all the people whom it used to count as A and E attendances. The figure does not give you the overall trend, which, for the whole country, is 150,000 people a month, and is roughly stable.

That does not deal with the points about where people are going and holistic care. I completely agree that we should give people the most appropriate care in the right place at the right time.

The data in exhibit 5 is—how best to describe it?—weak. I do not think that we code that particularly well in the national health service. Let us take the two hospitals that you used as examples. The rates of self-referral to Ninewells and Aberdeen royal infirmary are given as 50 and 75 per cent respectively. The table also says that 27 per cent of people come to Ninewells in a 999 ambulance, as opposed to 7.2 per cent for Aberdeen royal infirmary. That cannot be true; cases are being coded differently. We are talking about two major district general hospitals, one of which says that a third of its patients come in ambulances and one of which says that 7 per cent come in ambulances. The data is not coded well by the health service.

Mary Scanlon: The issue came up with Audit Scotland last week. It is difficult for us to do the job when we do not have accurate, comparable data. I can only work with what is in front of me. Audit Scotland said that the data are not comparable. I will leave it to the convener to pick up on that—I am only the deputy convener.

The Convener: Professor Leitch said that the data is weak, but that is not Audit Scotland's fault. Audit Scotland can compile only what is presented to it. If the data is weak, that is the fault of the NHS and the health department. It is not Audit Scotland's responsibility. Why has the NHS, collectively, not sorted out the issue of weak data, to enable Audit Scotland to do an effective job on behalf of the public?

Paul Gray: Because the data are not routinely collected for publication and so are not subject to the standards and strictures that would apply if they were.

In the interests of transparency, let me say that I discussed exhibit 5 with colleagues yesterday and made it clear that when I see chief executives this afternoon I will say that, given that the data that we have tells us that there are differential approaches to collecting it, we must improve in that regard.

I am not hiding behind the data. It was given to Audit Scotland. No criticism of Audit Scotland is intended or implied in the presentation that we are making to the committee. We did what we could do with what we had available. If we are asked for new information, which we do not routinely collect for publication, the information will generally be of a lower standard.

The Convener: I understand that. However, we are not talking about something new; we are talking about something that is done on a semi-regular basis. The report is a performance update, not the initial report. You have known about the issue for a considerable time. Why did it take until yesterday for you to raise the issue and why is it taking until this afternoon for you to say that there is a serious problem with statistics?

Paul Gray: There is not a serious problem with published statistics—

The Convener: So the data is not weak.

Paul Gray: The data is weak, but these are not—

The Convener: And that is not serious?

Paul Gray: If there was a serious problem with routinely published statistics, that would be a very significant issue. If we are asked for something on an ad hoc basis, we do our best to provide it, as we did in this case.

I am not suggesting that you are saying this, but if the committee would prefer us to stick to data that is routinely published and subject to the quality controls in that regard, we will do so, but I do not think that that would be a service to the committee. I am simply telling you that I am taking up the issue with chief executives this afternoon because we have a meeting with them. The issue was clear to us some months ago, we have been working at it, and I have got to the point at which I want to speak to chief executives about it.

10:00

The Convener: It would not be appropriate for the committee to tell you which sets of data to collect and not collect. That is not our responsibility. Our responsibility is to analyse and

comment on reports that are produced by Audit Scotland on behalf of the Auditor General. Audit Scotland asks you for information, so you clearly need to have a discussion with it.

However, I am surprised that you say that this report—which is a performance update—contains a set of statistics that are not routinely collected but which appear to me to be part and parcel of a continuing observation of the performance of accident and emergency. We can explore later with the Auditor General whether that set of statistics is unusual and, therefore, subject to the weaknesses that you have described or whether it has been collected for some time, in which case it seems surprising that the problem is being addressed only now.

I will ask you one other thing before I—

Mary Scanlon: I have one more question to ask, when you are ready.

The Convener: It is a slightly different issue on the Ambulance Service and accident and emergency, but you go first.

Mary Scanlon: I had only two questions, the second of which concerned the point that was raised by the medical director from NHS Grampian about the NHS Scotland resource allocation committee figures and, previously, the Arbuthnott formula. I do not have the figures in front of me, but I remember them and they were accurate. Per capita, Ninewells hospital gets around £1,945 and Aberdeen royal infirmary gets £1,500. Therefore, every person in NHS Grampian is funded at nearly £500 less than a patient in Tayside.

Is Aberdeen being punished for being the oil capital? I remember Arbuthnott 1, Arbuthnott 2 and all that, but is the NRAC formula appropriate? Are we really funding Grampian appropriately to provide the service, given that we can easily criticise its performance?

Paul Gray: I will bring in John Matheson on that point. However, to be absolutely clear, since you have asked the direct question, NHS Grampian is not being punished for anything.

Mary Scanlon: Why does it receive £500 less funding per person?

Paul Gray: Mr Matheson will explain the formula.

John Matheson (Scottish Government): The basis of the formula is the population of the individual health board areas. It is then adjusted for age and sex—

Mary Scanlon: The figures that I gave are per head of population.

John Matheson: The formula is based on population and then adjusted for age and sex, morbidity and life circumstances. An excess cost index is then brought in to recognise remoteness and rurality.

The formula is dynamic; it is continually under review—we have just reviewed the remoteness and rurality—so what the results tell you is that the population of NHS Grampian overall makes less demand on the healthcare service than the population of the other parts of the country.

We recognise that not all boards are at NRAC parity, and NHS Grampian is one of the boards that is below parity. We have an agreed way forward to bring it and the other boards that are below parity to within 1 per cent of parity by the start of 2016-17.

The difference that Ms Scanlon highlighted is driven by the formula, which was agreed across the NHS and is under continuous review to ensure that it is appropriate and up to date.

The Convener: This is a complex and complicated issue, and it is one for separate discussion at another time. No doubt we can come back to it if Audit Scotland produces a report on it.

From what Mary Scanlon and Mr Gray said, a question comes to mind about the connection between the different services. You have a target of a four-hour wait, to which you aspire and which you admit will be challenging. I have an inquiry from a constituent about the Ambulance Service—no doubt others will have similar inquiries. The woman had to wait seven hours for the ambulance to arrive. When she got to accident and emergency, the clock started for the four hours but, potentially, it was 11 hours from her reporting an issue to her being through the system. Is that acceptable?

Paul Gray: Without knowing the detail of the individual case, convener—

The Convener: I would not expect you to know the details. I am talking about the concept of a four-hour target when the reality could be an 11-hour wait.

Paul Gray: I would not like to draw too many conclusions from an individual case—in which the wait for the ambulance sounds long—but one of the important points about how we are trying to help the public better understand what we do is that, particularly in serious cases, if an ambulance arrives with qualified clinicians, the definitive care to the patient starts when the ambulance arrives, not when the person gets to A and E.

There is still something of a mental model in the minds of the public—for which I accept responsibility—that the job of the ambulance is to pick up the person and take them to A and E as fast as possible. In fact, definitive care is delivered at the roadside or in the patient’s home. That is

the life-saving care that is often delivered. The decision by the qualified ambulance practitioners or paramedics to take the patient to hospital is informed by their assessment of the patient's clinical condition. It is right to have a target for the Ambulance Service to arrive, based on the category of the call, and that we then have a target relating to performance at A and E.

Of the cases that I was privileged to be part of during my short time going round with the Ambulance Service, only one patient out of five was taken to A and E. In other cases, care was delivered in the person's home or by the roadside and there was no requirement for them to go to A and E. I do not think that we can join the two together.

Colin Beattie (Midlothian North and Musselburgh) (SNP): The committee has come up against data collection deficiencies across the board again and again. The report in front of us is almost entirely data driven, and the conclusions that we take from it are entirely dependent on the quality of the information that is provided. It is a concern that there are inconsistencies across the service that make it difficult for us to do comparisons or to draw the conclusions that we might need to draw. I am sure that you will be addressing that—I hope that you will.

Paul Gray: As I said in response to the convener, there are standards for published data, which must be upheld and maintained. We seek to be transparent. If we hold information, we will give it, with the caveat that it might be partial or incomplete. We are not in the business of withholding what we know, even if it tells us that we need to get better.

Colin Beattie: It was said previously that the Scottish Government was encouraging NHS boards to make use of emergency departments and the emergency medical workload tool. How widely used is that tool, and what conclusions have been drawn from its use?

Paul Gray: I ask Dr Keel to help me out with this, as I am not familiar with that level of detail.

Dr Keel: The short answer is that I do not know how widely the tool is used. We are certainly promoting it as a means of measuring workload—not just the volume of patients coming through the door, but the case mix and the severity of the conditions from which those patients are suffering. John Connaghan can probably say a bit more about how widely the tool is being implemented.

John Connaghan: The tool is still under development. We have reached the later stages of its development, and we have piloted it in a number of boards. The plan is that we will start to roll out the tool on a national basis in 2015, as early as we can.

It is a different kind of workload tool compared with what we have used in the past. Scotland leads the way in this area, from a UK perspective, and most of the tools that we have developed have been more devoted to nursing staff. The accident and emergency tool covers all the staff who work there, including doctors, allied health professionals and nurses; that is why the development phase is taking a little longer than we would have liked, but we have done a lot of work on it. As I said, the tool is breaking ground in a UK context and the plan is for us to roll it out in 2015. I do not have the roll-out schedule to hand, but I can supply more information if it is needed.

Colin Beattie: It has been highlighted that a substantial number of people are self-referring to A and E; however accurate the figures are, the number is substantial. As we have heard, there could have been alternative solutions for many of those patients. A lot of them are signposted to other services—for example, primary care and so forth. How confident are we that there is sufficient capacity within those other areas, such as primary care, to deal with the patients who are signposted on?

John Connaghan: In the past couple of years, we have established a requirement for each board to produce a local unscheduled care action plan. Those local unscheduled care action plans are now in their second year and should take account of the demand and capacity in each part of the system that supports unscheduled care. The matter is very much for local boards to determine, but we have set up that national requirement for boards to make those action plans, which are published on the boards' websites.

Colin Beattie: You say that it is up to the local boards to determine their plans. Is there any consistency of approach and are there guidelines that they have to follow?

John Connaghan: We issue guidance annually and we continuously refresh that guidance with our partners—for instance, the College of Emergency Medicine—to ensure that it is accurate and up to date. We call that the national unscheduled care action plan.

Ken Macintosh (Eastwood) (Lab): Most of us were worried by the Audit Scotland report when we first saw it, because it shows that Scotland's performance against the A and E targets has deteriorated over the past four years. We spent some time trying to work out the main reasons why that might be the case in order to ensure that the matter is being addressed.

Last week, we had a good and frank discussion with colleagues from the NHS in which we touched on staffing, delayed discharge, sustainability issues and other things. One particular issue

emerged, starting with a comment by Professor Ferguson, who is an emergency consultant in NHS Grampian. He said:

> "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".

I followed the matter up with the Cabinet Secretary for Health and Wellbeing, Alex Neil, and he said that there is no evidence to suggest that. However, Dr Dijkhuizen, the medical director at NHS Grampian, said of the international studies that show that there is an issue at weekends:

> "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."

When he was questioned again by the convener, Professor Ferguson later suggested:

> "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?" [*Official Report*, *Public Audit Committee*, 1 October 2014; c 19, 28, 32.]

What do you make of that, Mr Gray? Do we have a problem with excess mortality at weekends in our A and E departments or in our hospitals generally?

Paul Gray: The evidence that we have tends not to support that suggestion. You quote colleagues saying that they "assume". I ask Professor Leitch to give us some insight into what the data is, what it is telling us and what the international reports say. You ask a fair question, Mr Macintosh, and we anticipated it, so we have prepared an answer.

Professor Leitch: Mr Macintosh and I have discussed the matter previously and there was a freedom of information request.

Some international studies suggest an increase in mortality at the weekend compared to mortality on weekdays, although they tend not to explain why and they do not adjust for everything that could be adjusted for because it would be very difficult to do that. It could simply be that patients are sicker or more complex, that there is more trauma or that there is more alcohol use on Fridays and Saturdays.

There are two pieces of Scottish evidence. One is the Handel study, "Weekend admissions as an independent predictor of mortality: an analysis of Scottish hospital admissions", which was quoted in the committee last week. That study does not adjust for admitting diagnosis—so it does not make any decision about why a patient comes in—and it does not adjust for the severity of the diagnosis, so it does not tell us whether a stroke was very bad or very mild.

10:15

The Handel report concludes that

> "It may also be that emergency departments see a different, more unwell population of patients at weekends, since, in one study which used a biochemical measure of severity, adjustment for this variable rendered the weekend effect insignificant ... This could mean that the effect we observe is actually due to admissions over the weekend comprising a more unwell population of patients, who would suffer a higher rate of mortality regardless of factors that may apply exclusively to the weekend."

In response to your previous questions, both in the Parliament and to Mr Neil, we asked ISD to examine Scottish data in particular. You have had that FOI response. It examined all deaths from 1 January to 31 December 2012 by specialty and of course there is variation—by day and by specialty. There is constant variation because the mortality rates do not stay the same all the time. ISD says:

> "the assumption that mortality is higher for patients admitted at the weekend cannot be backed up by statistical evidence ... The data only took the type of admission into account. To understand this issue fully there are a number of factors ... such as case-mix, age and underlying health issues."

I am not dismissive of the weekday-weekend mortality literature, but I am passionate about mortality in the whole week. I am passionate about unexpected mortality and what we are doing about it in Scotland's hospitals.

The committee will not be surprised to hear me use the example of the Scottish patient safety programme—it exists on Mondays and on Saturdays and Sundays. The programme is about sepsis, venous thromboembolism and early warning scoring. The witnesses who appeared before the committee last week used it as an example of trying to fix the whole system all the time. In global terms, it is the best recognised safety programme in the world. It is about reducing mortality every day. I am not rejecting completely the weekday-weekend mortality thing, but I am more focused on reducing unexpected mortality throughout the whole system.

Ken Macintosh: Thank you for that and for following up the issue. If there is no shared acceptance or identification of the problem—if people do not think it exists—it is very difficult to address.

I want to pick up on the points that you made. The figures that you published through the FOI were welcome. I have spoken to several people about this, but I was contacted by Professor Paul Aylin, who is professor of epidemiology and public health, and co-director of the Dr Foster unit at Imperial College London. The Dr Foster unit has

been influential in changing health patterns in England and I imagine that that is why the issue matters to its staff. Professor Aylin gave me his views on the information that was published through the FOI:

> "the document cited by Mr Neil, which claims to support the fact that there is no excess mortality at weekends in Scotland is inconclusive. The analysis as it stands breaks down the data into individual specialties by day of the week and as such the numbers are just too small to show an effect either way."

Although you referred to one comment in the *BMJ* paper, which was authored by Dr Handel and many others, the paper's conclusion was actually that

> "There was a significantly increased probability of death associated with a weekend emergency admission compared with admission on a weekday".

That is key. The paper did say that "further research should be undertaken", but it also showed other factors. The study spanned 11 years and showed a decline in mortality over that time. It was quite a positive study; it was not unremittingly negative about what was happening in Scotland—far from it.

There have been other studies. Professor Aylin, along with others, published "Weekend mortality for emergency admissions. A large, multicentre study", which also showed differences between weekend and weekday admissions. There have also been international studies showing that difference.

My point is that in England, the NHS is taking policy action to address weekend mortality and readmission rates—it recognises the issue and has changed its policy. I am not going so far as to say that we should do that; it could be that the patient safety programme is doing that. I am trying to work out whether we can conclude, as Mr Neil suggests, that we have no problem at all. The figures that you published in response to the FOI request suggest a marked improvement between 2009 and 2012.

The *BMJ* study and others showed quite a difference—a 40 per cent difference in excess deaths at the weekend, which is significant. If your figures show that there is now no difference, can you point to the policy initiatives that have made the difference? Can you show what is working? That is important to us. If a decrease has happened, we should welcome and celebrate it. We should also work out what caused the beneficial effect. I suggest that the figures that you have published do not prove anything; they do not demonstrate a problem one way or another.

Professor Leitch: Indeed. That is precisely my point. I do not suggest that the Handel study does not tell the truth. It shows an odds ratio of 1.42 in comparing weekends with weekdays but, by its own admission, it does not adjust for severity of diagnosis. One conclusion that could be drawn is that weekend patients are expected to die, for lack of a better description, because they are sicker than those who are admitted during the week.

We could isolate Tuesdays and spend all our time looking at the data on Tuesdays if we were worried about Tuesdays. I am worried about mortality and the safety of our healthcare system every day, which is why the Scottish patient safety programme and its interventions apply every day. That does not mean that we are not tackling seven-day working and seven-day services, but that is about not mortality but the flow, care and getting people out—reducing delayed discharges. Within seven-day working is, of course, safe and effective person-centred care.

We have the policy initiatives that the English have. I know of nothing in England that is specifically on the safety of care at weekends in comparison with weekdays. I know that the English have been up to look at the Scottish patient safety programme and that, if they can, they will launch 15 such programmes in the regions of NHS England. I have seen nothing in England to show that the English are doing something special at weekends to reduce mortality in comparison with levels during the week.

I would advise against specific interventions to deal with safety on a weekend day that we would not use on a Tuesday. I know of nowhere where such interventions apply. That does not mean that we do not want to increase the use of diagnostics at the weekend to improve the flow, to increase the use of pharmacy and to do all the other activities that are part of our seven-day-working service. However, the thousands of people who worked in the national health service last Saturday and Sunday already believe that it is a seven-day service, so we should not pretend that we are not already working in a 24/7 environment.

Ken Macintosh: I do not want to spend too long on the issue. I agree that we should not draw the wrong conclusions from the *BMJ* article. As you said in relation to evidence in Audit Scotland's report, evidence reveals problems, but we do not want to draw the wrong conclusions.

I am trying to work out whether we accept that mortality at weekends differs from that on weekdays. Professor Ferguson—a consultant who works in NHS Grampian and who gave evidence last week—believes that there is a difference.

Professor Leitch: The Handel study suggests that that is true.

Ken Macintosh: The study suggests that that is true. It says:

"Particularly influential to policies has been the report by Dr Foster on an increased hospital mortality in the UK at weekends, which has been linked to a reduced cover by senior doctors at weekends."

That is a separate report.

Professor Leitch: Foster does not have Scottish data.

Ken Macintosh: That is exactly the case.

Professor Leitch: Foster has only English data.

Ken Macintosh: There are different reports, from which different conclusions might be drawn.

Professor Leitch: Indeed.

Ken Macintosh: At this stage, I am not suggesting even that we draw conclusions. I am just trying to work out whether we accept or believe that there is a problem of increased mortality at weekends. In his answer to me, Alex Neil said that there is no problem at weekends. He accused me of scaremongering, but I was not scaremongering in the slightest; my questions arose from a constituent's case and I was trying to work out whether that was an individual situation or typical of what happens at weekends. I was slightly worried by what struck me as complacency on his behalf. If he believes that there is no problem, based on a survey that is not peer reviewed and is statistically inconclusive, according to Professor Aylin, that worries me. It seems that this is the one study that proves to Alex Neil that there is no problem at weekends.

Would it be possible for you to provide exactly the same evidence as Professor Aylin, Dr Foster and other medics including Dr Handel and all the ones at the *BMJ*? They studied evidence over 11 years up to 2009. Would you be able to provide the same evidence, breaking down, for example, not just weekend and weekday admissions but elective admissions. Basically, could you provide something comparable with the *BMJ* paper so that we could actually make the comparison?

Professor Leitch: Hanlon has the Scottish data. He has as much as is available to all the countries. The difficulty is that nobody measures severity of diagnosis so nobody knows how sick the patients are when they arrive. Hanlon is a very good researcher. If he had had severity-of-diagnosis data, he would have adjusted for it. He has not done that not because he forgot but because the data are unavailable in all our countries. We do not have a neat measure of how sick people are when they come to A and E.

You should remember that we have done safety across the whole nation, with the safety programme and early warning scoring operating every day; the assumption is that that safety system is in place on Saturday and Sunday, just as it is on Monday. The system is not perfect, and sepsis care and infection care are not perfect. However, my focus in leading the safety programme and the focus of the hundreds of people who are doing that work is in making those things better every day. That needs attention on a Saturday, but it also needs attention on a Tuesday.

Ken Macintosh: I am not being critical of the safety programme.

Professor Leitch: I understand that.

Ken Macintosh: I do not think that anybody is—far from it. It is just a question of trying to work out whether the safety programme by itself is going to address the weekend issue and whether the issue at weekends is a lack of cover.

This is not a political issue. It is a reflection of society and the five-day week. It is not a reflection of the political Government of the day, but it has to be addressed by the Government of the day.

The patient safety programme addresses patient safety. It does not address the issue of weekend working and whether there is a problem or not.

Professor Leitch: That is correct. The work around seven-day services addresses staffing, diagnostics and all the other elements. I am confident that patient safety is not affected more at weekends than it is on weekdays. However, the seven-day working process is about making the system and the service better, and not just about making the service safer.

Ken Macintosh: So, you have a seven-day programme despite the fact that you do not think there is necessarily a problem with—

Professor Leitch: The seven-day programme is not about making it safer. It is about improving the flow through the system and making delayed discharges better.

Traditionally, in my job, it was more difficult to discharge on a Saturday than on a Thursday or Friday. The family may have been perfectly happy to have the patient home on a Saturday, but doing so was more difficult because diagnostics and pharmacy services were not available. We are fixing that element of seven-day working. It was very unusual to do scheduled surgery on a Saturday, but now it is becoming more usual to do day surgery on a Saturday. That is what the seven-day working process is about.

Ken Macintosh: Those are all good things.

Do you accept—this is the key thing—that a number of studies in Scotland, the UK and internationally have all suggested there is an issue at weekends? Do you accept that that is the case and do you believe that it applies in Scotland or not?

Professor Leitch: I believe that there are a number of studies that suggest that mortality is higher at the weekend than it is during the week, and I think that that may well be true in Scotland. What I do not accept is that that is a patient safety problem. I think that it is a severity-of-illness problem.

The Convener: Dr Keel wants to comment.

Dr Keel: I was just going to say the same. The evidence, such as it is, is deficient because we do not have the case mix or severity-of-illness scores for patients who come in at weekends. As Jason Leitch does, I think that they are probably a sicker cohort of patients. As he said, seven-day working is about trying to speed up the patient journey through hospitals because we know that the longer people stay in hospital, the more likely they are to get a healthcare-acquired infection. Patients do not want to be in hospital unnecessarily. The idea of sustainable seven-day services is to improve access to routine diagnostics at weekends and get patients discharged at weekends, rather than having to wait until the next week to get those investigations.

Until we have studies that look at the case mix of patients coming in at the weekend, compared with those coming in Monday to Friday, we will not know the answer to Mr Macintosh's question about whether there is a problem. The data indicate that more patients are dying at the weekend, but do not tell us why.

10:30

The Convener: Professor Leitch said much the same thing. Some of it might be down to sicker patients coming in, as you suggested. The nub of it is, can you say with certainty that there is no increase in mortality rates at the weekend over weekdays?

Professor Leitch: I can say quite the opposite. There is an increase in mortality rates at the weekends, compared with the weekdays.

The Convener: So why did the Cabinet Secretary for Health and Wellbeing say with certainty that there was not that problem?

Professor Leitch: He was referencing the fact that it is not a patient safety issue. I can also show that there may be higher mortality rates on a Tuesday than on a Thursday. There is variation according to case mix. There is no systematic safety problem at weekends, compared to weekdays, that causes excess mortality.

The Convener: So the answer that the cabinet secretary gave referred only to patient safety and not to the rates? We can check that.

Ken Macintosh: What he actually said was:

> "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 28811.]

You have just said, Professor Leitch, that the mortality rate at weekends is higher than it is during the week.

Professor Leitch: The Handel study, which is the best study that we have, found higher mortality rates at the weekend. More people die on a Saturday and a Sunday. My premise is that that is not to do with safety but that it is to do with case mix.

The Convener: That is not what was said. You are saying that there is a higher mortality rate at the weekend. The cabinet secretary said that there is not. That is something that we need to explore further, so I think that we should move on now.

Bruce Crawford (Stirling) (SNP): I appreciate the candid and thoughtful responses that we are receiving this morning, and I was grateful to Paul Gray for laying out in his correspondence the areas where key actions and improvements had taken place.

I would like to move on from the issues of data or statistics that Ken Macintosh was dealing with and get to the core of what we as a committee are trying to do, which is to find a positive way forward with regard to flow through hospitals. Before I do that, however, I want to comment on Mr Macintosh's rather sweeping statement in his opening remarks that in recent years performance in A and E had deteriorated. From the figures for 2012-13 that Mr Gray has provided to us in his correspondence, it seems to me that waits of over four hours have reduced by 19.2 per cent and that waits of over 12 hours have reduced by 66.4 per cent. Mr Gray, can you confirm that I have got those figures right, and can you comment generally on what you believe to be the overall performance in A and E?

Paul Gray: Over the winter period between November 2013 and March 2014, there was a 66 per cent reduction in patients remaining in A and E for more than 12 hours, and less than 1 per cent of all patients remained in A and E for longer than eight hours. That is the information that I have to hand.

Performance in A and E, which was 91.4 per cent in the previous year, is now up to 94 per cent. Indications from a number of boards—this is their data, not the published data—are that a number of them are continuing to meet the 95 per cent target. As I said in response to the convener, I am not certain that all boards will meet that target, but the trajectory is in the right direction.

We are treating 1.5 million patients a year and the vast majority of those patients get treatment

within the time that we said they would get it. The target is 95 per cent because there are some people for whom it will not be clinically appropriate to have them out of A and E within four hours. We are talking about 1 to 2 per cent of patients who are not being seen and discharged or admitted within the time set.

A and E staff—consultants, trainees, nurses, other professionals, administrators—are working under high pressure, and I do not think that it is the committee's intention to undermine that work in any way. Indeed, at the previous evidence session that I attended, the convener was quick to assure everyone that the committee did not intend to undermine the work of NHS staff. I appreciate that point and want to make it again.

John Connaghan: It is quite interesting to look at where Scotland has been, in relation to the other home countries and those further abroad. For a considerable time, Scotland's performance has been better than that of Northern Ireland or Wales and pretty comparable with that of England—in fact, it has been almost the same.

Scotland's position on median waits is the best in the UK. It is roughly 10 per cent better than England's and has been considerably better than that of Northern Ireland and Wales over recent years.

The committee might be interested in a study published in June 2014 by the Canadian Government that looked internationally at best practice in waiting times, particularly in A and E. Using the phrase "Imagine a land where", it highlighted Scotland and then compared Scotland's performance with Canada's. It showed Scotland in a relatively positive light and is a good read.

Bruce Crawford: Mary Scanlon asked about how individuals present themselves, which is, as you have accepted, something that we need to understand better. Where in Scotland is best practice taking place? From what we saw last week, one of those areas seems to be Tayside. Now that Tayside has reached that performance level, the job not only for boards but the centre of the organisation—in other words, Government—is to ensure that others can achieve the same high performance rates. How can we use the Tayside experience and other good practice to get other boards up to the same level of outcomes and help the people of Scotland?

Paul Gray: Before I ask John Connaghan and Professor Leitch to provide more detail, I will give you an example to ensure that we do not give you just a series of generalised propositions. Andrew Russell, the medical director of NHS Tayside, has been to NHS Grampian to assist the development of its processes and protocols, including those for A and E, precisely because we believe that there are good lessons that Grampian can learn.

John Connaghan: I want to say a few words about NHS Tayside and then make some comments about flow. Professor Leitch might also want to add to my update about flow.

A practical example of some of the good practice in Tayside is signposting, which addresses some of the points that Ms Scanlon raised about self-referrals. For some time now, Tayside has operated a relatively good signposting system; we took a look at it and, earlier this year, issued signposting guidance to boards.

Bruce Crawford: Can you tell us for the public record what signposting is so that we can make it more visible?

John Connaghan: Signposting is directing the patient to the most appropriate point of treatment, which could be an out-of-hours referral back to the GP or treatment in accident and emergency. Signposting is clearly important, because it gets the patient to the most appropriate treatment.

As I have said, we used the Tayside experience in guidance to NHS boards that was issued earlier this year. We are now reviewing how that has gone down and it is quite likely that, in the very near future, we will issue refreshed guidance based on the first six or nine months' experience of its roll-out.

You used an important word—"flow"—and I will explain what I mean by that in a minute. However, I do not want to give you the impression that the flow programme for Scotland is a recent invention; flow has been addressed for a considerable number of years. Committee members might remember Audit Scotland reports on day-case surgery, which is one element of promoting better flow, because the more we move people from an in-patient setting to a day-case setting, the better the flow through in-patient beds and throughout the hospital resource.

Last year, in the course of our consideration of the national unscheduled care action plan, we established a national flow programme. We are piloting new techniques in four boards, and we have imported from the Institute for Healthcare Optimization the best international experience and advice on how to set up the programme. Particularly in NHS Forth Valley, we are at a fairly advanced stage of assessing how we can promote better flow.

There are three main components to the flow programme, the first of which is better utilisation of operating theatres. The second is smoothing the elective programme. As Professor Leitch said, when we look at elective care—that is, non-

emergency in-patient care—we find differences between, for example, Mondays and Tuesdays and Fridays, Saturdays and Sundays. Smoothing out those differences will give boards a much better chance of being able to cope with unexpected peaks in demand for unscheduled care. Smoothing electives is important.

The third component is managing some of the natural variation in unscheduled care. An example of the kind of thing that we want to look at and promote is discharge time of day. When we profile how hospitals discharge patients, we find that far too many patients are discharged late in the day. If we could shift the curve and have more discharges much earlier in the day, we could ease the congestion that we sometimes see in some hospitals.

Those are a couple of practical examples. Professor Leitch will talk about other aspects of flow.

Professor Leitch: I will be brief. The sharing of best practice across systems the size of our NHS is a big challenge, and a global challenge is to find ways of sharing with everyone what is going well such as Lanarkshire's hospital-at-home service, which is probably the best in the country, or NHS Tayside's signposting system, which, again, is probably the best in the country.

We have a number of ways of doing that. We do it through improvement programmes, using improvement science; we have the safety programme, the early years collaborative and the person-centred care programme; and we have learning systems that create the opportunity for practitioners, in particular, to share best practice.

The quality and efficiency support team—or QuEST—which is part of John Connaghan's organisation, applies the same method to efficiency and productivity, bringing people together to share data and best practice and sending people on visits. For example, Bill Morrison, the A and E consultant in Tayside, is regularly in other A and E departments, sharing what Tayside has done on signposting.

NHS Lanarkshire has started to use public advertising. Its nurse director is on the back of a number of buses—not literally, of course; she is on a poster—telling people about the most appropriate person to engage with, particularly over the winter.

I commend John Connaghan's comments on the flow programme. Professor Litvak, who has worked principally in the United States, is probably the global expert on hospital flow, and we have engaged his organisation, which is working with Forth Valley first. Two weeks ago, John and I spent a day with the team, which is beginning to do the data crunching on flow through the board's hospitals. We will then start work on what could be a fairly radical redesign of how we do scheduled care, in particular, and on engaging surgeons on how they might change their weeks. After that, we will spread the approach to another three boards. Having seen what it has achieved elsewhere, I am confident that it will make a significant difference.

Bruce Crawford: The complexity and scale of what you have to deal with are quite mind-boggling.

You mentioned the Lanarkshire hospital-at-home service. We want to ensure that integration of social care and hospital care works better, and I assume that that is what the service is about. Will you say more about how it operates? Am I right in thinking that the service is designed to improve the delayed discharge position, thereby helping with flow and stopping the backlog in hospitals?

10:45

Professor Leitch: The service is provided by what is called the age specialist service emergency team, or ASSET. Most of us have visited it, and it is a shining light for how to do things. However, I do not want to give you the impression that it is the only such service in Scotland; NHS Ayrshire and Arran, for example, has a very good system. However, the Lanarkshire one—ASSET—fundamentally involves moving hospital care into houses.

A friend of mine is a carer for his elderly wife, who is very frail, with multiple morbidities. In my old world of hospital work, she would have been in hospital for a long time, but she never is. Instead, she is cared for at home, where intravenous fluids and antibiotics can be administered. Doctors and nurses can visit, and every morning, there are virtual ward rounds at a certain location during which each of the patients is discussed. Nurses will then go out to those people. I am astonished at how well sick people can be looked after in their own homes. That is certainly a big change.

I might make a mistake here, because I cannot quite remember the statistic, but I think that according to ASSET's most recent data it has reduced over-75 admissions from 70 to 11 per cent. You might want to put brackets around that—I will get you the real figures later—but the system represents a fairly radical approach to the way in which we deliver care. Lots of people have visited the service, and lots of people are using it.

I should point out, however, that contexts are different. Inverness is different from Motherwell, and we cannot just take this sort of system to Inverness or to the Western Isles. It will need adjustment. In any case, people are increasingly using it; indeed, NHS Lothian is very interested in investing in it.

You are right to point out that it requires the integration of health and social care. Not all the people who visit the patients' houses are national health service employees; they are also social workers and care workers, but the badges that they wear become less relevant to the family.

Bruce Crawford: That helps our understanding. The system stops older people going into hospital in the first place. Given that some older people are still causing delayed discharges—I am not going to use the term that has been used in the past—can you give us a general feel for how the integrated social care work that has been going on through the relevant legislation will help to improve things over the next few years? That will help A and E, because—if I have got this right—more beds will be available and people will be able to get in there a bit quicker.

Paul Gray: When an elderly person with multiple morbidities goes into hospital, their case is probably of a category that is more likely to become a delayed discharge. If the lady mentioned by Professor Leitch went into hospital, the difficulties associated with her getting out might be more profound than they would be in an ordinary case. If we can prevent older people from going into hospital in the first place, the likelihood of their becoming a delayed discharge will be reduced.

At the other end of things with regard to the integration of health and social care, we are bringing together provision by local authorities, the third sector and the health service. At the moment, people are waiting for care packages, which holds things up. What can we do to make the process for getting a care package slicker? Is there anything that the NHS can contribute to the development of care packages?

It is not just a matter of saying what the NHS's job is and what the local authority's job is, and never the twain shall meet. We need to have a conversation that brings together the people who are developing the care package to ensure that they understand better, from a health service point of view, what the individual actually needs and to ensure that we avoid making a mechanistic assumption in all cases that someone cannot leave hospital until they have X.

I can give you a very simple example. A hindrance to a person's being able to leave hospital was that they had to be able to go up three steps. The person in question might live in a bungalow, but the standardised approach meant that, until they could go up three steps, they could not leave hospital. If my mother was in hospital—mercifully, she is not—and was asked to go up three steps, she would probably never get out. The point is that we need to make these conversations happen so that we take away any misunderstanding—however well meant things might be—between the various aspects of the care provision.

I know that this discussion is about accident and emergency, but there is a 75 per cent correlation between delayed discharge and increased pressure on accident and emergency. In many pockets of Scotland, there is a straightforward lack of care home places. One of the discussions that therefore has to happen—and which is happening—between the NHS and local authorities is about what we can do to provide more step-down facilities and how we can ensure a sufficiency of care home places. The committee will be aware that Glasgow City Council was not able to let a contract for care homes because of the economic conditions and the differential between what the council was prepared to pay and what the market wanted.

The integration joint boards and the chief officers of those boards will work with the health service and local authorities to seek to address a number of issues, but market conditions are also involved. I do not want to leave that point out.

Bruce Crawford: I recall from my time as a council leader—I am sure that the convener will, too—that councils sometimes withdraw from the market and that, in those circumstances, the private sector is left to deal with the market in its own way, so sometimes a wee bit of regulation is needed.

I have taken up a fair bit of time, convener, so I thank you for your forbearance, and I thank the officials for answering my questions.

The Convener: I will stick with the issue of what we can do to improve things. Earlier, I referred to Dr Martin McKechnie. He said that

"there was no problem recruiting young doctors to the first years of emergency medicine training in Scotland, but they were not completing the course to become senior doctors or consultants."

Last week, we heard from Mr Thakore from Tayside about his concern that medical students are being asked to specialise very early, sometimes before they have even completed their courses, I think. He said that that is prejudicial not just to accident and emergency but to their training. Are you looking at that issue?

Paul Gray: We are certainly keen to ensure that such flexibilities as can be made available are made available. I saw the point to which you refer. Dr Keel can say a bit more about that.

Dr Keel: The current trainee doctor recruitment system, which is called modernising medical careers, was introduced in about 2006-07. The aim was to better match the number of trainees to the number of expected consultant jobs at the end

of their training. Doctors were recruited to what was called run-through training, in which they were set on a career specialty course very early in their career, after they had done their house jobs. As I said, the main aim was to better match the number of doctors that we were training to the number of available consultant or GP posts, but the aim was also to shorten the length of time that it took to train a specialist. In fact, the average length of specialty training is still between eight and nine years, so it has not got much shorter.

Some members may be aware of the Greenaway review, which was published a few months ago and which looks at the shape of postgraduate medical training, recognising the new world that we all inhabit. Much of what we have talked about today is set in the context of an ageing population, more people having more than one health condition, or multimorbidities, and the question whether we have the medical workforce that is best able to deal with the new population of patients. The conclusion probably is that we do not have that at the moment and that we need to roll back a bit from the subspecialisation to produce more generalist doctors who are better able to cope with the whole patient and to deal with their multimorbidities.

Therefore, we are in a transition period, because we are beginning to explore how we might implement the Greenaway review across the UK. That would offer benefits not only to the NHS in providing a more flexible medical workforce, but to the trainee doctors in that they would be recruited to broad-based training schemes involving groups of conditions—such as women and children's health—the training would bridge primary and secondary care, and there would be more opportunities for them to opt out of one particular course of training if they thought that it would not suit them. Therefore, there would be more flexibility in the workforce that we produced for the NHS and more flexibility for doctors, because they would not be locked into a specialist route.

We have a UK steering group, which, it so happens, is chaired by somebody from the Scottish Government. A number of stakeholder events have been held throughout the UK. We will gather the views from those and make a decision about how the Greenaway report should be implemented in Scotland. That will not happen overnight, but the aim is a better, more flexible, more generalist-trained medical workforce.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): The message from what Bruce Crawford said was to recognise that performance in A and E has significantly improved over the years rather than deteriorated. I am less concerned about whether we achieve the 95 per cent target because, only a number of years ago, performance was 84 per cent and that was hailed as fantastic. Statistics can tell us different things and we can use them in different ways. As a member of the Public Audit Committee, I am more concerned to hear from witnesses that there are systems and processes in place to continually improve and address the issues that arise from time to time.

I am encouraged by many of the things that I have heard during this and previous meetings. I am particularly encouraged by what we heard from the NHS Tayside representatives who came last week. Bruce Crawford raised their issue—they talked about signposting and trying to deal with patients as they arrive to send them to the appropriate care route. I sincerely hope that such lessons are being learned and shared with the rest of the boards.

Can you say with any confidence that we will get to the 95 per cent? Do we have to? You said, Mr Gray, that it might not be appropriate for some patients to be pulled out of the system within four hours. I was quite struck by that. As politicians, we will react to the performance figure when you release it regardless of whether you achieve the 95 per cent target, but I would like to hear your view of that as health professionals. Are we going in the right direction? Are we improving the service? Will we reach the 95 per cent target? Do we really have to achieve it?

Paul Gray: First of all, I should say that the health professionals who are with me today are Dr Keel and Professor Leitch—I have other professionals from other disciplines with me, too—so I will ask them to comment.

My view—I emphasise that it is my view—is that, when we say that we are going to do something, we should make a determined effort to do so. A target is set to be challenging; it is not set to be simple. I could just say that we should achieve a figure of 90 per cent and then we would be achieving the target all the time, but that does not seem to me to be realistic. For the sake of public confidence, when we say that we are going to do something, we should do it.

I spoke to the lead A and E consultant in the Borders general hospital about whether he thought that 95 per cent was the right number. We could argue whether 94 or 96 per cent is the right number but, in his view, the 95 per cent target gives a sufficient amount of what I call impetus to the system to ensure that people are not left in A and E beyond the point at which it is clinically appropriate for them to be there.

That consultant was equally clear that, in a number of complex and difficult cases, there are no benefits and some disadvantages to taking

patients out of A and E if that is the best place for them to receive care. Therefore, having a 100 per cent target would be plain wrong, because it would disadvantage patients and mean that they got worse outcomes.

One could argue about a few percentage points either way but, as a national health service, we have committed to working towards the 95 per cent target. It is important for public confidence that we do so, but we should never at any point allow a target to cut across a safe clinical judgment.

Perhaps Dr Keel and Professor Leitch want to add to that.

11:00

Dr Keel: I agree with Willie Coffey's question—we need constantly to ask whether it is worth driving that extra percentage, but as Mr Gray said, it is clear that emergency medicine consultants think that the four-hour target is a good one, which gives the 5 per cent flexibility for those who need to be in A and E for longer.

In my professional life—this is going back many decades—I can remember patients languishing in A and E for well over 12 hours. They were there the next day when you went back to the department. The amount of improvement that has been achieved by NHS Scotland staff is quite incredible, even if you look back just a few years.

I think that the performance is great and it is clear that consultants—the medical profession—want the target to remain. They do not like all the targets that we have, but they like this one, so we need to stick with it.

Professor Leitch: I agree that we should strive for the 95 per cent target, but I also accept the premise of Willie Coffey's question that it does not make a huge difference whether the target is 94, 93 or 96 per cent. To use a target to make simplistic judgments about the quality of services is not the right thing to do. That is one lever that we have to improve the quality of the service that we deliver to the population, and I think that we should keep it. Underneath that, however, the fact that we treat and discharge or admit half of patients within two hours probably says as much about the quality of the service that we deliver as performance against the 95 per cent figure does.

The target is part of a package of things around quality improvement methods, scrutiny and the delivery of the quality service that we should aim for. I emphasise Mr Gray's point that at no time should the target supersede clinical judgment. If somebody should stay in A and E because they should wait for a surgeon, they should stay and wait for the surgeon. At no time should the target be used to undermine patient safety in any way. I am confident that that does not happen.

Willie Coffey: I am pretty sure that you will never hear anyone at the Public Audit Committee taking a view like that about targets.

A good example was raised during the previous evidence session—the issue of people being discharged at weekends and queues building up for admissions on Mondays and Tuesdays, which seemed quite an obvious area in which we could win. That could help push up the target, if that is what, collectively, we all want to achieve.

Are people discharged more slowly at the weekend across the NHS? There can be a glut of people arriving on Mondays and Tuesdays because they have waited all weekend to present. What can we do about that? How can we smooth that over across all the boards and push up the target even further?

John Connaghan: You make a very good point, which I think I addressed in part when I talked earlier about the flow project. One of the things at the heart of the flow project is how we can better balance the other half of the work: the elective or planned work. In our experience, there is a weighting towards that work being done at the beginning of the week. Mondays and Tuesdays are very popular operating days for surgeons; Thursdays and Fridays are perhaps less popular. As I said earlier, one of the things at the heart of the seven-day project is consideration of how we can utilise the NHS's entire resource over seven days, to smooth out those peaks and troughs.

Professor Leitch: Willie Coffey is right that discharging at weekends and discharging earlier in the day helps with the flow. It sounds simple—just discharge the patients—but the patients are often frail and elderly and often need adjustments to be made at home. They often do not have ready-made carers who just happen to be in the family, and they can require extensive drugs on discharge. The bag of drugs is only one element of the discharge process; patients require very clear instruction and education about what will happen with their drugs. It is not always as simple a process as we are led to believe, so we cannot just push them out at 3 o'clock on a Saturday and think that all will be well.

The seven-day project is about making that process better, in conjunction with social care colleagues and those who put in the little doors on patients' showers so that they can be at home. It is not just healthy people who have had scheduled surgery whom we need to get out on a Saturday and a Sunday.

Willie Coffey: I will pick up on the debate about mortality at weekends. I was fascinated by the exchange between Ken Macintosh and Professor

Leitch. If we look at statistics about anything, we can find a story, can we not? We can ask when people are more likely to be killed in a car accident, for example. There is probably a time and a day when that is more likely.

I understood you to say that the question is whether the figures that were discussed reflect neglect in the system or a lack of resources or management on a particular day, or whether they just reflect a characteristic of the population and general behaviour. I took it from your explanation that the answer is probably the latter, because we are uncertain about the reality and the facts.

People are people; we do not always act uniformly and consistently, and our behaviour varies. Until or unless you have data, analysis and research that pinpoint causes, we will be no further forward.

Professor Leitch: To be critical about my position, I am not remotely complacent about safety in Scotland's hospitals. I do not think that anybody could accuse me of that. If anybody has been focused on the safety of our hospital care, I suggest that it is me through our leadership of the safety programme.

I care about the data and about making it better. If I see things in the data, narratives or stories that suggest something different, I will be the first to implement appropriate change.

Willie Coffey: You have not seen such data yet.

Professor Leitch: That is correct.

Colin Keir (Edinburgh Western) (SNP): I will go back a question or two to Dr Keel's answer about difficulties in relation to people going through training. Does the NHS track the destinations of people who have been trained? We hear all sorts of stories about people being trained who have set their minds on a future in research, for instance. How do you encourage people not to follow the popular subjects after training, given that you really want to fill local vacancies?

Dr Keel: NHS Education for Scotland is beginning to do such tracking, which has not been commonly done but is becoming more feasible. As for people who train in emergency medicine, it is clear from trainee fill rates in A and E—the numbers of trainee posts that are filled—that the specialty is in difficulty. That is multifactorial. People in that specialty—consultants and trainees—work extremely hard. Younger doctors might not be as keen on the lifestyle choices that must be made to follow an emergency medicine career.

People in that specialty work under enormous pressure, at the hospital's front door. That cannot be done for a career that will last 30 or 40 years. Increasingly, we must recognise that, as people go through their career and become consultants, they cannot do the sharp-end front-door stuff that they did when they were in their late 20s and early 30s. However, adjusting the system to accommodate that is difficult.

When young doctors enter training, they look at issues such as lifestyle choices. We know that significant—although not vast—numbers of them are choosing to emigrate to Australia or New Zealand. That relates to lifestyle and work patterns in those countries; it is not all about the climate. We are paying attention to all that. On retaining people to work in Scotland, we know that, if someone trains in Scotland and has a good training experience in a specialty, they are more likely to stay in the country.

Role models in the medical workforce are incredibly important to junior doctors. If someone ends up working with a consultant who is enthusiastic about how their career has panned out and about their work, they are much more likely to be enthused and to stick with the training. If—unfortunately—someone ends up with a person who is a bit more burned out and cynical, they will pick up on that and might not stick with the training. It is incredibly important and part of the chief medical officer's role to ensure that the medical leadership is there to demonstrate to trainees that what they are doing is worth while and a rewarding career, and that they should stick with it.

Colin Keir: The position is not unusual to Scotland; it applies everywhere.

Dr Keel: Indeed. Emergency medicine has vacancies across the UK—filling roles in the specialty is difficult.

The Convener: I thank all our witnesses for their contributions. It is clear that the area is challenging and there is no doubting our witnesses' commitment to improvement.

We will have a short break before hearing from our next set of witnesses.

11:11

Meeting suspended.

11:17

On resuming—

Section 22 Report

"The 2013/14 audit of the Scottish Government Consolidated Accounts: Common Agricultural Policy Futures programme"

The Convener: We move on to agenda item 3, under which we will hear evidence from the Auditor General on her report "The 2013/14 audit of the Scottish Government Consolidated Accounts: Common Agricultural Policy Futures programme".

With us are Caroline Gardner, the Auditor General for Scotland; Mark Taylor, assistant director at Audit Scotland; and Gemma Diamond, senior manager at Audit Scotland. I invite the Auditor General for Scotland to make an opening statement.

Caroline Gardner (Auditor General for Scotland): Thank you, convener. Today, I am bringing to the committee a report on an issue arising from the audit of the Scottish Government consolidated accounts. The report is about the common agricultural policy—or CAP—futures programme, which is a five-year business change process to deliver CAP reform in Scotland.

The programme is currently expected to cost £137.3 million. It has two elements: first, the redesign of working practices to focus on the customer and generate efficiencies; and, secondly, the development of a new information technology system to deliver the new CAP and improved ways of working.

The programme is a significant one for the Government. Each year, it distributes approximately £700 million of European funding, through the CAP, to Scottish farmers and rural businesses, and any failure to meet the new European Commission regulations could lead to significant costs for the Scottish Government.

The purpose of my report is to highlight the significant risks that the programme is carrying. The Government recognises that risk in the governance statement that is included in its 2013-14 accounts. My report is based on a high-level review of progress in the first 18 months of the programme. We are undertaking more detailed work and will report on that as the programme reaches its critical milestones over the months ahead.

Overall, my report highlights that the programme has so far proved significantly more complex and challenging than the Government anticipated. The programme team has recognised that, and it has recognised that there is significant risk to the programme arising from the potential late delivery of milestones and also from increasing costs.

The business case for the programme was approved in December 2012. At that stage, detailed information on the EC requirements was not known. The programme has experienced continuing difficulties since then, and total forecast costs have increased from £88 million to £137 million as the team has had more detail on the EC requirements and the IT that is needed to deliver on them.

It is important to note that the programme is working to fixed regulatory timescales. Within the next three months, the team will have to make critical decisions about whether the new IT system will be ready to manage the payments application process or whether it needs to implement contingency plans.

In a bid to meet the timescales, the programme team has had to scale back some of the original scope of the business case, changing plans for the IT component to map registered land and removing some of the wider business change elements that were originally included.

Management acknowledge the difficulties and are taking action. The most recent independent assurance review, which was in May 2014, concluded that significant changes to the programme were required immediately if successful delivery was to be achieved, and as a result the programme board established a corrective action plan. There is evidence of progress against the plan, but it is too early to see whether the actions will increase the confidence in successful delivery by the required milestones.

I have concluded that the futures programme will carry significant risk right up until implementation and beyond. The purpose of my report is to bring that to the Parliament's attention together with the continuing risks to successful delivery of the programme and overall value for money.

As always, convener, my colleagues and I are happy to answer questions from the committee.

Mary Scanlon: I was surprised how interesting the report is. I had thought that we would just note it, but the more I read, the more concerned I became.

I have some brief questions. First, paragraph 5 states:

> "The Scottish Government has estimated that it could incur costs of up to £50 million per year if the IT system failed to deliver ... CAP reform".

That is a lot of money, and it seems obvious that that is a possibility. Where would that money come from?

My second question relates to paragraphs 8 to 10. You said that the cost in the original business case was £88 million and that the forecast cost is now £137 million. Who is the IT partner?

My next question relates to exhibit 2 on page 7. Will the farmers be paid? For December 2015, the exhibit quotes the following “Risk arising”:

> “Reputational risk as customers have previously been paid in December... new complexities ... may affect the usual timetable.”

For June 2016, which is the EC deadline for making payments, the “Risk arising” is:

> “Regulatory risk with financial penalties arising from non-compliance.”

I ask you to comment first on the £50 million cost that the Scottish Government might incur, which seems to me to be some sort of fine for not achieving deadlines; secondly, on the huge increase from £88 million to £137 million for the IT system; and thirdly on the uncertainty for farmers. I have no doubt that they will be paid, but will it be when they expect to be paid? They need the money to purchase grain for the following year. Also, will there be future fines for the Government in June 2016, given the financial penalties?

Caroline Gardner: First, I am delighted that you are finding the consolidated accounts interesting. We think that they are fascinating, and part of our mission is to convince you all that that is the case.

Mary Scanlon: My life is very sad, really, but thank you.

Caroline Gardner: I will start on value for money and the costs, and then I will bring in my colleagues. We will then move on to the IT system and the impact on farmers and rural businesses.

The financial or value-for-money risks fall into three categories. First, the cost of the system is clearly already significantly higher than was envisaged, given the increase from the original estimate of £88 million to the current estimate of £137 million and the possibility that that might increase further.

Secondly, and linked to that, we already know that the scope of the system and the programme will be more limited than was originally planned, with some important elements being taken out of the current phase. If they are to be developed, they will need to be part of a future business plan, and future costs will be associated with that.

As you suggested, the third cost relates to the possibility—it is only a possibility at this stage—that, if the programme cannot deliver the EC requirements, the Scottish Government might incur direct financial consequences or penalties. I will ask Mark Taylor to talk about the £50 million.

Mary Scanlon: My other question was about farmers.

Caroline Gardner: I will answer that question before I bring in Mark Taylor, because it is key. It is fair to say that the Government is absolutely focused on ensuring that payments can be made to farmers. Farming is a vital part of Scotland’s economy, and it is a huge part of the economy in some areas. A lot of attention is being paid to making payments. That still involves a risk, but it is the focus of efforts.

Another risk is that payments will be made without all the EC requirements on controls being met, which raises the possibility of fines. We can expand on that as our answers develop.

Mark Taylor (Audit Scotland): The £50 million is the Scottish Government’s estimate of what might be at stake in relation to the European Commission’s system to police how the Scottish Government ensures that it pays the right amounts to the right people at the right time.

Long-standing members might remember that the committee previously discussed how the Commission has the power to withhold funding when it feels that the control systems—the checks that are required to ensure that the right people get the right amounts—are not as robust as they should be. Requirements on how systems should work are laid down.

The Government’s assessment is that, if it develops a system to deliver the new CAP programme and the European Commission identifies that some of the checks are not built into the system or are not being operated as robustly as they might be, £50 million might be at stake. That number is factored into the business case.

The Government has made it clear that it needs improved systems so that it operates a system that is as robust as it can be, which will prevent the £50 million from being at stake. We think that a lot of work has still to be done, which the Government recognises, to put in place robust systems. That is why the report refers to the £50 million, which features in the Government’s business case on the need for the proposed system.

Mary Scanlon: What you say makes me more concerned, but I will leave it there.

The system will be more limited. Paragraph 15 says:

> “this investment will not provide all the functionality originally planned.”

We will not have the new system that we wanted; we will have to try to make an updated system work.

You did not mention who the IT provider is.

Caroline Gardner: Gemma Diamond will pick that up.

Mary Scanlon: I mentioned the £50 million and the risks to farmers and the Government from not meeting deadlines. The £50 million is sort of allocated to not meeting the deadlines. Could an additional penalty be imposed? Mark Taylor said that the EC could withhold funding if appropriate systems were not in place. Could the figure be more than £50 million?

Mark Taylor: The short answer is yes. I make it clear that the £50 million is not an amount that has been budgeted for and allocated. The assessment in the business case was that, if the systems were not ultimately as robust as they needed to be, that amount might be payable and might need to be budgeted for and allocated in the future.

Mary Scanlon: Would the £50 million come from the agriculture budget?

Mark Taylor: To be clear, the Scottish Government would have to find the money from somewhere and manage that across its budget as a whole.

Mary Scanlon: Would the Scottish Government have to find the amount from the agriculture budget or from the budget as a whole?

Mark Taylor: From the budget as a whole.

Caroline Gardner: Gemma Diamond will answer the question about the IT provider.

Gemma Diamond (Audit Scotland): The Scottish Government has contracted with CGI Group, which was previously known as Logica, as its IT delivery partner.

Mary Scanlon: Thank you. I will leave it there.

Bruce Crawford: First, I want to check that we are dealing with like-for-like figures. Are the £88 million and the £137 million like-for-like figures?

Caroline Gardner: Not exactly, mainly because of reductions that have been made to the scope of the project. When the business case was originally put together in 2012, the overall estimated cost was £88 million. That has been revised upwards over the period since then and the current estimated cost is now £137.3 million, but that £137.3 million is forecast to buy a more limited IT system than the one that was planned at the start of the process.

11:30

Bruce Crawford: I get that bit. My question was more to do with whether VAT was applicable to both figures.

Caroline Gardner: I will ask Gemma Diamond to talk you through that to make sure that we do not mislead you. There are some factors about the treatment of VAT and contingency that are important.

Bruce Crawford: That is why I want to make sure that we are dealing with like-for-like figures.

Gemma Diamond: There are difficulties in comparing the business case figures and the spend to date because of how some factors have been implied, including inflation, so I will take you through it.

The original business case estimated the cost at £88 million without any VAT or inflation applied. The most recent business case, which was produced in March 2014, estimated the cost at £111 million. That is directly comparable to the £88 million.

If we then add VAT and inflation to the £111 million, that converts it to £127.8 million. That, in essence, is the full cost in the revised business case and we can compare that £127.8 million to the £137.3 million, which is the current forecast for the spend.

Bruce Crawford: Let us take this back to the beginning then. If we applied VAT and inflation to the £88 million, what would that give us?

Gemma Diamond: That was not calculated in the original business case. Because we could not compare the two, we have taken the steps to take you from the £88 million to the current spend to date, but we have not converted that original cost in the business case because the Scottish Government did not apply inflation factors and VAT at the time.

Bruce Crawford: Are you able to give us those figures? We need to be able to compare one with the other to get the real level of uplift. Is it possible to obtain that?

Caroline Gardner: We can give you our estimate of it separately. Gemma Diamond's point is that it was not included in the original business case.

Bruce Crawford: I understand that, and it probably should have been, but it would be useful for the committee to be able to examine the real starting figure and potential end figure.

I have a question about the possible £50 million fine, which would be a concern if it were to become a reality. Is the fact that the Government has removed some elements that were originally

part of the functionality and is prepared to spend a bit more money to get to where it needs to be, even though the estimates are higher than they were at the beginning, an advantage in avoiding having to pay a £50 million fine?

Caroline Gardner: We certainly welcome the fact that the Government recognises the significant risks that are associated with delivering the programme—which is key to the rural economy: farmers and rural businesses—and the fact that, as problems have become apparent, a lot of effort has gone into forecasting the potential impact on the Government's budget and on farmers and rural businesses and into considering the options for responding to that impact.

There are two elements to that response: one is making contingency plans for dealing with applications from farmers when they come in if the system is not able to do it at that stage; the second is examining how the system can be reduced in scale to make it more possible to deliver what is required. That planning is a good thing. Having said that, we would all rather not be in the position where it is needed, given the importance of the investment to such a major programme with a big impact on large parts of the economy.

Bruce Crawford: I am grateful for the report, because it highlights the risks clearly. However, Scotland's farmers—Mary Scanlon has identified how important they are—will realise the complexity of the CAP and the scale of the challenge that we face in getting the system right.

In May or June this year—I am not sure of the exact date—we became aware of what the common agricultural policy regime would look like. It takes into account a myriad of aspects. Last night, I wrote down a few of the aspects that I know of: modulation between pillar 1 and pillar 2; convergence uplift payments; measures to deal with slipper farmers; regionalisation; specific provisions for islands; specific provisions for new entrants; measures around greening and ecological focus areas; voluntary coupled support for the beef sector; and voluntary coupled support for the sheep sector.

It is being asked that a hugely complicated system be designed to cope with all those elements. In those circumstances, are those some of the reasons why the Government has had a challenge on its hands to ensure that it has an IT system that is fit for purpose, given how late in the day it knew about what the elements would be?

Caroline Gardner: There is no doubt that the complexity of the new CAP scheme and the late points at which some of the details became available to Governments across Europe have made things more complex.

One reason why I thought that it was right to report to the committee at this stage is that some of the underlying factors in the delivery of the programme are consistent with what we have reported in the past about large IT developments in the public sector. We have seen continuing problems in getting the right capacity and capability of staff; problems with the programme management from the outset of the business case and the development of the project; and changing governance arrangements that have not made it easier to deliver a project that was never going to be straightforward.

Both those things are true: the project is complex, and we think that there were shortcomings in its management that are common to a number of other public sector IT developments.

Bruce Crawford: On the wider European perspective, I am aware of the opinion of the European Court of Auditors, as I did a Google search for that. On 8 March, it produced a report in which it expressed

"doubts as to whether the measures proposed"

in the CAP

"can be implemented effectively without imposing an excessive administrative burden on managing agencies and farmers."

As far as CAP reform was concerned, it also said:

"The limited simplification and additional administrative burdens introduced will have an effect on the costs of the reform which the Commission estimates are likely to represent an increase of 15 % overall. Member States consider that the percentage increase in costs may be even bigger."

According to the European Court of Auditors, the problem is not just a Scottish problem; it is a European one. Do you share that view?

Caroline Gardner: I have said that it is clear that the scheme is complex to administer. Some members will be aware that we as auditors will be required to do more to verify the payments that are made in Scotland. The administrative costs and complexity are greater; there is no question about that. At the moment, I am not equipped to answer the question whether that investment is justified for the benefits of the scheme.

Mark Taylor is our expert on European agriculture funding. He liaises with auditors across the other UK Governments on the progress that is being made and the challenges that are being seen. He may want to amplify what I have just said about that.

Mark Taylor: It is fair to say that the challenges that the Scottish Government is facing at the most basic level to put in a new system against a tight timetable, fixed deadlines and the complexity that

has been outlined are shared across Europe—of course they are—and different organisations and different countries are at different stages of responding to that.

Historically, there have been issues with other paying agencies in other parts of the UK, which have had difficulties in implementing their systems. Those difficulties are well documented in the rest of the UK, and each of the component parts of the UK currently faces such problems.

As the Auditor General said, we are keen to highlight to the committee the risk around the particular project, but against that context, we are also keen to highlight the way in which the programme has been managed. We do not underestimate the challenge. Common themes are coming out about some of the difficulties, which the Scottish Government has recognised. To be clear, we understand that it aims to address them, but as the Auditor General said, there are underlying issues to do with capability and capacity and detailed planning around a plan that is very difficult to put together.

I think that there has been some frustration internally within the Government that it has taken the period that it has taken to get more specific and detailed plans in place. I think that it recognises those issues, and we think that it aims to do something about them, but there is an underlying risk, which we are keen to share with the committee.

Bruce Crawford: It was obvious from the 2005 CAP reform, I think, that huge difficulties were experienced in England in bringing in the new system. Obviously, that caused it huge problems, and I hope that we do not get to that level of difficulty here.

Colin Beattie: I want to continue exploring the issues to do with costs. The original business case was approved in December 2012. Several comments have been made about the delays in getting clarification on the regulations. Is it reasonable to say that it was the clarifications that drove the review of the business case in March 2014? Was that done reasonably timeously?

Caroline Gardner: Gemma Diamond might be able to pick that up.

Gemma Diamond: I think that it was part of the reason why the Government revised the business case. In essence, the programme team was further through the project and had more information and detail, so more was known about cost. The team had also been working with its IT delivery partner on the scope of the IT requirements, which were very much linked to the EC requirements.

The programme team keeps the business case as a live document and minor revisions are regularly made, but we are talking about a major update in March 2014.

Colin Beattie: Almost the entire increase in the overall business case is caused by IT costs. One can be cynical about IT costs, which always seem to work out as a multiple of what was expected, but is it reasonable to say that the virtual doubling of the IT costs relates directly to compliance with the new regulations and a realisation of the complexity in that regard?

Caroline Gardner: I do not think that it is fair to say that, but Gemma Diamond worked closely on the area, so she can say more.

Gemma Diamond: The EC requirements are part of the issue. When the programme team started working with the IT delivery partner, a long time was spent on looking at the requirements for the IT. So far we have done only a high-level review, as the Auditor General said, but we will continue to look at the issue and consider the most significant problems that the programme has encountered to date.

The EC requirements were part of the problem. However, the team was also looking internally at what it wanted to achieve, because the programme was about not just the IT but delivering business change and change in working practices. That involved working internally, to be clear about what that would mean in practice.

Colin Beattie: However, the increase in costs in the business case is almost entirely IT related and is not to do with the other part of the project. I take it that that is correct, because it is what you said in your report.

Caroline Gardner: It is IT related, but what we are trying to convey is that that does not relate only to the EC requirements. For example, the Government wanted to have mobile technology that field officers could use when going out to verify land parcels and features of the businesses that attract grant. The approach was intended to generate efficiencies in the Government's running costs, as well as to satisfy EC requirements. The EC requirements were part of the issue, but so were the requirements to do with ways of working more generally in the Government's administration of the programme. Both issues affected the IT costs.

Colin Beattie: Those upgrades were in the original business case and the original IT costs.

Caroline Gardner: That is right, and they are not in the £137 million forecast costs at this stage; they have come out of the scope, to try to contain costs and increase the probability of delivering a successful system on time.

Colin Beattie: The changes to the EC regulations must have been startling, if the IT budget has doubled despite a lot of key elements having been taken out of it, to keep things moving forward. There must have been quite horrific changes.

Caroline Gardner: A number of things are going on. The first is that the scheme itself is different—the basis on which money is paid is different from the basis of the previous CAP scheme. The EC's requirements in relation to controls, checks and validation, to ensure that money is properly paid, are more rigorous than they were in the past. Also, the Government was hoping to secure efficiencies in ways of working by investing in the new programme, by investing in mobile technology and the ability of landowners to update records of land parcels online. All three factors drove the IT requirements, so the EC requirements are just one part of that. They are important, but they do not account for the whole shift in the IT costs.

11:45

Colin Beattie: When did the IT partner come on board?

Caroline Gardner: Gemma Diamond can confirm that.

Gemma Diamond: The IT delivery partner was appointed in March 2013.

Colin Beattie: They were not part of the original programme that was agreed in December 2012—or did they participate in that?

Gemma Diamond: The business case that was approved in December 2012 had an options appraisal in it about how the Government would contract with an external contractor to deliver the IT system. The option that was chosen within that business case was to appoint an IT delivery partner. Subsequent to that approval, the Government went through the tender process to appoint the external contractor in March 2013.

Colin Beattie: So when the external contractor came on board, in March 2013, the Government must have accepted the budget that was available.

Gemma Diamond: The original business case had a forecast cost of £88 million. The tender documentation that went out for the IT delivery partner was not a fixed contract that was signed, because the Government knew that it would need to go through a scoping phase with the IT delivery partner to determine what was going to be delivered. At that stage, the forecast cost for the delivery partner was £20 million.

Colin Beattie: I presume that a contract is now in place that has a figure on it.

Gemma Diamond: It is still the same contract that was signed at that time—it is not a fixed-price contract.

Colin Beattie: It is not a fixed-price contract.

Gemma Diamond: No.

Colin Beattie: So, how is the pricing determined?

Gemma Diamond: The pricing is determined through discussion with the supplier.

Colin Beattie: Each component part is priced and that price is agreed by the Government and the IT supplier as part of the contract. It is not an open-ended contract.

Gemma Diamond: The Scottish Government and the supplier are taking an incremental approach to delivery of the IT, which means that they are delivering it not in big stages but in little bits at a time, and they are costing it according to that process. It is a different way of approaching it from the one that the Government has been used to in the past.

Colin Beattie: You are comfortable that the controls around it are adequate and robust.

Caroline Gardner: Within the terms of the contract, the controls are adequate and robust. However, as is the case with many large IT developments, it is practically impossible to let a contract that has a fixed price at the outset. Costs increase as the work develops, the scope becomes clearer and the programme management improves. So, as we say in our report, there is a risk that costs could increase. At this stage we have no cause to be concerned about the way in which the contract is being managed, but there are significant risks to cost as well as to delivery, as we say in the report.

Willie Coffey: It sounds to me like a requirements and specification issue rather than a specific IT issue. It is not about failing computers or software; it is akin to a builder being asked to build a house before they have the drawings and then discovering, when they get them, that they are being asked to build a block of flats. That was a common issue in the IT projects that I worked on over the course of my professional career, and it is what happens when the customer—in this case, the European Commission—is not clear about what is required at the outset. It is hardly a surprise that, as the specifications and requirements are developed, the costs go up. That is not down to the IT partner, the Scottish Government or anyone else; it is, I presume, down to the requirements that were set out by the Commission.

When the system is up and running, will it last us for a period of time? Is there a lifespan

attached to the system? Is it for as long as the CAP reforms are in place and until Europe changes them again? How long will the system stand us in good stead once it has settled down?

Caroline Gardner: I will address your first point first, Mr Coffey. It is true that some of the increase in costs is due to the way in which the EC requirements have emerged over time. It is also true, as I say in my report, that we think that there are weaknesses in how the programme has been managed and governed, which have contributed to that increase in costs. Both those things are true—I do not want to suggest that it is one or the other.

On the lifetime of the programme, the new CAP scheme is a five-year scheme, but it is quite possible that parts of the system that is being developed can be used for future iterations. For example, one way in which the Government is looking to contain costs and improve the likelihood of successful delivery is to reuse elements of the old land-mapping system in the new system. It should be possible to reuse some of the programme for future iterations of CAP, assuming that it continues in something like the current form. Some of it may need to change, but I do not think that we are in a position to say that it will at this stage.

Do you want to add to that, Mark?

Mark Taylor: I reaffirm that last point. We are clear that there is more audit work to be done to understand the progress of the project and some of the detailed governance arrangements and controls that are in place, and we intend to do that work.

On how long it is for, the business case set out a period—Gemma Diamond will be able to help us with that—and the spend is based on getting benefit over that period of time.

Gemma Diamond: The futures programme, which started in 2012-13, is a five-year programme to deliver business change and an IT system to help to deliver that change and the EC requirements over that period. We are currently 18 months into the programme.

Willie Coffey: If the potential cost is £700 million a year over the five years—I think that the Auditor General mentioned that sum—we are talking about a £3.5 billion programme. We want to get the system right on as tight a budget as possible, but it is a question of managing that size of budget, is it?

Caroline Gardner: Yes. On current figures, the amount going into Scotland's rural economy—to farmers and small rural businesses—will be about £3.5 billion over the period. The cost of the IT system is the cost of delivering that, but the aim is also to deliver efficiencies and better customer service and to avoid the risk of regulatory penalties if it goes wrong. It is an important investment given not just the direct financial costs but the wider costs and benefits that are associated with it.

Willie Coffey: Is everyone now totally clear about what the requirements are? Software engineers will say, "Tell us what you want and we will build it for you." Is everyone now clear about the requirements and are they getting on with the job?

Caroline Gardner: I think that everybody is now clear what the EC requirements are, and there has been a focused piece of work by Government to review the business case and to be clear about what should be delivered to maximise the chances of successful delivery over the next 18 months. However, that is not to say that there might not be more changes in how it is done. We all know that there might be such changes.

I ask Gemma Diamond and Mark Taylor whether they want to add to that general answer.

Mark Taylor: As you will understand, Mr Coffey, this is a long-term project with a number of releases and a number of different parts to it. The initial focus is on the early releases and on getting an application system that allows farmers and other rural businesses to apply for a grant. I think that those requirements are now well understood and work is progressing on them. The next challenge is to get the back-end processing in place, which will allow the data to be processed. There is a fair amount of understanding of that, but the detail is still to be worked through, and I do not think that that is entirely linked to the European regulations. There is a bit of work still to be done around that.

One issue that we have come across is the Government's challenges in having the right commercial and contract management skills. We have talked about how it works with an IT provider, and it has recognised that it has not been doing that as well as it might have been in terms of getting clarity and the right relationship with the IT provider. As we go on to do more detailed work, one of our main areas of focus will be to really understand how that is working.

Willie Coffey: Okay. I look forward to hearing about that when you carry out that work.

Ken Macintosh: It was depressing enough to read in the report about the money that the scheme is now costing even though no payments have yet been made, but I also note the depressing familiarity of it all.

We previously looked at your report on managing information and communications technology projects. Am I right to say that that was

produced in 2012, before this contract was awarded and signed?

Caroline Gardner: Yes.

Ken Macintosh: I do not know whether you have asked them, but has anybody in charge of this project read your report on ICT?

Caroline Gardner: I will ask Gemma Diamond to comment, but it is important to set the context. We are reporting the project to you now because of the risks associated with it and because it arises from the Government's 2013-14 accounts. We are also doing a significant piece of work to revisit the 2012 report that you mentioned and look at how the recommendations have been picked up. Conveniently, Gemma Diamond is leading that piece of work as well.

Gemma Diamond: The business case for the project makes reference to our 2012 report and some of the recommendations in it. The themes that we raised in that report—certainly the ones on capacity and capability—are not easily dealt with quickly. Our report was published in August 2012 and the business case was approved in December that year, so the weaknesses that we reported on in that report certainly could not be fixed that quickly—a continuing focus is required to make an improvement.

Ken Macintosh: You suggest that there is increasingly little contingency. What contingency plans does the Government have? If the programme is not in place and does not work, will the Government go back to manual payments or what will happen?

Gemma Diamond: The Government is actively considering a range of contingency options—it is putting a lot of work into that to minimise the risk to the payments. Those options include manual processing, using existing systems for a bit longer and accelerating certain parts of the new build and maybe holding back on others and so prioritising what needs to be done. The Government is also considering stand-alone existing IT applications that it might be able to use.

Ken Macintosh: So there is an app for this, is there? [*Laughter*.]

You say that there has been difficulty filling some of the posts. Is that still the case?

Gemma Diamond: Filling the posts has been a constant difficulty for the team, although most of the senior-level posts that were vacant, which related to programme management and contract management, have been filled. That relates back to the theme that we raised in our 2012 "Managing ICT contracts" report about capacity and capability across the wider Scottish Government in managing IT projects.

Ken Macintosh: The programme has only been running for over a year. How many programme directors or IT directors has it had?

Gemma Diamond: The programme has had one consistent senior responsible officer over that period.

Ken Macintosh: What about the IT director or chief technology officer? Has that post changed?

Gemma Diamond: That has changed. The chief technology officer is quite a new post.

Ken Macintosh: Who is the minister in charge of the programme?

Gemma Diamond: I cannot remember the full title—it is quite long.

Caroline Gardner: It is the Cabinet Secretary for Rural Affairs and the Environment who has overall responsibility.

Ken Macintosh: Right—Mr Lochhead. Has he reported on the issue to Parliament or to the Rural Affairs, Climate Change and Environment Committee? Are we the first committee to be aware of the matter, or are any of the subject committees in the Parliament aware of the crisis in the programme?

Caroline Gardner: I cannot answer for any reporting that may have happened to other committees of the Parliament. I thought that it was an appropriate time to report to this committee, given your specific responsibilities for overseeing the use of public money and the value for money that is achieved for it.

Ken Macintosh: Are you aware of any processes of accountability in relation to the programme so far? Has it been debated or discussed in committee at all?

Caroline Gardner: I am not aware of that, but that does not mean that it has not happened.

The Convener: It is not for the Auditor General to reflect on committee business in the Parliament.

Ken Macintosh: Good point.

Mary Scanlon: I have a small point on that. From memory, when we took evidence on the "Managing ICT contracts" report, we were given an assurance that, because of the huge cost increases that had happened, IT contracts over a certain amount would in future be managed by a team in the Government and would not just be left to public sector organisations, small and large. We were told that it would be much more professional. I hope that my memory is right, but I remember being given an assurance that we would not again see the likes of the issues in Registers of Scotland and the problems in the Procurator Fiscal Service and other bodies because a team in the

Government would oversee all the contracts. Is my memory right and, if so, two years later, what has happened to that team in respect of the contract that we are considering?

Caroline Gardner: I caveat my remarks by saying that we are looking at the wider follow-up of those recommendations and we are not in a position to report on that yet. Having said that, the information systems investment board was a new part of the governance arrangements that were envisaged for large IT contracts, and the business case for the programme was approved by that board in December 2012. We hope that that has improved some aspects of governance, although it is clear to us that some problems with governance remain. The committee will be hearing from me over the next few months regarding problems with other large IT investments.

There seems to be something systemic happening here, which we and the Government need to get to grips with, not only because there are often significant unanticipated associated costs, with benefits not being achieved, but because of the wider question of how public services respond to the continuing financial pressures that we know will be in the system for the foreseeable future. That will have to depend on making better, more creative use of IT. Collectively, we are not very good at that. I do not want to pre-empt the question of how well the recommendations have been responded to, other than to say that there is clearly still a systemic problem that has not been resolved.

Gemma, do you want to add to that, drawing on the work that you have been doing so far, or would you rather hold your peace until we are ready to report?

12:00

Gemma Diamond: I would probably rather hold off. We have seen elements of what the Government said it would do after our 2012 report, for example with regard to the information systems investment board becoming a significant part of the governance process for IT projects within the Scottish Government. As we follow up our recommendations in the round, we can see what improvements have been brought to the process.

Mary Scanlon: I find this quite disappointing. We were assured that that crack team from the Government would ensure that the errors of the past would be unlikely to happen again in future. Your report mentions a programme that

“will carry significant risk right up until implementation and beyond.”

I noted the assurance that the new Government team overseeing contracts would be quite rigid, and I put my trust in that. I am disappointed at what we see, and obviously more must be done.

The Convener: Do you have anything to add, Bruce?

Bruce Crawford: I will leave it until agenda item 6, given the time.

The Convener: I thank the Auditor General and her colleagues for their contribution.

Major Capital Projects

12:02

The Convener: Item 4 is on major capital projects. The latest report has been circulated. I invite comments or questions.

Mary Scanlon: Just to maintain consistency for the three years that I have been on the committee, I will mention two items. The first is the new prison for Highland, for which £40 million was allocated in 2009; £62.8 million is allocated in 2014. The current project status is given as “In Preparation”. Five years on, there is an increase of £43 million and the project is still in preparation.

My second point, which I have raised on all these occasions, is about the dualling of the A9. One of the projects was on the section from Kincraig to Dalraddy, and I am pleased to note that that is on-going. The other, more significant, section of the dualling that was mentioned previously was from Luncarty to Birnam, but that has disappeared. I would like an update on what has happened with that previous commitment for the road between Luncarty and Birnam. I am very pleased that the work between Kincraig and Dalraddy, which is about 3 or 4 miles, is going ahead, but, from memory, the distance from Luncarty to Birnam is about 10 to 12 miles, and I think that that is the most congested part of the road.

The Convener: We can clarify the matter with the Scottish Government. There could be a number of issues. One might be that the amount does not meet the minimum requirement for reporting; the other is that the process has not yet reached the outline business case stage. As I say, we can clarify that.

Mary Scanlon: I emphasise the point that the section from Luncarty to Birnam is three times the length of the section between Kincraig and Dalraddy, which is why I mention it. It will be two to three times the cost.

The Convener: We will clarify that with the Scottish Government.

Ken Macintosh: I want to clarify a couple of issues. I note the new format that I think we are going to adopt. Is my understanding correct that we are going to have an evidence session on the next occasion, in six months’ time, with the ministers or the Government officials responsible?

The Convener: An update is due in March 2015.

Ken Macintosh: Right. The update document is clearly useful, but I am still slightly concerned about how much it flags up change, delays and slippage. We can see some examples, but I would like the one about Inverness College clarified—perhaps Mary Scanlon could do so.

The Convener: Which page is it on?

Ken Macintosh: It is pages 31 to 32. The document is laid out in such a way that the Government is supposed to flag up in the annex the projects in which there has been a change. For example, the completion date for Inverness campus, which I assume is a Highlands and Islands Enterprise building, appears to have slipped from May 2013 to November 2014. Inverness campus is not the same as Inverness College and has a separate entry in the document.

Mary Scanlon: Highlands and Islands Enterprise has an input into Inverness campus.

Ken Macintosh: Yes. Clearly, a number of dates have slipped, but that information emerges towards the back of the document. I am not 100 per cent convinced by the way in which the document is laid out that everything is immediately transparent. For example, I have a question about the south Glasgow hospitals project at the Southern general.

Bruce Crawford: What page is that on?

Ken Macintosh: Page 26, but it is also on page 5. It goes back to my worry about what we are saying about these projects. The document seems to give us at least some indication of what has happened over the past six months, which is useful, but it does not really give us a starting point and an end point.

When the plan was first drawn up—excuse me, but this is etched on my mind because it was of great political significance to me—and the decision was made to house the new hospitals at the site of the Southern general, the cost was estimated at—I think—£260 million. The decision to locate the new hospitals at the Southern general site was taken on the grounds of cost because that location was seen as being about £10 million or £11 million cheaper than another location. However, within a year or so, the estimated cost had risen to about £360 million.

In 2007, the project was going down the line of producing a public sector comparator figure for a non-profit-distributing programme, which is where the figure of £841 million came from. The estimate went from £260 million to £360 million and then to £841 million, which is a comparator figure that I assumed was the cost of the NPD route. The project then went back to being a traditional capital procurement one, yet the cost stayed at £841 million. I have to be honest: I have never quite understood how those jumps were made. The current cost is more than three times the original cost.

The costs were all in the public domain and were hugely debated. They were debated intensely in Parliament and in the local area where I live. This is the sort of thing on which I would like further information. I want to know how we got to this point. I am not sure whether it is a question for the Government or for the Auditor General for Scotland, but it is the sort of issue on which I would like further information. This document does not really satisfy. It sort of offers an assurance, but I do not find it assuring. How would I be able to pursue my concern about the south Glasgow hospitals project?

The Convener: There are a number of different points here. There may well be particular issues that you want to follow through as an ordinary member of the Scottish Parliament. As far as the committee is concerned, it would not be for Audit Scotland or the Auditor General to answer the specific points that you raised; it would be for the Scottish Government to do so.

You asked a specific question about how the costs for the south Glasgow hospitals project went from the original figure to the figure that included an amount for NPD calculations, then stayed with the same figure although the project had reverted back to being a capital one. The only way in which we can get that clarified is to write to the accountable officer and ask for clarification on it, and we can certainly do that.

You may want to pursue the wider issues yourself, but we will have a chance to raise some of them when we have an oral report in March 2015. There are issues that you might want to pursue, but we will ask the accountable officer specific questions on them.

Bruce Crawford: I think that that is a wise piece of advice for us. What we have been asked to do is look at how the update document is laid out and see whether we are capable of interpreting it as showing enough differences to flag up to other people.

The Government has been on a journey with this committee—since before I became a member of it—trying to produce improvement after improvement after improvement on how the information in the update document is laid out. Frankly, I do not know where else the Government can go now to improve the report or provide more detail without it becoming more burdensome than we require. From what I can see, the information on the new south Glasgow hospitals tells us when construction was started, when the project went to market, what the overall costs are and that a full business case is now available. Any member of this committee could seek that out to see what the variances are.

I am happy with the update document's general direction in terms of how it is laid out. I, too, could crawl through it and look at every single project that is relevant for my area and my constituency, but it is not my job to do that here.

The Convener: We can also ask Audit Scotland for its comments on whether the document is an improvement in reporting terms and whether it helps us to identify issues. I accept what Bruce Crawford has said, which is that it is not necessarily our job to go to through everything with a fine-toothed comb, but at the same time it is appropriate for the Audit Committee to identify and address areas of concern.

We can also seek comments from Audit Scotland, but for the moment—

Ken Macintosh: Can I make another comment?

The Convener: Yes.

Ken Macintosh: The other material that goes with the document is the programme delivered by the Scottish Futures Trust on the hub projects. That information is produced online but, again, the difficulty with it is that it does not draw attention to slippage on dates and increased costs. That is the fundamental problem. It is not about whether projects are desirable or otherwise; it is about whether they are being managed properly.

I still have a problem with the updates on major capital projects. The difficulty with the process of information coming to this committee is that it implies in some way that we are approving or auditing it, or giving it some sort of official imprimatur. I do not think that we are doing that in this case. I just want to raise my concerns about the lack of information and the lack of scrutiny that we and the Auditor General are able to apply to the projects concerned. Just to round off my comments, I note that we are talking about billions of pounds of public money here.

The Convener: It is useful to put on record that what we are not doing in considerations such as this one today is giving an imprimatur that indicates whether we think that the figures or the progress are acceptable. We are considering a report that is trying to lay out in a more helpful way the progress that has been made. There are a number of parliamentary routes available to members of other committees to pursue some of the report's information. However, where we identify a problem, we can legitimately ask questions on it. We will have the opportunity to do that when we have the next oral update in March.

It would be wrong to suggest, however, that every time we get the update report on major capital projects it is up to us to go through each item or that, if nothing is said on one, that

indicates the committee's approval. That is not the purpose of our consideration.

We will seek clarification from the accountable officer on the report but, otherwise, I suggest that we note the report. Is that agreed?

Members *indicated agreement.*

The Convener: Thank you for that. We will move into private session for the next agenda item.

12:14

Meeting continued in private until 12:46.

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