The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 5 November 2014

Session 4

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PUBLIC AUDIT COMMITTEE
17th 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:

Stephen Boyle (Audit Scotland)
Caroline Gardner (Auditor General for Scotland)
Jillian Matthew (Audit Scotland)
Liam McArthur (Orkney Islands) (LD) (Committee Substitute)
Tricia Meldrum (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 5 November 2014

[The Convener opened the meeting at 09:32]

Decision on Taking Business in Private

The Convener (Hugh Henry): Good morning and welcome to the 17th meeting in 2014 of the Public Audit Committee. I have received apologies from Tavish Scott—Liam McArthur will attend at some point. I also have received apologies from Bruce Crawford; David Torrance is here in his place. I ask everyone to switch their electronic devices to in-flight mode, so that they do not interfere with the electronic equipment.

Do members agree to take items 5, 6 and 7 in private?

Members *indicated agreement.*

Section 23 Report

"NHS in Scotland 2013/14"

09:33

The Convener: I welcome Caroline Gardner, the Auditor General for Scotland, Tricia Meldrum and Jillian Matthew. I invite the Auditor General to make opening remarks.

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

The national health service in Scotland plays a significant role in the lives and work of millions of people every day, and it is essential that the service is able to meet the needs of the population and deliver good-quality healthcare. Spending on the NHS accounts for about a third of the Scottish Government's total budget.

My report comments on the performance of the NHS in 2013-14 and on its future plans. The overall message is that the NHS in Scotland faces significant pressures at the same time as it needs to make major changes to services to meet future needs. We know that NHS boards are finding it increasingly difficult to cope with those pressures in a tightening financial situation. The report also comments on the increasing evidence of pinchpoints in the complex health and social care system, which can lead to delays in patients getting the care that they need in hospital or in the community. Some of those pinchpoints are shown in exhibit 13 on page 40 of the report.

We found that NHS boards in Scotland delivered a small surplus of £23.4 million, against an overall budget of £11.1 billion in 2013-14. All NHS boards met their financial targets, but several boards required additional funding from the Scottish Government or relied on non-recurring savings to break even.

Despite significant efforts, the NHS did not meet some key waiting time targets in 2013-14. We consider that the current level of focus on meeting waiting time targets may not be sustainable when combined with the additional pressures of increasing demand—such as from the growing older population—and tightening budgets.

We highlight in the report that increasing numbers of people being admitted to hospital from accident and emergency departments, rising numbers of delayed discharges and more demand for out-patient appointments are creating blockages in the system, which put further pressure on services. NHS boards need a more detailed understanding of current and future patient demand, of how they use their capacity and of how patients move through the system.

That will help them to assess how they can deliver services differently in the future better to match needs.

The NHS has made good progress in improving outcomes for people with cancer or heart disease, and in reducing healthcare-associated infections, but progress has been slow in moving more services into the community. Further significant change is needed to meet the Scottish Government's ambitious 2020 vision for health and social care. It is clear that the NHS will not be able to continue to provide services in the way that it currently does. We recognise that it will be challenging for the NHS to make the scale of changes that will be required over the next few years, but doing so will be critical if it is to meet the 2020 vision and the future needs of the population.

We make a number of recommendations in the report. They focus on NHS boards working with their partners to develop clear plans about how they will deliver sustainable and affordable services in the future, including how they will release and move funding to provide more services in the community. We also recommend that NHS boards and their partners use information better to understand where the blockages in the system are that lead to problems such as people having to wait in hospital for longer than they need to.

Looking at the bigger picture, the NHS needs to take a step back and look at what it is trying to achieve. It also needs to develop clear long-term plans for delivering sustainable and affordable services for the future. As part of that, we have recommended that the Government reviews its performance framework to ensure that targets and measures for the NHS are consistent with and support its 2020 vision.

As always, my colleagues and I are happy to answer questions.

The Convener: Thank you.

You mention that the waiting time targets may not be sustainable, yet we know that the setting of targets has had a remarkable impact on service delivery. We need only think back some years ago to the waiting times that people used to have for treatments that are now seen as relatively routine things that can be done quickly. If you think that the targets may not be sustainable and if it is accepted that targets have made a contribution by improving the service for patients, what is the solution?

Caroline Gardner: It is important for us to be clear that we are not saying that targets are not important and may not be useful. We know, for example, that waiting times matter to all of us and our family and friends in knowing how quickly we will be treated and ensuring that we are treated as quickly as possible. However, after a long period in which, as you said, waiting times across the system have been coming down, that trend is starting to be reversed.

We have particular concerns about increasing waits for out-patient appointments when people enter acute hospital care and about delayed discharges when they are waiting to go home. Our concern is that the focus that people in the health service are putting on meeting those targets is making it harder to step back and look at how the acute system as a whole is working, and at how it fits into the wider system of health and social care. With the tight budgets that we know are likely to be in place for the foreseeable future and the growing needs of older people, our concern is that balance may not be sustainable. We are not saying, "Do without the targets." We are saying, "Make sure that the targets are achievable and moving the health service in the right direction."

The Convener: Which is the most critical factor—increased demand for services or squeezed budgets?

Caroline Gardner: It is a combination of all the factors; it is not possible to pin down the contribution that each of them makes. We know that the Scottish Government has protected the NHS revenue budget with slightly above-inflation increases year on year. We know that healthcare costs tend to go up faster than general inflation, so that money is not going as far as it would do in other services. We also know that the population is getting older, and older people tend to have more complex healthcare needs. We have more challenging waiting time targets now, and we outline in the report how some of the targets have got tighter over the past few years. All that together is contributing to the picture of increased pressure that we are painting today.

The Convener: When we look at exhibit 5 on page 23, we see particular issues in some health boards compared with others. For example, in NHS Grampian and in NHS Greater Glasgow and Clyde, there are a number of areas in which we see a deterioration, no improvement, or just a failure to meet the targets. NHS Forth Valley also has significant areas of concern. Are there specific reasons in those health board areas? Is it a management issue? Is it a budget issue? Why do those issues arise in some boards and not others?

Caroline Gardner: There are specific issues in specific boards across Scotland—that will always be the case—but we believe that the evidence shows pressure on the health service right across Scotland. Later this morning, you will be looking at section 22 reports on NHS Highland and NHS Orkney, which suggest that the pressures that are coming out there particularly strongly are financial pressures. For the boards that you have

highlighted in exhibit 5, I think that the pressures are coming out particularly in clinical performance, especially with regard to waiting time targets.

We highlight other boards that have had an increasing focus on non-recurring savings or support from the Scottish Government to balance their budgets. One of the lessons that we have learned in recent years is that it is risky to look at financial performance or service performance in isolation. You have to look at the picture in the round, and all the evidence suggests to us that there is increasing pressure in the system.

The Convener: At paragraph 48, you mention that the NHS

"spent £128 million on bank and agency nursing and midwifery staff in 2013/14, an increase of 15 per cent".

That is a staggering figure, yet at the same time, in exhibit 7 on page 28, you show that the number of nursing and midwifery vacancies is rising. There is an increase in vacancies and we are using more private staff. Why can we not simply recruit some of those private staff to fill the vacancies?

Caroline Gardner: In general terms, there are often occasions when using temporary staff is a good thing because there are peaks in the workload. For example, when long-term sickness absence needs to be covered, in our view using bank staff is the preferred option. Bank staff tend to cost less than staff from private agencies and, because they are on the hospital's own bank, they tend to know the hospital and its safety and quality procedures better. The question is why there is overall pressure on nursing staffing and how it can best be managed.

The Convener: I understand that but, in paragraph 48, you also say that spending on agency staff increased by 46 per cent, and that followed a rise of 62 per cent in the previous year. We are not talking about marginal and trivial changes; we are talking about substantial changes.

Caroline Gardner: Absolutely, and that is why we have drawn attention to it in the report. Spending more on agency staff in that way is a pressure on the finances of the NHS; it also brings additional risks to patient safety, because the bank staff are less familiar. I ask Tricia Meldrum to talk you through the background.

Tricia Meldrum (Audit Scotland): Prior to the past two years, the general direction has been that we recognise that there is a need for some flexibility around the nursing and midwifery staffing and that has come largely through the bank staffing; the staff are people who are already employed by boards, are already working there and can do some additional hours. That is seen as being the more efficient and effective, and the safer, option. Obviously, the bank has not been able fully to meet the needs and that is why we have seen an increase in the use of agency staffing. Sometimes that is in very specialist services where one would not expect bank staff to be available. That can be an issue, but it is an indicator of increasing demands and pressures. It is still a very small percentage of the overall spend, but we have highlighted it because of the change in the trend that reverses what has been happening in recent years.

09:45

Mary Scanlon (Highlands and Islands) (Con): I want to return to information technology. The committee has talked about IT a huge amount and it seems that lessons are never learned—we are always told that next time round all will be fine.

Case study 3 on page 15 is on "NHS 24's Future Programme". It states:

"NHS 24 has delayed implementation as it considers that the new application … developed does not meet … patient safety".

The original business case was £29.6 million, but the total cost to date is £38 million. The report goes on to say there is

"brokerage of £16.9 million and £0.8 million in revenue funding"

and then a further £2.2 million. The original business case was £29.6 million. How much is this costing at the moment? When is it likely to be finished? Have lessons been learned? What is the final cost and why has it gone so badly wrong?

Caroline Gardner: There is a limit to what I can say about that particular case at the moment, Mrs Scanlon.

The Convener: There is a court case and some of this may be sub judice, so I think that we must bear with the Auditor General in any comments.

Mary Scanlon: I was not aware of that. It is on the record, but can we flick over carefully from that one? I apologise, convener.

The Convener: Okay.

Caroline Gardner: We will report more in due course when we are able to do so.

Mary Scanlon: It is certainly worthy of further investigation, so I will watch that carefully.

I appreciate that we are coming to NHS Highland under the next agenda item. However, NHS Highland was being told 15 years ago that it should not depend on non-recurring savings. That was in 1999-2000, but it is now 2014. NHS Highland is not the only one; I mention it because exhibit 3 on page 17 shows that many boards are dependent on non-recurring savings, obviously

apart from NHS Greater Glasgow and Clyde and, to an extent, NHS Forth Valley. Why is this still happening when it was a problem 15 years ago? Nothing seems to have changed.

Caroline Gardner: It is a concern for us across Scotland. I think that you are referring to exhibit 3, which shows that NHS boards across Scotland are relying on non-recurring savings to varying extents. They can be a useful way of balancing the budget in year, but they add to the pressures on health boards in the longer term, because those savings must be found again in future years. That is why we have made recommendations about improving both longer-term and in-year financial planning. Not only does it take pressure off in future years, but it makes it more likely that savings are helping to reshape the services for the medium term, rather than running the risk of making that more difficult by making easy cuts that may well make it harder to develop community-based services and new types of service for the future.

Mary Scanlon: That could explain why NHS Highland is facing the pressures that it does, but I appreciate that that is for the next agenda item.

I turn to exhibit 5 on page 23. I notice that NHS Grampian has not achieved any of its targets for 2014 and that NHS Highland has achieved only two. No health board has achieved the out-patients target for within 12 weeks. Five out of 14 boards achieved the day-case treatment time guarantee target. Five out of 14 met the accident and emergency target. On urgent referral to first treatment for cancer, the figure is also five out of 14—almost a third. For delayed discharge, it is three out of 14.

The report states:

"Performance against some waiting time targets deteriorated".

Having read these reports annually, I wonder whether the waiting time targets are too stringent, or is the money simply not there? Why are things getting worse rather than better? Is it a management problem? Is it a financial problem? Is it how we do things? Every time that we come to this, there are a myriad problems, which we are told will all be sorted by next year. Then the next year comes along and we are full of optimism, but things have deteriorated again. Why have most health boards not achieved their targets? I appreciate that there are difficulties with Grampian and Highland, because they do not receive their full national resource allocation committee allocation.

Caroline Gardner: There are a combination of factors, which apply across the health service but apply to differing extents in individual boards.

First, we know that finances are tight. The Government has protected NHS revenue budgets for the front-line delivering boards, with increases that are slightly above inflation, but healthcare inflation tends to be higher than that. We know that the population is getting older, so there are more old people who tend to have more complex needs and who need more support to be discharged from hospital once admitted. We also have particular financial pressures in some boards, such as those that are below their NRAC allocation, which adds to their challenges. You can see from looking across the table that some boards are managing better than others, and we have talked before about examples of how services are being delivered and redesigns that help to manage those pressures at a local level.

The NHS as a whole is doing some work to improve its understanding of patient flows and the pinchpoints. Some of the targets have become more stringent over the past few years, which is why we suggest that it is time to take a step back and to ensure that the balance of targets, the available funding and the longer-term vision to reshape healthcare are all in the right place to be able to work effectively, rather than running the risk of inefficiency by focusing on an individual target at the expense of the bigger picture.

Mary Scanlon: Looking at this report, it does not seem to be progressing, but let us have hope for the longer term.

My final point is on exhibit 13 on page 40, which I thought was quite interesting. It is about digging below the figures, quite a few of which stood out, but I am sure that colleagues will raise issues about them, too. In the bottom right, in one of the red boxes, it states that there has been a 4,200 per cent increase in the number waiting for more than 12 weeks. We would always like to think that the focus is on clinical need rather than on meeting targets, but that seems to suggest that more and more people are having to wait for longer than 12 weeks and are perhaps just being treated before the day of the target in order to come in on target. That is a huge increase. Does that mean that, regardless of their clinical need—I am putting words in your mouth, but this is how it appears to me—more and more people are having to wait for the target to kick in, rather than being treated on the basis of their need? A figure of 4,200 per cent is one of the highest that I have ever seen as far as a change within one year is concerned. Am I misunderstanding that, or could you explain it and clarify it?

Caroline Gardner: We can do; I will ask Jillian Matthew to come in on that specific point in a minute. More generally, we are trying to ensure that we understand the way in which this complex system works in practice, because we know that

some targets are being met by most boards, although not all of them, but we are seeing these warning signs of pressure building up for out-patients waiting for their first appointment, and delayed discharges of people waiting to leave hospital safely at the end of their treatment.

The convener asked earlier whether the targets were a good or a bad thing, and the answer, of course, is that they are both. It matters to all of us that we are seen as quickly as possible and that we have some certainty.

Mary Scanlon: I think we would all agree with that.

Caroline Gardner: Indeed, but equally having a target that is unachievable—so that people's efforts simply go on meeting the target, rather than on ensuring that the whole system can work smoothly—is not helpful.

We have tried to identify where the pinchpoints are—where there appears to be real pressure in the system—and where the risks of managing to the target may be higher than they would be elsewhere, when a system is running in steady state. Jillian Matthew will pick up the specifics of what is happening with that particular aspect.

Mary Scanlon: Some clarity would be helpful, thank you.

Jillian Matthew (Audit Scotland): The figure that you referred to is around out-patient waiting times for 12 weeks. On page 24 of the report, we lay out some of the figures around what is happening there. The number of people is increasing at a much higher rate than the number of people who are being seen, but that is going back to the overall increase in demand from various issues around the ageing population and more people with long-term conditions.

With exhibit 13, as the Auditor General said, we were trying to show overall where some of the main pressures are for the NHS. Out-patients was one of those pressures, along with delayed discharges and increasing numbers being admitted from A and E, especially older people. Out-patients is one of the areas in which we are seeing the pressures, but the boards are trying to look at the whole system. In the past, the boards would have looked at separate areas such as A and E and what is happening in out-patients, but they are starting to look at the whole system.

Work is going on, and the Government is supporting some boards in piloting a new approach to look at the whole system, patient flows, what is happening in A and E, what impact that has on in-patients, out-patients and community care, and how that is all joined up. That work is quite early, but there is quite a lot going on around understanding that better.

Mary Scanlon: That relates to my previous question, and to the fact that no board met its out-patient target.

Am I right in saying that, in March 2010, 157 patients waited for more than 12 weeks, and that in March 2014, 6,754 patients waited for more than 12 weeks? Let us say that everyone who goes for a hip operation has different levels of pain and need. Does it appear that clinical need is being surpassed to meet targets, because more people are waiting for more than 12 weeks? It is significantly more—4,200 per cent more. Is there a distortion?

We all agree on targets. No one wants to go back to a two-year wait for orthopaedic surgery, but at the same time we do not want the urgent cases to be lumped in with the 18-week target. This seems to be the first indication that I have seen that everyone, regardless of need, has to wait longer than 12 weeks. Am I interpreting that wrongly?

Caroline Gardner: No, but we have not found evidence that people are being managed to the target or, for example, that people with less need are being seen sooner than people with greater need just because of the target. However, we are seeing that increase in the number of people who are waiting for more than 12 weeks—the number is still relatively small if you compare it with the 350,000 or so people who are being seen as out-patients each year, but it is going up markedly. As Jillian Matthew said, more people are being added to the out-patient waiting list than are being taken off it, so at the moment the trend is for that number to keep increasing.

That is the pinchpoint that we wanted to identify in the report as one of the signs of the system being under pressure. It may be that the 12-week waiting time target is not quite right. It may be that the targets for treatment after that could be adjusted. We think that the Government needs to take a step back and say, "How do we get the system in balance? How do we make sure that the targets we are setting are helping us to reshape the service for the 2020 vision rather than making it harder?" We think that that is the risk at the moment.

Mary Scanlon: Do you agree that the increase is significant?

Caroline Gardner: It certainly is.

Colin Keir (Edinburgh Western) (SNP): We are getting the percentages and the amounts, but what is the total through number of out-patients in the service? That will give us an idea of how many people out of the total are failing to meet the target.

Caroline Gardner: The number of new out-patients seen during 2013-14 was 367,259 so, as I have said, the number of people waiting more than 12 weeks is a relatively small number at 6,754. It is increasing, however, and the current trend is that it will continue to increase.

Colin Keir: I am trying to get the number in perspective. Although the percentage rise may well be a trend that you have identified, in terms of the total amount going into the system, it is still a relatively small number.

Caroline Gardner: Absolutely. As I said, it is about 6,750 people out of 367,000 new appointments, but the trend is upwards.

Colin Keir: That takes me back to the question that the convener asked about bank staff and, of course, private staff. I assume that the total number that has been taken in is very low in comparison with the total staffing number for the health service, which shows that there is not—shall we say for the sake of argument?—a privatisation menu. The aim is simply to deal with the pressures that are being faced at this moment. There is no policy decision to move to using private or bank staff on a permanent basis for a service.

10:00

Caroline Gardner: As Tricia Meldrum said, the £128 million spent on bank and agency nurses last year is a relatively small amount in the overall spend on the NHS, and the evidence available to us suggests that it is meeting short-term needs for staffing in different health services.

Colin Keir: My next question is about something that has come up over the past couple of weeks in various places. Reducing Westminster budgets have meant a 10 per cent reduction in Scotland's overall fiscal budget—the cash revenue and capital combined—between 2010-11 and 2015. That has meant a capital cut well in excess of 20 per cent. As the Scottish Government is using non-profit-distributing programmes to ensure that investments in NHS infrastructure are carried on, would you consider the equivalent capital value in future NHS budget assessments?

Caroline Gardner: The report looks at the amount that came out of the information from the audits of all NHS boards last year. You might recall that we reported last year on a wider basis across the Scottish budget about the importance of improving and increasing transparency, particularly about revenue-financed investment.

We know that the capital budget is decreasing and that, for the known planning period, it will be reduced. For understandable reasons, the Government is investing in other ways through the NPD and other models and is planning to use the new borrowing powers that it has under the Scotland Act 2012. All those are entirely appropriate policy choices for any Government to make but, in my view, it is important to have transparency about that spending, what we are getting for it and what the long-term revenue commitment is, to enable the Parliament to understand the context of the Government's financial decision making and the longer-term choices that that involves.

Colin Keir: I am asking about keeping a broad perspective on how the Government is dealing with the problems of diminishing capital investment.

Caroline Gardner: We have tried to give as much information as we can in the report about the revenue and capital budgets and about outturns. There has been a further announcement just in the past few days about new health service investment coming from the NPD model. That is not included in the report but, as it comes through the NHS accounts, it will be in the future.

Colin Keir: So you would put that into this sort of report in the future.

Caroline Gardner: As investment comes through the NHS accounts, it is always included.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I am looking at paragraph 13, at the top of page 16, which is on the allocation of funding. The Scottish Government is aiming for all NHS boards to be within 1 per cent of their allocation by 2016-17, which is not very far away. At the moment, four bodies are below their target allocation. Two of them—NHS Highland and NHS Orkney—are featuring today under agenda item 3 because of a funding issue. Is the target realistic? NHS Highland and NHS Lanarkshire seem to be going the wrong way. Is there a plan? Have you seen it?

Caroline Gardner: We understand that the plan is for each board to be within 1 per cent of its allocation by 2016-17. The background is that the formula has been in place since 2009-10. It takes account of the make-up of the population, levels of deprivation and other health needs, and the costs of providing services in remote and rural areas. The intention is that each board should be funded on that basis by 2016-17. At the same time, we know that the Government has made an explicit declaration of policy that, in moving towards that aim, it does not want to destabilise individual health boards and particularly those that would lose by having money moved away from them. The formula is a way of allocating the overall NHS pot and not of providing more money to the boards whose allocations are currently below their formula level.

We understand that the policy intention is in place. I think that we have seen additional funding to NHS Grampian in recent months to help it to move forward more quickly, in recognition of the clinical challenges that it has faced. In broad terms, it is a policy decision for the Government to make about how quickly to move towards the intention and what exceptions it might make in either direction for particular boards.

Colin Beattie: Just to be clear, the funds—there is quite a bit of money there—have to move from other parts of the national health service to achieve the aim.

Caroline Gardner: Yes. The formula is a way of allocating the overall NHS budget, not of adding new money into the system.

Colin Beattie: There has been some talk about bank nurses and so on. The last sentence of paragraph 48, on page 29, says:

"Agency staff are likely to be more expensive than bank nurses, and also pose a greater potential risk to patient safety and the quality of care."

Why is that the case?

Caroline Gardner: That is because bank nurses are employed by the local NHS hospital or system. They are on the bank permanently, so there is the chance for proper induction, for continuing training and development and for them to build up their awareness of things such as the crash procedure, if somebody has a heart attack on a ward, and how things are done to maintain drug safety on ward rounds.

Agency staff are employed by a private agency. They tend to be used for shorter periods and in different areas of the health service, so they do not have the opportunity to be trained and inducted in the same way or to build up their experience of how the system works. The broad professional consensus is that bank staff are cheaper and can provide a better quality of care. Agency staff may be needed on occasions, but they should be a last resort that is used when needs cannot be met from bank staff.

Colin Beattie: Agency staff are increasingly being used. You say in paragraph 48 that the spend on them has increased by 46 per cent. Surely they are trained up to the same standards as NHS staff. Surely it is in the agencies' interest to ensure that they are trained in NHS procedures. I am concerned about the comment on patient risk.

Caroline Gardner: You are absolutely right—agency staff are trained to the same standards as nursing staff across Scotland, and a good agency has every incentive to invest in professional development for its staff. The issue is familiarity with how things work in a hospital, a speciality and a ward, and the ability to build up experience of knowing where the drug cart is, what the processes are and about the other members of the team, which are also important elements in the quality of care for patients. It is that familiarity more than anything that makes the difference.

Colin Beattie: So the issue is nothing to do with the skills of the agency nurses who are employed; it is to do with the short-termism of their attachment and their potential unfamiliarity with the area that they are working in.

Caroline Gardner: That is right.

The Convener: Can I clarify the reference to the evidence for the report's comment? Is that evidence from the 2010 report "Using locum doctors in hospitals"?

Caroline Gardner: Yes. We did work on bank and agency nurses further back than that, so we have been building our expertise in that area over a long period.

The Convener: So there is evidence about nursing staff as well as doctors.

Caroline Gardner: Yes—very much so.

Colin Beattie: Paragraph 59, on page 33, deals with pensions, which have come up before. Public sector pensions are quite a big issue, because almost every area is running a deficit. You have not quantified any deficit in the NHS. Do you intend to do any work on public sector pensions in the future?

Caroline Gardner: We have not quantified the deficit in this report because we have focused on changes and future pressures. We have reported a couple of times on NHS and public sector pension schemes more widely.

One challenge for the NHS scheme is that it is not a funded scheme, so there is a large liability, but there is no asset against which to match it. The challenge is ensuring that the liability is understood and that its long-term cost implications are being factored into long-term financial planning. There are moves across the United Kingdom to make changes to pension schemes—both to the way in which costs and benefits are shared and to the way in which they are funded, to make them more sustainable in the long term—but the NHS scheme is currently unfunded. The report refers to things that are changing the pressures that health boards face.

Colin Beattie: If the scheme is unfunded, does that mean that there is no pension pot?

Caroline Gardner: You are right.

Colin Beattie: So pensions are paid out of revenue.

Caroline Gardner: Yes.

Colin Beattie: That is quite a big liability.

Caroline Gardner: It is, and that is the case for most public sector schemes, apart from the local government one. The local government superannuation scheme is the only one with a pension pot to match the liabilities, but all the others are paid from revenue, which is why we have reported in the past on how the overall liability is being managed, and why we have focused in the report on how the costs of meeting that liability are increasing because of known changes that are coming through.

Colin Beattie: I realise that this is a UK-wide issue, but did you say when you were thinking of doing the next review of public sector pension liabilities?

Caroline Gardner: We keep that under review all the time, because it is significant. We are likely to include information on it in our next report on developing financial reporting, which is due in the new year. I have not made a decision on doing another in-depth look at pensions, but that might well come up in the programme in the next couple of years.

Ken Macintosh (Eastwood) (Lab): There are a number of worrying comments in your report. Am I right in thinking that there have been about 2,000 fewer beds over the past four years in our health service?

Caroline Gardner: That number sounds right; I will ask colleagues to keep me right on the detail. We have reported to the committee before that a large part of that decrease is because there is very much a move from surgery being provided on an in-patient basis to day surgery. The number of beds has decreased, but the impact is not the same as might appear on first impressions.

Ken Macintosh: You say that people are moving away from being in-patients, but you also point out that there is a huge increase in out-patients, that no one is meeting their out-patient targets and that the length of out-patient waiting lists has increased from 187,000 to more than 250,000.

Caroline Gardner: As I said earlier, it is clear that one of the pinchpoints in the system is the time for which people are waiting for out-patient appointments. That is partly to do with the fact that, as a population, we are ageing, and older people tend to have more complex health needs and to make more calls on the health service. That is one of the pressures that underlie the challenges that health boards are facing in balancing their budgets, meeting targets and reshaping services for the future.

Ken Macintosh: There are fewer beds and out-patient waiting lists are getting longer at the same time. Is the Government addressing the issues? Do you detect that there are initiatives in place to address those problems?

Caroline Gardner: In part 2 of the report, we say quite a lot about what the Government and health boards are doing to manage the challenges. We mention the QuEST—quality and efficiency support team—work that is being done with NHS Forth Valley and some other boards to understand the flows of patients, where their pinchpoints are and how they can manage those pinchpoints. Work is going on.

My concern in the report was to say that, even with that work, it feels to us that the combination of the tight budgets that we face, higher healthcare inflation, an ageing population and tight waiting times targets is making it harder to reshape services in the way that they need to be developed for the future. Work is going on, but the question is whether the big picture is sustainable as it stands.

Ken Macintosh: I will return to that in a minute. Is the Government aware of—or doing anything about—the fact that out-patient waiting times are rising?

Caroline Gardner: Yes. We say in the report that considerable efforts are going on across the NHS to manage individual waiting times targets and the broader HEAT—health improvement, efficiency and governance, access and treatment—targets, which do not focus just on waiting times, and to meet the financial targets. A huge amount of effort is going into that at health board level and in the Government. The challenge is whether that is possible to do, and particularly whether it is possible to do while making quite significant changes to move more services into the community to help us all to live longer and healthier lives at home. Our concern is that the focus on short-term targets is making that harder.

Ken Macintosh: Pardon me if I am getting this wrong, but I should have thought that out-patient activity would increase if we were going to a different model that moved away from in-patient care—you have pointed out that there are 2,000 fewer in-patient beds—to more out-patient care. The Government is supposed to be addressing the issue, yet every single board is missing its target. Why is it getting that so wrong?

10:15

Caroline Gardner: The answer is that the subject is very complex. More new out-patients are being seen. The number of out-patients rose over three years from about 324,000 to 367,000. The numbers have gone up markedly over that period, but the number of people who are looking

for out-patient appointments has gone up faster, which is why the number of people who are waiting for more than 12 weeks has increased. The number waiting for more than 12 weeks is quite small, but the trend is in the wrong direction.

The challenge is not just to meet the out-patient target but to develop the whole system, so that people can be seen as out-patients, receive the treatment that they need—whether that is as an in-patient or a day case—and be discharged safely home, while at the same time services are reshaped across the piece. That is a complicated thing. It would be hard to do in any circumstances but, when budgets are tight, it is that much harder.

Tricia Meldrum: The QuEST team that we talked about has quite significant programmes of work on supporting changes and redesigning out-patient services. The case study about fracture clinics on page 25 is one example of how a board is trying to release capacity by preventing people from having to go to out-patient clinics. We know that there is also quite a big drive towards increasing use of things such as telehealth and telecare, which help people to avoid having to come into hospital in the first place. Quite a number of programmes of work are aimed at reducing some of the pressure.

Ken Macintosh: One pressure that you identified is delayed discharge—it was called bedblocking in the past. Bedblocking has been around for a long time, yet you say in the report that it has increased over the past five years, despite the political and Government attention that it is supposed to be getting.

Caroline Gardner: The number of delayed discharges came down for a period and now the trend is going in the wrong direction again. Once more, we think that that is one of the signs of pressure on the system. Discharging people from hospital needs to be done quickly and safely; they need to be able to get things in hospital and those things need to be right. There also needs to be an assessment of the services that they need in the community, and those services need to be available.

The report focuses on the NHS, but we know from previous work that local government social care budgets are under pressure at the same time, because the population of older people is increasing. The system as a whole is under pressure. The out-patient waiting times for people coming in and delayed discharges for people leaving the health service both show the same picture of increasing pressure.

Ken Macintosh: You are not making me feel any better.

Caroline Gardner: It is important to say that there are no easy answers, which is why there needs to be a step back to ask how to best balance what matters to people on waiting times, access to services and the money that is available for spending on the NHS against the other services that we all rely on and the bigger picture of an ageing population that needs different services. That is a difficult set of choices for us to make as a society. There is no magic wand that will make it right.

Ken Macintosh: Indeed. You point out that delayed discharge costs £78 million. Is that right?

Caroline Gardner: I do not have the figure to hand, although colleagues will. That is the figure in the report. It is one of those classic examples of things going wrong in the system that are not only making things harder for patients but tending to cost more money. The challenge is breaking out of that system. We think that the answer is to step back a bit and look at whether the individual short-term targets are right and are helping us to make the moves that we need to make towards the 2020 vision.

Ken Macintosh: You paint a vivid picture of hard-pressed staff doing their utmost to address short-term or immediate, urgent problems, but the whole health service and care generally are creaking under the strain of demand and not enough resources.

Caroline Gardner: We know that the short-term targets are there for good reasons. Waiting time targets matter to all of us. We are asking whether all those aspects are in balance and whether, with the available funding, the milestones that the Government has set towards 2020 are likely to get us there. There are clear signs of pressure in the system financially and in waiting times. We need to step back and look at what will help us to ease the immediate pressure so that we can invest in change on the scale that is needed. That is the question that I am asking in the report.

Ken Macintosh: There are a couple of other milestones. You pointed out that the Government was supposed to get rid of all the high-risk capital maintenance backlog, but it has failed to do so. It was supposed to reduce its significant-risk maintenance backlog by 2016, but you suggest that it will fail to do so quite dramatically.

Caroline Gardner: As you say, the figures show that the backlog maintenance estimated cost has increased and that it will take longer than expected to clear the high-risk backlog. That is not surprising in the context of the financial pressures that we are talking about, but it is another pressure that has to be taken into account when setting the financial and performance targets for the health service and thinking about the investment needed for the longer term. It may be that some models of hospital care that we have in parts of Scotland are

not right for the future. That all needs to be played into the estimate of the cost and the priorities for spending.

Ken Macintosh: On a slightly cheerier note, the graph that gave me the greatest hope in the whole report is on page 34. As far as I can see, we are all going to live for ever, according to your report.

Caroline Gardner: The changes in life expectancy are startling. The life expectancy of a baby born today is decades longer than it was when we were born—I am making assumptions about our relative ages. Life expectancy is changing year on year. The General Register Office for Scotland estimates are changing very fast. That is a huge success story. We should all be proud of it and individually pleased by it, but it brings costs with it. We know that older people tend to become frail, whatever happens. We have more complex health needs and older people need different health services from 20-year-olds, who are at risk of breaking a leg or being injured in some other sort of accident. That is why the issue is so important; it is at the heart of things.

Ken Macintosh: That is greatly encouraging. Unfortunately, the previous page points out that the health budget will fall by 1 per cent over the next two years.

Caroline Gardner: We know that the finances will stay tight for the foreseeable future across Scotland and the United Kingdom. That is the case whatever scenario we might look at over the next period.

The challenge is to think through how we can manage the competing pressures. We have the ageing population and we have tight public finances. Healthcare inflation will continue to be higher. All those things mean that the questions will not go away. There is no quick fix for them. As a society, we need to debate that and make choices about it.

Ken Macintosh: The key thing is not to take a short-term approach but to look at the bigger picture. Is that your key message?

Caroline Gardner: Yes. We have been talking about long-term financial planning for a while. That is part of the key. Another issue is to ensure that we understand the impact of the short-term financial and performance targets, which are in place for good reason and are helping with the long-term picture, rather than making it harder.

James Dornan (Glasgow Cathcart) (SNP): I will go back to a point that Mary Scanlon raised, because it put in a nutshell a lot of the pressures that we are talking about. She rightly pointed out that there has been an increase in people waiting to be seen but, at the same time, there has been a 13 per cent increase in those who have gone through the system, which suggests that the health service is taking this seriously and is dealing with more people every day.

The other side of it—the increase in those waiting—shows the continuing pressures that we are under, with an ageing population and, of course, the on-going financial situation. Targets are coming up time and again. Almost every questioner has asked you about them. This is probably more of a question for the whole committee, but do you think that there is a case for the Scottish Government to come and explain to us the rationale behind its targets—why it selects certain targets and its judgment in putting those targets forward?

Caroline Gardner: That would be a really helpful conversation to have. I recall the evidence session that you had with Scottish Government colleagues a few weeks ago about A and E waiting times. They were very clear that the four-hour target for A and E is a good target, because seeing people more quickly keeps the system moving and leads to better outcomes for those patients.

There is always a judgment to be made, but we know that a number of targets elsewhere in the system have got tighter over recent years. I do not know whether the debate has been had about whether the 18-week referral-to-treatment target is the right period and about how it fits with out-patient targets and delayed discharges, but it is important for the committee to discuss the sense of the whole system and the way in which targets play into that.

James Dornan: Ken Macintosh talked about having no short-termism. Surely that is what the 2020 vision is all about—it is about looking at things in the round and ensuring that we get there. We have to deal with short-term issues, because every short-term issue is a person with a problem, but at the same time as we are dealing with those, we have a responsibility along with health professionals to ensure that, sometimes, we put away our political hats and look at the picture in the round, which is not easy for any of us. Is there anything that you as Auditor General have picked up while you have been producing the report that you would suggest is crucial or helpful to put in the mix for the discussions that we should be having?

Caroline Gardner: You have already put your finger on it. There are good reasons for having annual or short-term targets for the finances and for performance. Ensuring that those fit together in the system in the year is one important issue, and ensuring that all of them are moving us towards the 2020 vision, rather than making it harder, is the second issue.

My concern is that both those aspects look to be getting more difficult for health boards and the Government to achieve because of external pressures, such as the rate at which we are all getting older and living longer. Taking a step back and saying, "Is this moving us in the right direction towards the 2020 vision that garners widespread support across the piece?" would be an important contribution for the committee to make.

James Dornan: The only thing that I will say is that, the older I get, the happier I am with the graph that Ken Macintosh pointed out.

The Convener: That is a frightening thought.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): Hello, Auditor General. You have mentioned several times that the Scottish Government has protected, in real terms, the revenue budget, and there is evidence to support that. There are plenty of good messages in your report, including improving outcomes in cancer, heart disease and healthcare-associated infections, and increasing patient satisfaction. On page 32, you say that spending from the UK to Scotland is forecast to reduce by 0.7 per cent in 2016-17 and 2017-18. Is there a quantifiable amount of money associated with those reductions? Are those reductions compounded—in other words, are we talking about 0.7 per cent on top of another 0.7 per cent in the second of those years?

Caroline Gardner: The cumulative percentage reduction is shown on the right-hand side of the exhibit as 0.93 per cent. We can certainly put a figure on that; I am not sure that we have that information with us just now, but we can provide it. The point of the exhibit was just to give the sense that the financial pressures are going to increase, whatever decisions Government and the Parliament make about the funding for the health service in Scotland.

Willie Coffey: With regard to the discussion about targets, have you found any evidence that the failure of a particular health board to meet a particular target is having any consequential impact at all on health outcomes or patient satisfaction? Is there any evidence to support that at the moment?

Caroline Gardner: We do not have evidence of that, but it would be a useful area to explore with Government. First, we know that, for any of us, it is a disappointment not to be seen within the time that we expect to be seen within. Given that we want to be treated as quickly as we can—and that we want to have some certainty about that because it helps us make plans for the rest of our lives—the missing of targets has an impact. We know of conditions where it will have an impact, either because the condition itself gets worse or because with things such as hip or knee replacements people have to live with discomfort for longer than they should, but there are other areas where it might not make very much difference other than inconveniencing people.

The bigger question is the way in which individual targets fit together. Having a very short waiting time target for out-patients followed by a longer period for treatment might make less sense than having a longer out-patient period and then a quick follow-up, but that is really a policy and clinical decision rather than an issue for us. Because a lot of this is about patient flow, targets need to fit together throughout the system.

I come back to Mr Dornan's question about this being the time to have that debate. My sense is that people right across Scotland know that there are difficult choices to make because of all the pressures on the health service; they do not expect everything to happen instantly. If the committee were to have a public discussion about what mattered most and about how to balance the different priorities, it would be a very timely move.

Willie Coffey: We know from other data that patient satisfaction is higher than it has been for a number of years and that overall waiting times are lower. Having listened to your message about the significant pressures on the health service, I wonder where for us as an audit committee the chances and opportunities to make the greatest gains can be found. Can we make greater gains by looking at these targets? If there is no evidence to support the suggestion that failure to meet a particular target is having a consequential impact on health outcomes, do we need to look at the targets in a bit more detail? Is that where we might gain most?

10:30

Caroline Gardner: Looking at the individual targets and the way they fit together, looking at the clinical evidence and the evidence about what matters to people and asking people about this whole issue could really help to move the debate along. My sense is that people might well be prepared to wait a bit longer if they were sure that they would be seen within the time that was set. That might help the whole system to run more smoothly and would let people divert their attention to the longer-term changes that are needed instead of firefighting.

Tricia Meldrum: Some of the pressures manifest themselves in areas that are not particularly covered by targets. With regard to in-patients, for example, one of the issues that we have raised in the report is about boarding—in other words, patients not being managed in what is necessarily the correct ward or being managed

in a ward for a different speciality—which we know can have a detrimental effect on the patient experience, patient outcomes and length of stay. Some of the pressures do not necessarily come through in the targets, but they come through in other indicators.

Willie Coffey: My last point is about the Auditor General's remarks in her opening statement about the slow progress in delivering health in the community setting. I have made the same point several times at previous committee meetings. Are you getting a sense that we are making progress here, or do we need to do much more work to effect real gains in this area and influence any future report like this one that might come to the committee?

Caroline Gardner: When, back in June, we reported on reshaping care for older people, our finding then was that progress was slow. Efforts were being made, but I think that there is increasing evidence in this report that those efforts have been made harder by the need to keep the system running in the short term in order to meet short-term financial and performance targets. Taking a step back and looking at the whole system will make acute hospitals run more smoothly for everyone involved—health service staff as well as patients—as well as provide the breathing space, the money and the time for people to think about how to reshape services for the longer term. It seems to us that that is a really important debate to have, and we need to think about the best way of moving us to where we need to be with the 2020 vision.

Mary Scanlon: I have just a brief question. Like you, Auditor General, several colleagues have mentioned the ageing population. Given that, the need for home care and so on, I was a little surprised to see in exhibit 13 on page 40 that the number of care homes is down by 10 per cent and that they have 36,578 fewer residents.

Moreover, it has always been our understanding that much more personal care would be delivered at home, but that is down by 11 per cent. I think that I am right in saying that the figure is taken over the past five years, but the figure of 60,950 fewer people receiving home care is significant. Given everything that we know about demography, I had assumed that there would be an increase in care homes and care home places and a significant increase in home care, and I do not understand why the figures are going in the opposite direction.

Caroline Gardner: I think there are broadly two things going on here. The first is the increasing recognition that for many older people care homes are not the best place. If we can stay at home for longer with good quality of life, we should be doing so, and I think that that accounts for some of the fall in the number of care homes and the people who live in them.

Secondly, the care-at-home figures seem to reflect higher thresholds from local authorities. An increasing number of people who might have received an hour or two of help a week in the past are not qualifying for social care at home and, instead, care is being focused on people with more complex needs who really need that help to keep them at home.

Again, this is another sign of the pressure on the system. We know that the 2020 vision will require a much wider range of services that can provide much more flexible and responsible support to older people and keep up with their changing needs as they get older and frailer.

Mary Scanlon: What you are basically saying is that the eligibility criteria for free personal care for the elderly have increased—I should note that the convener and I were both members of the committee that passed that policy in the first session of Parliament—and that, in order to get care at home, your needs must be far greater than they would have needed to be 10 years ago.

Caroline Gardner: It is about not just free personal care, but all social care—

Mary Scanlon: Well, all home care.

Caroline Gardner: The answer, though, is yes. There is more of a focus on people with more serious and complex needs than was the case in the past.

David Torrance (Kirkcaldy) (SNP): I have a question about the maintenance backlog, which is mentioned on page 18 of the report. I note that Fife had the largest increase—of, I think, £13.5 million—but is that because in the past year it has moved to a new hospital extension and because it now has a large number of buildings that are surplus to requirements and which have been vacant for a year, if not longer?

Caroline Gardner: I do not know if we can answer that specific question for you this morning. We know that some of the increase is because of new backlog maintenance requirements that have been identified through surveys, but we can follow that up with the committee in correspondence if that would be helpful.

The Convener: I thank the Auditor General and her staff very much for a very full contribution. This is clearly an issue of huge interest not just to politicians but to the public right across Scotland, and I do not think that any of us underestimates the strains and challenges involved in delivering services. This is not just about party politics. You have outlined the broad demographic and financial strains very well, and we will no doubt come back to the matter.

Section 22 Reports

"The 2013/14 audit of NHS Highland: Financial management"

"The 2013/14 audit of NHS Orkney: Financial management"

10:36

The Convener: Agenda item 3 is consideration of two section 22 reports. Before I get to them, I should remind members that a section 22 report entitled, "The 2013/14 audit of NHS 24: Management of an IT contract", which was laid on Friday 24 October, is not on the agenda. That is because under rule 7.5 of standing orders, which relates to matters that are sub judice, consideration of that report will be deferred until such time as any investigations are resolved.

I thank the Auditor General again for appearing before us again. This time, she is joined by Stephen Boyle, assistant director, Audit Scotland, and Tricia Meldrum, senior manager, Audit Scotland.

I invite the Auditor General to speak to the reports.

Caroline Gardner: Thank you, convener.

As you have said, this morning, I bring to the committee two more reports, which highlight concerns in NHS Highland and NHS Orkney and were included as case studies in the report that we have just discussed. I prepared the reports under section 22 of the Public Finance and Accountability (Scotland) Act 2000, which, as you know, allows me to bring to the Parliament's attention issues that have arisen from the audit of the accounts of public bodies.

At the outset, I highlight the fact that the external auditor, Stephen Boyle, gave unqualified opinions on the 2013-14 accounts of those organisations, which means that he is satisfied that the accounts provide a true and fair view of the boards' financial positions. However, I have prepared reports on the boards because I believe that Mr Boyle's report highlights issues of concern that should be brought to the Parliament's attention through this committee.

I will cover the main issues in the two reports in turn. Both relate to weaknesses in financial management. As public sector budgets continue to tighten, effective financial management has never been more important and, indeed, is fundamental in helping those in charge of governance make informed decisions.

In relation to NHS Highland, the auditor reported that weaknesses in financial management were a major factor in the board's needing brokerage of £2.5 million from the Scottish Government to break even in 2013-14. That was mainly because of an overspend on the operating costs for Raigmore hospital. The auditor highlighted the fact that weaknesses in financial management at the hospital emerged late in the year, and other factors that contributed to the need for brokerage included financial pressures in the acute sector from costs associated with hiring agency staff, especially locum doctors, and meeting national waiting times targets. The auditor also highlighted the board's continued reliance on non-recurring savings.

Up until February 2014, NHS Highland forecast that it would break even at the end of the financial year. Monthly reports throughout the year to its board of directors forecast a break-even position at year end, but the actual outturn position showed significant overspends against the budget each month, and no sufficiently detailed plans were in place to bridge the gap between the board's in-year deficit position and its forecast break-even position.

In February 2014, NHS Highland approached the Scottish Government to agree brokerage of £2.5 million to enable it to break even. Brokerage can be positive and give more flexibility if the board and the Scottish Government plan for it appropriately as part of a clear financial strategy. In this case, however, the board had to request it late in the financial year when it would have been unable to break even without the additional funding. Officers of the board did not formally report the brokerage agreement to the board members until close to the end of the financial year. I also note that NHS Highland is due to repay the brokerage over the next three years.

NHS Highland continues to experience financial pressures in 2014-15, and the auditor has reported that its financial position will remain challenging for the next five years. He also highlighted that the cost of delivering adult social care services in Highland continues to pose a financial risk to the board. The board has put in place a new management team at Raigmore hospital, and training is being organised for all budget holders. A programme board has been set up to oversee the delivery of savings, and the board is focusing on delivering savings to achieve financial balance.

With regard to NHS Orkney, weaknesses in financial management were again a factor in its requiring brokerage of £1 million from the Scottish Government to break even in 2013-14. In that case, the need for brokerage was mainly due to the hiring of locum doctors to cover vacant

medical posts. The board continues to face difficulties in recruiting staff, and that remains a cost pressure. The auditor also highlighted the board's continued reliance on non-recurring savings and concerns about the capacity of the finance team, given the financial pressures facing the board.

Throughout the year, NHS Orkney was reporting an overspend against its revenue budget and continuing to forecast that it would break even. However, like NHS Highland, it did not have detailed plans about how it would bridge the gap between its on-going overspend position and the forecast break-even position at the end of the year, and it did not provide reports to its board of directors about how it would achieve that. NHS Orkney approached the Scottish Government in February 2014 to request brokerage of £0.75 million, which was later revised to £1 million in March 2014. The chief executive asked the board's internal auditor to undertake a detailed review of the 2013-14 financial position, including its approach to budget setting and in-year financial management. That report was presented to the board's audit committee in late September 2014 and the board is currently developing an action plan.

NHS Orkney still faces significant challenges in making the savings it needs to meet its financial targets. The board has set out its plans to break even in 2014-15, but it continues to place a high reliance on non-recurring savings, which might not be sustainable in the longer term.

As you have said, convener, alongside me today is Stephen Boyle, the appointed auditor responsible for the audits of NHS Highlands and NHS Orkney. Together with Tricia Meldrum, we will do our best to answer the committee's questions.

The Convener: Thank you, Auditor General. You have mentioned weaknesses in financial management in the boards highlighted in both reports. Are these the only boards in Scotland that have weaknesses in financial management?

Caroline Gardner: They are certainly the most significant weaknesses that came out of last year's audit. In the previous evidence session, we talked about the financial and other pressures that face the NHS right across Scotland, and they are also a factor in these two cases. In my view, however, financial management was not good enough in these two boards, which is why we are here today.

The Convener: You said that their weaknesses were the most significant. Does that mean that other boards have weaknesses in financial management, but they are not as significant?

Caroline Gardner: Financial management varies across public bodies right across Scotland, and there are often areas where there is room for improvement. These are the two bodies in the health service where I felt that the weaknesses were significant enough to merit my bringing them to the committee.

The Convener: You also identified in both boards problems associated with the costs of hiring agency staff, particularly locum doctors, although I presume that, in the case of NHS Highland, that would refer to other staff as well. With regard to our previous discussion about the costs associated with that, are there other boards in Scotland where this is also a significant problem but where, because of their finances, it does not impact on them as badly as it does on these two boards? Are these two boards more exposed to this problem?

Caroline Gardner: I will ask Stephen Boyle to respond in a moment, but my view is that they are more exposed to this problem because of where they are and the challenges that they face in providing services in very remote and rural areas. However, the weaknesses in financial management made those pressures even more difficult for the boards to manage.

10:45

Stephen Boyle (Audit Scotland): The experience we saw in both Orkney and Highland was twofold. There was the challenge of filling the posts and a large increase in the hourly rates that the health boards had to pay to secure the services of temporary members of staff during the year that contributed to the significant increase in costs at both health boards.

There are clearly a number of factors behind that. In Orkney, in particular, it was noted that the organisation thought that it had secured key clinical posts only to find that the successful candidates later changed their mind. That compounded the financial challenges experienced.

The Convener: That does not sound as though it is a problem that is likely to disappear any time soon. If there is a general shortage of staff in certain areas of specialism in the NHS across Scotland and if these areas are seen as less attractive to work in—for whatever reason, possibly remoteness—those who have the skills can drive the price. Is there any indication that the problem will not recur in future years?

Caroline Gardner: The indications are that the pressure will continue, especially for NHS Orkney. It is probably worth noting that the committee heard from NHS Grampian a few weeks ago that, for different reasons, it faces some of the same challenges. In a part of Scotland that has a high cost of living, the board is struggling to recruit staff to fill key vacancies. It is another financial

pressure on the health service, and one that affects different parts of Scotland differently.

The Convener: Can you give me a significant example of non-recurring savings?

Caroline Gardner: Stephen, do you want to talk through your experience in either or both of the boards?

Stephen Boyle: Perhaps the best example of non-recurring savings is vacancy management. The previous question was about the inability to fill a post. During the period between that being identified and the new postholder taking up the position, that gap would be an example of a non-recurring saving.

Colin Beattie: Obviously, these reports do not make for happy reading. There are two things that I do not see coming out in the reports: one is retribution and the other is resolution. Are the people responsible for the situations still in place? I see that one of head of finance is being replaced, but there must be other people who are responsible—who failed to give the information that the board required. It is a serious failing.

Caroline Gardner: The Scottish Government is working closely with both boards to understand what went wrong and to resolve it. Stephen might be able to give you more information about the specifics on each of the boards as it currently stands.

Stephen Boyle: I will start with NHS Orkney. It is safe to say that it is a small organisation—it is our smallest territorial health board—but the demands on the finance team are the same as in any other territorial health board. The nature of the changes in that team were such that the head of finance left the organisation—I think in December 2013—and the organisation thought that it had sufficient capacity to deal with the requirements that would be placed on it in the intervening period. Perhaps what compounded the factor in NHS Orkney during the year was that it had to deal with the five-year revaluation of its land and buildings estate. During the course of that revaluation exercise it was identified that it was more complicated and more difficult than it had anticipated. As a result of that experience, the board sought to review its requirements again, and it has now appointed a replacement for the post of head of finance, so it is back to the level of finance capacity that it previously operated with.

In respect of NHS Highland, its financial management circumstances were such that they were compounded by the situation in Raigmore hospital, and the extent of its financial position only became clear later on in the financial year. That prevented it from delivering the forecast break-even position that it had been working on over the course of the financial year, which then resulted in the requirement to seek brokerage funding from the Scottish Government.

Colin Beattie: I do not get the feeling that the situation has really been taken a grip of as yet. You may have more information on that. Are you satisfied with the steps the boards are taking to bring everything under control?

Stephen Boyle: It is a positive step that NHS Orkney is back to a full complement of finance professionals in the team. I would not say that that will guarantee its financial position or alleviate the financial pressures that it faces, but I think that it is a positive development that it now has the level of skills and expertise that it requires.

As a by-product of its circumstances during the audit of financial statements, NHS Orkney forged strong links with NHS Fife to allow it to deliver the conclusion of the financial accounts and audit. That may be a mechanism to allow it to draw on expertise as and when required in future.

NHS Highland has an experienced team. It has also taken steps to address some of the financial challenges in Raigmore hospital through the installation, as the Auditor General mentioned, of a new management team at the hospital, complemented by a programme board chaired by the chief executives, to identify recurring savings to secure its financial position in future years.

Colin Beattie: These failures are not just within the finance team; they are outside as well. Other people are responsible.

Caroline Gardner: The responsibility for governance and financial management is clearly an organisation-wide responsibility that rests formally with the board. We have reported as clearly as we can the circumstances in both Orkney and Highland, and the circumstances are different in each place, but it is the board's responsibility to ensure that it has the full picture on both the finances and the performance of the board and that it is applying appropriate challenge to that.

Colin Beattie: Convener, I do not think that we can let this matter lie, so it might be appropriate to ask the Scottish Government, perhaps in writing, to give us more information on what steps have been taken, since the Auditor General says that it is closely involved in bringing the solutions through.

The Convener: We will discuss that under item 6 of the agenda.

Before I bring in Liam McArthur, I want to ask Mr Boyle something. You mentioned that Orkney had co-operated with NHS Fife to deliver some of the financial services. Is there any value in organisations such as NHS Orkney pooling and sharing the delivery of certain services—such as

finance, personnel and IT—with other boards, or is there value in them retaining a stand-alone function?

Stephen Boyle: It would be right for all boards to look at how best they deliver what are traditionally known as back-office services to ensure that they are achieving best value in securing value for public money. The example that prompted NHS Orkney this year was perhaps not in the kindest of circumstances, but it has allowed it to draw on expertise in the function in future, much like NHS Orkney does for its clinical services through the variety of arrangements it has to receive services from other health boards when it does not have the required level of expertise or facilities on the islands.

The Convener: Auditor General, if that is something that you identify as an issue or concern, will you be recommending to boards that they should co-operate and share services in order to ensure that the qualified staff are available to provide the required function?

Caroline Gardner: As Stephen Boyle said, a fair amount of that sharing already goes on, not least through the NHS directors of finance meeting regularly and having a strong network that allows them to call on help when it is required.

When a specific issue such as the ones in Orkney and Highland comes up, the challenge is being able to get the right help quickly enough and well enough plugged in to what is really happening to make a difference while it is still possible to recover the situation. There is probably a recommendation about doing that in a more proactive way, rather than waiting for a problem to be clearly on the table.

Liam McArthur (Orkney Islands) (LD): I was interested in the point that Stephen Boyle just made about shared clinical services. The closest relationships in NHS Orkney are with NHS Grampian and NHS Highland, but for obvious reasons that would not necessarily have been the most appropriate link in relation to the issues we are discussing.

Colin Beattie is right that the NHS Orkney report makes for alarming reading, particularly when you are a constituent of NHS Orkney as well as the elected representative. As well as the problems in the finance department, what clearly come through in the report are the problems relating to recruitment and the knock-on consequences in terms of the high cost of locums.

I can understand why there are perhaps similarities in the pressures faced by both NHS Highland and NHS Orkney in relation to recruitment, but I would expect the similarities to be greater between NHS Orkney and, for example, NHS Shetland and NHS Western Isles. Could you suggest anything from the audit process that those health boards appear to be getting right in terms of recruitment and from which Orkney could learn lessons? Similarly, in relation to the locum procedures, if it is inevitable that locums must be used, what things could be improved in order to bear down on the costs?

Caroline Gardner: I will ask Stephen Boyle to answer in a moment, but the context is that, particularly for the island health boards, losing one or two key people can have a really significant impact because of the scale of what we are talking about. Part of the picture is simply that Orkney has been hit with a number of vacancies this year—it could have been Shetland or Western Isles. That unpredictability is a factor that must always play in.

I will ask Stephen to pick up on whether there are wider lessens to learn.

Stephen Boyle: The Auditor General has touched on the issue. There is not an abundance of non-clinical professionals or clinical professionals in the board, and the loss of one person can be very significant to the delivery of services. NHS Orkney has connections with NHS Grampian and NHS Highland in particular, but it has also forged links with colleagues in the Western Isles and Shetland—through the islands care model—as a means of sharing best practice. Indeed, there is no guarantee that, when faced with particular challenging circumstances, it would be straightforward to resolve.

Liam McArthur: Obviously, recruitment is born out of an inability to retain. Are there particular examples of what is happening in the other island health authorities? Their retention rates are higher, and therefore they are not facing the problem of having to recruit in a market in which skills in certain areas are at a premium, which, as the convener says, increases the difficulties and the costs.

Caroline Gardner: There is nothing that we are aware of, but that is not to say that there may not be lessons to be learned.

One of the other clues came out in something that Stephen Boyle said earlier, which is that the issue is often less about the health board or the post than about the individual's personal circumstances. The things that make some people willing and very happy to live and work in an island community for a long time may be the things that make it harder for another individual because they have young children, a spouse who works, or whatever it may be. We know that factors about the individuals have made a difference from time to time, as well as there potentially being things about the way the board manages things that can make it easier or harder in what are always difficult circumstances.

11:00

Liam McArthur: I will take us on to the issue of the recurring and non-recurring savings.

Obviously, there are concerns about the level of non-recurring savings that NHS Orkney is making. There is perhaps more of a concern given the earlier predictions of recurring savings. I also note that in paragraph 10 of the NHS Orkney report there is an acknowledgement that NHS Orkney is about 12.2 per cent—£4.8 million—below its target funding allocation. There is an acknowledgement of that, and the Scottish Government has plans in place to increase the allocation by £0.5 million in 2015-16 and £3.8 million in 2016-17. Those are significant sums in relation to NHS Orkney's budget. Would it be reasonable to be making recurring savings when there is an acknowledgement of underfunding and there is a plan in place to provide that funding?

NHS Orkney, like all other health boards, would probably argue that it has made savings down to the bone where it can, and the danger of making further savings is that you dig very deeply into critical services. Colleagues referred to an ageing population and the pressures that it brings because costs are magnified in an island setting where there is a dispersed population. Should the expectation be that NHS Orkney will look to make recurring savings, or is it a process of trying to bridge the gap until the additional funding, the absolute essentialness of which has been acknowledged by the Scottish Government, is put in place?

Caroline Gardner: That is a really good question. As well as the increased funding due over the next two or three years, there will also be a move to a new hospital, which will provide new opportunities for providing services in different ways and generating longer-term savings or efficiency improvements. The concern is about making sure that the planned savings are delivered in practice, whether they are recurring or non-recurring. The challenge that non-recurring savings bring is that you have to look for them all over again next year. Stephen Boyle will know more about the specifics in Orkney.

Stephen Boyle: We have sought to report the board's performance against its own plan and the level of recurring and non-recurring savings that it has identified in its local delivery plan submitted to the Scottish Government and which it expects to make.

Recurring savings are clearly a far more sustainable way of securing financial balance, but over a number of years NHS Orkney has used non-recurring savings as a means of securing its financial position. It is also the case that some non-recurring savings are used to support non-recurring expenditure. As the Auditor General mentioned, that is the case with the new hospital, which will come online in a couple of years. NHS Orkney will have a period of non-recurring expenditure between now and when it opens the new facility.

Overall, fundamentally, we seek to report NHS Orkney's performance against its own plans.

Liam McArthur: You gave the example to the convener earlier of the recruitment of senior staff that then fell through, meaning they had to be replaced by locums at short notice. Are there other examples? In a sense, something of that scale in a smaller budget can account for a significant percentage of either the non-recurring costs or the problems being identified in a single year within the report.

Stephen Boyle: I am trying to think of a good example, Mr McArthur, over and above the vacancy management. I suspect that there will be many, albeit in a non-clinical setting, such as identified savings in the facilities costs on the estate. Perhaps, as has been suggested, there is the level of on-going upkeep for the old hospital relative to the new facility. If I can think of a better example, I will come back and answer your question later.

The Convener: May I clarify something, Mr Boyle? You mention vacancy management as a non-recurring saving, but if a vacancy runs beyond one year or is eliminated permanently, surely that will then become a recurring saving?

Stephen Boyle: That is correct, convener. The key to that is the duration of the vacancy.

The Convener: Is there a balance between the non-recurring savings due to vacancies and the recurring savings that are due to vacancies?

Stephen Boyle: We would expect savings of a recurring nature to be planned and identified and for there to be a service redesign analysis and a workforce plan. That would then have a connection with a financial plan. With savings of a non-recurring nature, the issue would be about the circumstances that the health board encountered as it went through the recruitment process or the time that it took to complete any recruitment cycle.

Mary Scanlon: I would like to start with vacancy management and the point the convener just made that if that continues over a certain period, non-recurring becomes recurring. Is vacancy management being used to balance the books—is it a recruitment problem or a financial problem?

I mention that because in recent weeks local newspapers have been doing freedom of information requests to NHS Highland and have discovered, for example, that 104 patients had to go elsewhere in Scotland in recent months for

orthopaedic surgery. I support that, because it is important that they get their surgery. However, we are finding that the issue is not all about recruitment. Patient waiting times are longer now. I do not think that I have ever known a time in which I have heard from more patients in NHS Grampian—my region covers Moray—and NHS Highland, given the waits for diagnosis, for scans and for treatment and the waits to see a surgeon.

There appears to be a serious impact on patient care. I appreciate that you are mainly looking at the finances, but, given that 104 patients in recent months have been travelling elsewhere, is it reasonable to say that this is becoming very serious indeed?

Caroline Gardner: I will start with your specific question about vacancies. It is clear that you can use vacancies to manage the finances by choosing not to fill a post for a period and, if that post is required, it is likely that that will have an impact on service levels, whatever the job is—whether it is a consultant post or a key post in the finance team. You may have a difficulty in recruiting somebody, which gives you an unintended saving but also, again, has an impact on the service that you are able to provide.

Stephen Boyle may be able to tell you more about what we know about what is happening in NHS Highland, but I think the key is in the point that he made about linking workforce planning to financial planning. Every board should be clear on what staff it needs to provide the services that it is responsible for, and its financial plans should be very closely linked to that. Vacancy management, other than at the margins, is not a sustainable way of making the savings that may be needed to balance the budget. If what you need is to reshape your staffing, you should do that and recruit to the new staffing structure, rather than keep posts empty for long-term periods. Short-term flexibility may be sensible; long-term vacancies are not.

Mary Scanlon: I think that it is worth mentioning that it is about a 350-mile round trip for patients before and after surgery.

Caroline Gardner: Absolutely, and clearly there are particular circumstances in both the boards that we are talking about today; there is no question about that.

Stephen Boyle: I am not sure whether I have any specific examples of the specialties and the impact on patients in NHS Grampian or NHS Highland, Ms Scanlon.

Mary Scanlon: Okay.

A second ago, the Auditor General said that it was the board that had responsibility for the finances. My question is really on the back of Colin Beattie's question. I do not think that in the three years that I have been on the committee, I have ever seen a paper that states:

"The chief executive and director of finance discussed the board's financial position with the Scottish Government"—

which of course they should do—

"in December 2013 but did not formally advise the Board"

about the fact that the board was not going to break even. That is stated on page 5 of NHS Highland report, and I would have thought that it was tantamount to gross misconduct. How serious is it that, one month before the end of the financial year, the board—NHS Highland—was made aware that it would not break even?

Caroline Gardner: We understand that the board's financial position was discussed informally with the board during board development sessions, but I agree with you that it is the sort of matter that should be formally on the board's agenda and available for the board to understand, to discuss and to challenge where appropriate. We have talked before to the committee about each board having a really central role in governance—in being able to take that big picture of the way the finances and clinical and other performance are looking and to provide the required level of oversight, scrutiny, challenge and support. One of the reasons why these reports are before you is the concern about financial management and, for Highland, the particular question of transparency.

Mary Scanlon: It is very difficult for us as an audit committee and, to be fair, for the Scottish Government to hold that board to account when it is being kept in the dark by its chief executive and financial director, as you state in your report.

Caroline Gardner: The chief executive and, I think, the director of finance are both members of the board. The issue is both whether the board was able to fulfil its role, and the legitimate public interest in such concerns. Earlier we talked about the need for debate about the way financial and other targets work together in the health service. I think that it is entirely legitimate to say these are the sorts of issues that should be discussed, at the appropriate level of detail, by a board.

The Convener: Can I just stick with that for a moment? There is a significant issue here about both the staff and the board. Paragraph 6, at the top of page 5 of the NHS Highland report, states that

"the actual year-to-date outturn position showed significant overspends against the budget each month. Monthly information prepared by the finance team for Board members and the Scottish Government had reported that the deficit would be addressed from 'management planned actions'."

The senior staff reported to the board that

"the deficit would be addressed from 'management planned actions'",

but you go on to say that the chief executive and the director of finance discussed the problem with the Scottish Government but not the board. I think that Mary Scanlon is right about the dereliction of duty. Surely the senior staff are obliged to report to the board; otherwise, what is the point of having a board? Maybe you can clarify that for me; maybe I am wrong. Maybe the chief executive, the director of finance and other senior staff should report directly to the Scottish Government, rather than the board. Is that the case? Is the board irrelevant in this?

Caroline Gardner: No. I have said that in my view these are exactly the sorts of issues that should be on the board's agenda. The board is responsible for scrutiny and oversight of the board's overall performance. We are told that the board discussed the issue informally, as part of a board development session, rather than as part of a formal board agenda, but in my view that does not meet best practice.

Stephen Boyle may want to add more on the background of what we know in the case of Highland.

The Convener: Sorry, but I have a question just before Mr Boyle does that. Are those staff still in post?

Caroline Gardner: There has been one departure from Raigmore hospital, I think—from the NHS Highland board. Otherwise, people are still in post.

Stephen Boyle: As the Auditor General notes, we would have expected that the forecast financial position, which stated that board would break even, compensated by planned management actions, would include more detail around what planned management actions would entail, and we did not see that during the year.

By way of context, I suppose that I should say that in previous years NHS Highland has also relied on non-recurring savings to secure its financial position and achieve its break-even point. The extent of brokerage, or additional funding, from the Scottish Government that it sought, which was £2.5 million, is only a very small percentage of its overall allocation. Nonetheless, we would have expected that the risks around achievement of the break-even point would have been clearer to board members.

The Convener: The more I hear, the worse this becomes. Frankly, I think that it is a scandal that these senior officers are treating the board like mushrooms—best kept in the dark. First, they did not advise the board at the time that they discussed the situation with the Scottish Government. Secondly, the same paragraph—paragraph 7 of the NHS Highland report—says:

"Officers did not formally report the brokerage agreed with the Scottish Government to the board until close to the end of the financial year."

What is the point of having a board if you do not discuss these serious issues with it?

Caroline Gardner: I think the word "formally", in both instances, is important. From our discussions with the board, we understand that there were informal discussions in board development sessions. I agree with you, convener, that these are the sorts of issues that should be on a formal board agenda, with proper papers and proper minuting of the action that has been taken, as a key part of good governance.

11:15

The Convener: I think the fact that there was informal discussion makes it even worse, because informal discussion will not appear in any records anywhere that the public can examine and hold the board to account about. The nod, the wink and the private conversation that there is a problem frankly seem to be a way of getting round public scrutiny and proper public accountability. Either the board is complicit in a situation in which there is no proper governance, or the board has been kept in the dark by senior management, but somewhere along the line there is a chronic failure of NHS Highland's board to hold the executives to account, or a failure of the senior staff to advise the board. Either way, it is significant failure; it may well be both. To have a board that is not formally told of discussions with the Scottish Government about brokerage is an outrage, I think.

I do not know whether that is happening in other boards, or whether it is just a local practice, but, as Colin Beattie suggested, we need to have some discussions with the Scottish Government about the issue, because there is something badly wrong here.

Caroline Gardner: One of the reasons why the report on NHS Highland is before the committee is that the way in which the situation was handled means that there is no formal record of papers to the board or minutes of decisions taken. That makes it hard for us to see and understand the level of board discussion and the actions taken. Those requirements are in place for good reasons, as you say—good governance and public accountability.

Mary Scanlon: Before I go on to my final question, which is on looking at the way forward, I note that the second paragraph on page 13 of "NHS in Scotland 2013/14" says:

"Until February 2014, the board was forecasting that it would break even at the end of the financial year."

You have told us that there were informal discussions, so the board was aware that there would be £2.5 million brokerage. Discussions took place between the chief executive, the financial director and the Scottish Government in December. Was the board lying about breaking even, was it unaware of the brokerage, or was it just being economical with the truth?

Caroline Gardner: I think that what paragraph 7 is describing is an evolving picture—Stephen Boyle will keep me right. My understanding is that the December 2013 conversation was about the financial position of the board and the challenges that were being faced, particularly at Raigmore hospital. In February 2014, that discussion had moved on to being about the potential requirement for brokerage.

As the NHS Highland report says, the board was formally advised about the need for brokerage

"close to the end of the financial year."

The discussions were evolving. What is clear is that they were not happening formally on the board's agenda and that the plans for closing the gap between the month-by-month position and the forecast break-even position were not detailed enough to give us satisfaction that the picture was being managed well.

Mary Scanlon: So what we have is a formal forecast of break-even by the end of the financial year and informal knowledge that that would require a £2.5 million brokerage.

Caroline Gardner: The picture appears to have been that the formal discussions at the board did not take full account of the board's financial position. They evolved until right at the end of the financial year when the need for brokerage was reported. Stephen Boyle may well want to add to that; he is much closer to the picture on the ground than I am.

Stephen Boyle: The Auditor General's understanding is consistent with my own. Certainly, the formal reporting of the requirement for brokerage, as the report notes and as Ms Scanlon said, did not take place until

"close to the end of the financial year",

but it was based on the February in-year position.

Mary Scanlon: So the formal position and the informal knowledge were quite different.

Stephen Boyle: I think that we would agree with that.

Mary Scanlon: I will move forward to the final paragraph of case study 1 on page 13. I hope that you will forgive me, but please could you explain it to me? For the board to break even at the end of the financial year

"a £12.3 million improvement on the financial position"

is required; £9.9 million of that relates to Raigmore hospital. What is

"a £12.3 million improvement on the financial position"?

Is that spending £12.3 million less to break even, or is that £12.3 million of efficiency savings in one department that will be taken and reinvested in another? I do not understand what that means.

Stephen Boyle: The £12.3 million that you refer to is the board's forecast year-end outturn as at the end of the 2014-15 financial year.

Mary Scanlon: Is that what the deficit will be at the end of the year?

Stephen Boyle: That is what the board projects the deficit will be if it does not take any steps to address that and meet its break-even revenue target.

Mary Scanlon: If it is predicting a £12.3 million deficit—sorry for being the daft lassie, but I want this to be understood—does that mean that it has to cut its spending by £12.3 million to break even on 31 March next year?

Stephen Boyle: I have just one point of clarification. I think that the board is actually projecting a break-even position, but it has identified that—sorry if this is not clear; I will try to be as clear as I can—

Mary Scanlon: I do not understand how it can be projecting that it will break even when it has a £12.3 million deficit.

Stephen Boyle: It is projecting that it will break even, but it has identified that it has a forecast gap of £12.3 million as things stand at the end of period 5 of the financial year. Indeed, it needs to take steps that will address the £12.3 million gap.

Mary Scanlon: So it needs to cut its spending by £12.3 million by the end of the financial year in order to break even. Is that accurate?

Stephen Boyle: Cut spending or identify other revenue streams or deliver services in a different way.

Mary Scanlon: And £9.9 million of that relates to Raigmore hospital. That is a huge financial improvement, cut or whatever you want to call it. Is it reasonable to expect NHS Highland to find £10 million of cuts, efficiency savings or financial improvements in six months?

Stephen Boyle: That would be very challenging in the remaining months of the financial year.

Mary Scanlon: I would have thought so.

Stephen Boyle: It broadly mirrors the financial position of the board last year. As we note in the paper, £9.5 million of the financial challenges that

are faced by the board are attributable to Raigmore, so the trend is broadly consistent.

Mary Scanlon: Have you been told how the deficit will be met? Has NHS Highland given you a plan for how it will break even? If so, is that something that the committee could see?

Caroline Gardner: I made reference in my opening remarks to the board's programme board, which it set up specifically to try to close this gap. It is both monitoring the situation and developing a series of plans for closing the £12 million gap in this financial year and ensuring that the longer-term challenges, which Stephen Boyle referred to in his report, are also met. Is that accurate, Stephen?

Stephen Boyle: Yes.

The Convener: Before I bring in the at least three other members who want to speak, Auditor General, I am aware that you have to attend the Local Government and Regeneration Committee meeting to give evidence. Are you content to leave at this point and let your colleagues deal with further questions, or do you wish to stay for the rest of the questions?

Caroline Gardner: I think that the Local Government and Regeneration Committee is content for me to stay here until you are happy on this item.

The Convener: James Dornan has a quick question and then I will call Willie Coffey.

James Dornan: Based on the informal and formal board meetings, did you get any sense during your audit that it had a plan to fill this £2.5 million gap? Was it a case of its saying one thing in public and another thing in private, or was it just sitting there hoping that something would turn up?

Stephen Boyle: It is difficult for me to talk about what is discussed in the informal sessions because, as has been said, we are not present at the meetings and we do not receive minutes. I could conjecture that the experience of NHS Highland's financial position has been such that it has delivered its financial position in previous years and anticipated that it would do so again in 2013-14, but the late detail around the challenges at Raigmore compounded its financial position and prevented it from doing so and it therefore required brokerage.

Willie Coffey: You came in earlier for the second time, convener, on a number of points that I wanted to raise, but I nevertheless want to ask the Auditor General a couple of questions.

This story reminds me of the Western Isles case of a number of years ago, when I served on this committee, in which significant management failures were pinpointed. We hoped that lessons would be learned. They were certainly learned in the Western Isles, but it seems to me, without knowing the detail, that similar management failures are happening again. What is extremely worrying is that it seems to be pointing to a lack of ability or willingness to scrutinise what is being said by whom to whom. A board cannot seriously say that it is going to outturn in balance through management actions, while projecting a shortfall, and not even decide to inquire what those might be. That sounds like what we heard in the Western Isles some years ago.

I cannot think of any possible reasonable or rational explanation that might explain this other than—well, I am not going to say. I just cannot understand why that would be the case. When in the process did it become clear that brokerage was required? Was it right at the end of the financial year, with a month or so to go? When did it occur?

Caroline Gardner: The picture that we have tried to paint for you is that it was clear that there were real financial pressures from at least December 2013 onwards. Although, as Stephen Boyle said, there was a history of making the savings that were required in previous years, the difficulties were compounded this year by the weaknesses in financial control at Raigmore and by the ambitious work that is taking place in Highland to integrate adult health and social care under the health board's leadership. The question is how well understood the reasons for that financial position were. In particular, how well positioned was the board to ask the right questions about the underlying reasons, about how good the plans for moving toward break-even were and about what other action may have been required? As Stephen said, we cannot be sure about that because the meetings were not held formally, so we do not have access to papers or minutes. However, it is the board's responsibility, and there are good governance requirements for good reasons, as the committee is exploring.

Willie Coffey: This is ringing another alarm bell in connection with our past experience. We have examples when even internal audit recommendations were ignored. The question that it raises is how on earth we ensure that what is said and reported in internal or external audits is done and scrutinised.

Mary Scanlon: Hear, hear.

Willie Coffey: It is one thing to report and make recommendations, but it is another to do those things and have someone else—if necessary, someone external—come in at a later stage to look at whether it has been done. That has to be in process. It is the responsibility of the board. It seems as though the same mistakes were made

by these two boards. Lessons need to be learned pretty quickly to stop this happening again.

11:30

Colin Keir: I have a similar question about the board meeting. We know that it was reported to the board later on, but maybe I have missed something of what has been said—I apologise if I have. I am trying to get an idea of what actions the non-executive directors of the board said should be taken in response. I want to see whether there was some form of dissent, comment, acceptance or whatever. I do not know whether I missed that or whether that information is not available because it is in minutes that you have not seen. It would be interesting to know whether the executive members, who are responsible for the day-to-day running, and the non-executives, who are supposed to be there for a specific reason, are up to the job of carrying this on.

Stephen Boyle: It might be worth noting that the board issued a response to the section 22 report, which stated that it takes the report seriously and intends to address the points in it. We have already commented about the timeline and the information that was provided to the board in the formal and informal sessions. It is perhaps worth noting that the basis for the Auditor General's section 22 report is the annual report on the audit. I presented it to NHS Highland's audit committee in September 2014, if memory serves me correctly. There is an action plan that accompanies the report, and I make recommendations for improvement. They were responded to positively, in my mind, and the next steps were discussed in full at that meeting.

Colin Keir: I would have liked to know what the initial response was. I know that, in doing the action plan, they have to agree to a series of forward plans to alleviate the problem, but I want to find out what the initial formal reply from the non-executive directors was when they found out that brokerage was required at virtually the last meeting of the year. If they accepted an informal discussion, that brings in the problem of whether the non-executives should be pushing for it to be formalised. Did they know about it? What was the initial reaction? I would really like to know how the board reacted initially when confronted with this. That would give us an idea of whether there were problems with the executive function of the board.

Stephen Boyle: The best answer that I can probably give, from my experience of that meeting, is that there was a degree of recognition among some non-executives who serve on the audit committee—that is not all the non-executives of the board—that they were familiar with the board's financial position. I am not sure that I could give you clarity about whether that then translated into an expectation or understanding that it would require brokerage from the Scottish Government to secure break-even.

Section 23 Reports

"NHS financial performance 2012/13"

"Management of patients on NHS waiting lists—audit update"

11:34

The Convener: I thank the Auditor General and her colleagues. Before you leave, Auditor General, can I ask you one question about the next item on the agenda? We have responses from both the Scottish Government and you. In your response, you say:

"My report on the NHS in Scotland 2013/14 will comment on the number of settlement agreements"—

that includes confidentiality clauses—

"and highlight any concerns raised by local auditors."

I cannot see any reference to it in the report.

Caroline Gardner: It is not in the report, and we are still planning to report back to you on that issue. We want to take the time to ensure that we have the information absolutely right before it comes to you.

The Convener: Thank you for that. The next item is the consideration of the responses from the Scottish Government and the Auditor General. Members can agree to note the responses, decide whether to take any further evidence or, indeed, refer it to another committee. If there are no comments, do we agree to note the responses?

Members *indicated agreement.*

11:34

Meeting continued in private until 12:06.

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