The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 14 January 2015

Session 4

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PUBLIC AUDIT COMMITTEE
1st Meeting 2015, Session 4

CONVENER

*Paul Martin (Glasgow Provan) (Lab)

DEPUTY CONVENER

*Mary Scanlon (Highlands and Islands) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Nigel Don (Angus North and Mearns) (SNP)
*Colin Keir (Edinburgh Western) (SNP)
*Stuart McMillan (West Scotland) (SNP)
Tavish Scott (Shetland Islands) (LD)
*Drew Smith (Glasgow) (Lab)
David Torrance (Kirkcaldy) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Caroline Gardner (Auditor General for Scotland)
Paul Gray (Scottish Government)
Alan Hunter (Scottish Government)
Dr Aileen Keel CBE (Scottish Government)
John Matheson (Scottish Government)
Mark Roberts (Audit Scotland)
Gillian Woolman (Audit Scotland)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

The Robert Burns Room (CR1)

Scottish Parliament

Public Audit Committee

Wednesday 14 January 2015

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

Interests

The Deputy Convener (Mary Scanlon): Good morning. I welcome members, the press and the public to the first meeting of the Public Audit Committee in 2015. I ask all who are present to ensure that all electronic devices are switched to flight mode, so that they do not affect the work of the committee.

We have received apologies, for obvious reasons, from Tavish Scott. He has had difficulty in getting here from Shetland due to the weather conditions. We also have apologies from David Torrance, who is having difficulties coming from Fife, also due to the weather conditions. We hope that David will join us later in the morning.

Before inviting the committee's new members to declare any relevant interests, I record my thanks, and those of the Public Audit Committee, to Hugh Henry, Ken Macintosh and Gil Paterson for their work on the committee.

I now invite Paul Martin, Stuart McMillan and Drew Smith to declare any interests that are relevant to the remit of the committee.

Paul Martin (Glasgow Provan) (Lab): I have no interests to declare.

Stuart McMillan (West Scotland) (SNP): I have no interests to declare.

Drew Smith (Glasgow) (Lab): I have no relevant interests.

The Deputy Convener: That is excellent. That was very straightforward.

Convener

10:02

The Deputy Convener: I now invite nominations for the position of convener of the Public Audit Committee.

Drew Smith: I nominate Paul Martin.

Paul Martin was chosen as convener.

The Deputy Convener: The committee has agreed. I congratulate you, Paul. I look forward to working with you on the committee.

The Convener (Paul Martin): Thank you, Mary. I thank colleagues for my selection as convener of the Public Audit Committee. I very much look forward to working with the committee.

I also take the opportunity to thank Hugh Henry for his previous two periods as convener, and the other previous members of the committee for their work.

We have a great deal to do ahead of us, so we will move quickly to agenda item 3.

Decision on Taking Business in Private

10:03

The Convener: The question is, colleagues, whether to take agenda items 8 and 9 in private. Are we agreed?

Members *indicated agreement.*

Section 23 Report

"NHS in Scotland 2013/14"

10:03

The Convener: We move to agenda item 4. I welcome Paul Gray, director general of health and social care at the Scottish Government and chief executive of NHS Scotland; John Matheson, the Scottish Government's director of finance, e-health and analytics; Alan Hunter, performance director for NHS Scotland; and Dr Aileen Keel CBE, the Scottish Government's acting chief medical officer.

I understand that we will hear a short presentation from Paul Gray, which will take no longer than five minutes.

Paul Gray (Scottish Government): Thank you, convener. My congratulations to you on your appointment to that very important role.

I am grateful for this opportunity to make some opening remarks. I will comment on the three key messages that are raised in the Audit Scotland report.

First, there is a challenging scale of change required to meet the 2020 vision, which is that everyone is able to live longer and healthier lives at home or in a homely setting by 2020. We will have a healthcare system that integrates healthcare and social care, with a focus on prevention, anticipation and supported self-management.

We want to provide care, as we do at present, to the highest standards of quality and safety, with the person being at the centre of all decisions. As we work to achieve sustainable quality in the delivery of healthcare services across Scotland, we want to continue to deliver improvements in the health and wellbeing of the people of Scotland.

On the demands on the health service and rising expectations, as the Audit Scotland report notes, demands are increasing as a result of demographic changes—particularly in relation to the growing numbers of elderly and very elderly people, and of people with long-term conditions—and of people's rising expectations of healthcare. We recognise the significant demands that are faced by the national health service in Scotland and I welcome the opportunity to discuss how we are addressing the demands proactively.

The integration of health and social care services, which I have mentioned, is crucial to meeting those demands. The Public Bodies (Joint Working) (Scotland) Act 2014 comes into effect from April 2015 and puts in place a framework to ensure that health and social care services are planned, resourced and delivered by NHS boards and local authorities together, working with partners in the voluntary sector, too, to improve outcomes for people who use the services and for their carers and families. The shadow integrated arrangements are being set up and integration schemes are being developed for them, which must be submitted to ministers for approval. Integration authorities must be fully functional by 1 April 2016.

On Audit Scotland's references to financial pressures and waiting times, NHS boards in Scotland delivered a small surplus of £23.4 million against an overall budget of £11.1 billion. For the sixth consecutive year, all boards have achieved their financial targets for the year in question, and are on track to achieve balance in 2014-15. Audit Scotland refers to the financial pressures that are faced by NHS Scotland, and the need to increase the focus on longer-term financial planning. We continue to improve our practices, and we believe that we have a strong and effective focus on long-term financial planning, which is demonstrated by the achievement of all boards having met their financial targets. We have made brokerage arrangements only exceptionally, and only when a board has demonstrated its ability to repay in full. We take extremely seriously the publication of section 22 reports by the Auditor General for Scotland, and we will continue to make progress towards addressing the issues that have been raised.

We undertake regular in-depth reviews of all NHS boards' three-year and five-year financial plans, including detailed validation of the core financial planning assumptions. We have on-going monthly monitoring and reporting at NHS Scotland level to ensure that financial performance is on track, and to ensure that we take appropriate action in the event of any significant deviation from plans.

On waiting times, the Government remains committed to supporting NHS Scotland to deliver the standard that has been set in Scotland. Our waiting time standards are among the strongest in the world, and performance in Scotland is among the best on record. However, there are challenges. We recognise them; in this year's local delivery plans, we have focused NHS boards' improvement activity on out-patient waiting times.

In closing, I welcome the acknowledgement in the Audit Scotland report of the good progress of the NHS in a number of areas, including in improving outcomes for people with cancer and heart disease, and reducing healthcare associated infections. NHS Scotland has many recent achievements and is a world leader in using improvement science to deliver outstanding results. That has been made possible only through the huge contributions of patients, carers, families

and volunteers and the dedication of the workforce.

The Convener: Before I invite questions, I remind members that case study 3 of the Auditor General for Scotland's report on NHS 24, which is also a separate section 22 report in its own right, is currently sub judice. Members might wish to note that when asking questions.

Mary Scanlon (Highlands and Islands) (Con): I thank Mr Gray for his opening statement. I do not think that there is anyone here who does not want improvements in health and wellbeing. However, as the Public Audit Committee of the Scottish Parliament, we are concerned with measurable outcomes. I have to say that in the eight years that I spent on parliamentary committees that had responsibility for health, we were looking for measurable outcomes then, but we did not find them.

The previous convener, Hugh Henry, wrote to you some time ago to put the committee's views:

"We consider that NHS performance measures should be transparent and clearly understood so patients, NHS staff and other interested stakeholders can easily assess the quality of care and timescales within which the NHS is treating patients."

That was in relation to my questions on what is a target and what is a standard. The previous cabinet secretary, Alex Neil, agreed that it can be confusing. We asked you to respond to that: as I see it, the response is 38 pages of bureaucratic fudge. I am no further forward in understanding a measurable outcome than I was in May 1999. I really thought that my question would be helpful and that the response would be helpful to the committee. Can you tell me how 38 pages can help us to measure outcomes?

Paul Gray: One of the outcomes that we are achieving is a significant and regular reduction in hospital standardised mortality ratios. That means that mortality in hospitals is reducing over time. That is an outcome that is of value to patients and the people of Scotland.

I am genuinely happy to try to assist the committee further on this point. We are not trying to make this difficult to understand. If there is something more that we can do, I would be very pleased to do it.

Mary Scanlon: It used to be that if a target was not met, it became a standard—targets changed to standards. You were going to simplify that. What I want is not just for this committee to understand it, but for people throughout Scotland to understand the improvements that we are seeing in health and wellbeing. Can you tell me today how this 38 pages of bureaucratic fudge—I am happy to accept your answer—simplifies our understanding, and the understanding of the people of Scotland, of how our health service is improving?

If we have a target and it is not being met, we know where we are going. No health board achieved the out-patient target of 12 weeks, five out of 14 health boards achieved the in-patient day-case treatment time, five out of 14 achieved the accident and emergency four-hour target, five out of 14 achieved the cancer urgent referral target and three out of 14 achieved the delayed discharge target. That is not a great record, but next year we can say that that was the target that was not achieved, but here are the improvements that are being made. How has that been simplified by this response?

Paul Gray: As I have said, I am happy to provide whatever further information the committee wants. A target is something that we aspire to; targets are challenging, but that is why we set them. A standard is something that should be met consistently by the NHS. That is how we seek to set such things out.

We have a number of health improvement, efficiency and governance, access and treatment—HEAT—targets. We have issued local delivery plan guidance to boards on both targets and standards. Mary Scanlon mentioned out-patient waiting times. I said in my opening remarks that out-patient waiting times is one of the areas for focus on improvement that we have set for boards.

If there is a simpler way that we can present the information, I am happy to reflect on it for the benefit of the committee. I take your point seriously, Ms Scanlon. We will review that documentation and if we can simplify it for the committee, we will do so.

Mary Scanlon: I want to consider the section 22 report before we move on. What is the difference between a target, a standard and a priority? Will you continue to have all three of them in the future?

Paul Gray: As I have said, a target is something that we aspire to; for example, we have a target of 95 per cent of people in accident and emergency being seen and treated within four hours.

We have standards that we have set. I can go over those, and my colleagues who work on performance can help, if necessary. For example, in this year's local delivery plans we have given priority to improving out-patient waiting times. We have set that priority for the boards this year based on an area that requires improvement. That is how we divide these things up.

10:15

Mary Scanlon: So it is priorities, standards and targets.

You mentioned the section 22 report that you take seriously, and you will be aware that the committee is going to Inverness to take evidence from NHS Highland. I have been quite vocal about the national resource allocation committee funding formula and how NHS Highland—and NHS Grampian, although I will just talk about NHS Highland—has not received its full funding. I have no doubt that that is because of some of the problems that it is facing just now. Given all those difficulties, as well as the Auditor General's section 22 report, which is a very serious matter, why was it the middle of winter when the Scottish Government suddenly came up with the funding that NHS Highland had been crying out for for many years? Why was the money suddenly found last week when NHS Highland has had to struggle for many years because it has not been funded in accordance with the funding formula?

Paul Gray: I will ask John Matheson to comment on that in more detail. The committee will be aware that a decision was made on distribution of the Barnett consequentials that provided additional resource for the NHS in Scotland, and the additional funding for NHS Highland was part of that. When that money became available, it was distributed appropriately.

Mary Scanlon: The money for NHS Highland was based on the additional NHS spending at Westminster that made money available in Scotland.

Paul Gray: Mr Matheson will give you the detail.

John Matheson (Scottish Government): The Scottish Government has a commitment to move boards towards NRAC parity in a measured way that does not destabilise the boards that are above parity. The previous cabinet secretary made the commitment that all boards would be within 1 per cent of parity by fiscal year 2016-17.

The additional consequentials have given us the opportunity to accelerate that progress, so all boards will now be within 1 per cent of parity by fiscal year 2015-16, which starts on 1 April. That is based on the current formula. As has been discussed previously at the committee, the formula is dynamic. For example, we recently reviewed the remote and rural weighting within the formula, which was beneficial to NHS Highland.

As a result, for 2015-16, NHS Highland will get an uplift of 4.7 per cent, which is second only to NHS Grampian in terms of the scale of the uplift. That is an additional £24 million.

NHS Highland received brokerage of £2.5 million last year. It is important that all boards are made aware of their budget at the earliest possible opportunity. We do that by giving advance notification and by working collegiately across NHS Scotland. That means that boards can make consistent planning assumptions about potential pressures from superannuation and so on. We give boards assistance by giving them information at the earliest possible point. We try to minimise compartmentalisation of allocations and to bundle them around themes rather than give individual allocations. We try to give allocations as early as possible in the year.

NHS Highland was clear about its allocation. It approached us towards the end of the year looking for assistance. As Mr Gray has indicated, we gave that assistance, predicated on our being reassured that it had a robust plan that included repayment of the brokerage. We have now been able to give NHS Highland further assistance through an enhanced uplift and we are working closely with the board on its financial plan for the future.

The Convener: Before I bring in Colin Beattie, I want to go back to Mr Gray's point about the way in which the targets are presented. Mary Scanlon raised the issue of how they are presented to the public. You advised that you would come back to the committee on that. When do you expect the committee to receive that advice? Do you accept that the information could be packaged and presented to the public more effectively?

Paul Gray: Is there a timescale that would be helpful to the committee?

The Convener: Perhaps we could write to you with a timescale.

Paul Gray: We would be happy to conform to your timescale and to do whatever is most helpful to the committee.

On your question on whether targets and standards could be more helpfully presented, I am sure that we could always improve. It has never been my stance to say that nothing can be made better. For example, a local development plan standard that we have at the moment is that at least 80 per cent of pregnant women in each Scottish index of multiple deprivation quintile will have booked for antenatal care by the 12th week of gestation. I think that I just about understand what that means, but I am sure that we could make it clearer. That is just a simple example of something that we could make clearer in a descriptive way.

Of course we have to be precise in statement of targets. Even for ones such as the 18 weeks for referral to treatment for specialist child and adolescent mental health services 90 per cent of the time, it is probably helpful to people receiving the services to know what that means in practice for them. I am sure that there are areas in which

we could look at how to describe more fully what the targets and standards mean.

The Convener: Thank you, I will write to you on that.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I start by asking for a clarification. Mr Gray's submission of 4 December refers to formula capital, which is not a term that I have heard before. What does it mean?

Paul Gray: I will ask my accounting expert to explain it. It may be something else that we could explain more clearly for the committee.

John Matheson: Formula capital is the capital that is allocated to health boards to deal with routine maintenance, including backlog maintenance and purchase of equipment. It is differentiated from capital that is allocated for major projects, such as the south Glasgow hospital development, for which the dedicated sum of £824 million has been allocated.

Formula capital is allocated on a formulaic basis, as the name suggests, using the NRAC formula. Each board gets a share of a total pot. The formula capital pot for 2015-16 is £15 million more than for 2014-15, so the formula capital allocation is going up. A particular area of focus in the utilisation of that is dealing with backlog maintenance.

Colin Beattie: What is the terminology to cover capital for major projects—just in case that comes up?

John Matheson: Major capital projects.

Colin Beattie: Excellent.

In paragraph 33 of the report, I see that the number of out-patient appointments went up 34 per cent in four years. We talk about rising health expectations, but that seems like a huge increase to be caused only by rising health expectations. It is also a big increase even if we take into account the fact that we are all living longer. Thirty-four per cent is an awful lot. Do we have a full grasp of what the reason for that is?

Paul Gray: One of the reasons will be that we are trying to treat more people on an out-patient rather than an in-patient basis, so there will be some structural changes based on doing that.

Aileen Keel will give you more detail.

Dr Aileen Keel CBE (Scottish Government): The main reason is the demographic change: the ageing population and the fact that, as people live longer, they develop more chronic diseases and have more comorbidities, and therefore require more and, in many cases multiple, out-patient clinic referrals. That is the major explanation. There may be others that we do not understand quite so well, but we need look no further than the ageing population to explain the significant increase in the number of out-patient referrals.

Colin Beattie: That feeds through into paragraph 35, which describes delayed discharges. They seem to relate mainly to patients aged over 75 who have complex needs.

We have commented before in this committee that the transfer of resources from the NHS to primary care does not seem to be happening at the pace that is needed. Are we in a chicken-and-egg situation? We need to build capacity in primary care to be able to cope with the patients with complex needs who are being discharged and will need to be looked after, and at the same time we need to decide how to transfer the resources from the NHS in such a way that the NHS can still handle that period of transition. I hope that that makes sense.

Paul Gray: It makes perfect sense. I will turn to John Matheson on the question of primary care funding in a second; I know that there has already been an announcement about some of that.

The delayed discharge situation is complex. Of course there is additional demand on primary care, but there is also demand on social care and on the availability of care home places or care at home. The 2020 vision that I mentioned looks towards having more people living longer, healthier lives at home or in a homely setting.

That is why the integration of health and social care is so important. I know that £18 million of additional funding has been announced recently to help with that programme and provide support in dealing with some of the pressures that will be faced, and a further £10 million is available for distribution in this financial year. The Government is taking it seriously, because it is clearly better for people to be at home or in a homely setting than to be in hospital, once they are well enough to go.

I ask John Matheson to say what funding is proposed for primary care next year.

John Matheson: As part of the draft budget for 2015-16, there is a dedicated sum of money set aside called the integration fund. The totality of that fund is £173.5 million, of which £100 million is going into board baselines. Of the remaining element, £40 million per annum has been identified and prioritised for primary care, £5 million has been identified for the development of mental health services, and £10 million has been identified to enhance the infrastructure around telehealth and telecare.

Mr Beattie referred to delayed discharge, and that is an important issue that we are tackling just now, but part of the solution to delaying discharge is to delay admission in the first place. If we can

get upstream through the intelligent use of telehealth and telecare, and if we can keep people out of hospital by dealing with chronic diseases before they require hospital admission, that is part of the challenge. The work that we are doing, partly with European funding, to try to embed that approach across Scotland is an area of specific focus.

Colin Beattie: In 2013-14, the budget for the NHS increased by roughly 3 per cent in cash terms, which equates to about a 1 per cent real increase. That still makes it quite a challenge to meet the exponential growth in patient demand. A number of NHS boards are clearly having problems meeting their targets, and the Auditor General has highlighted the fact that some of them are doing so in an unsustainable way, which presumably refers to non-recurring savings. What are you doing to work with those boards to help them get on to a more sustainable basis? I am talking specifically about the ones that have non-recurring savings.

John Matheson: There are a couple of things to say in response to that legitimate question. Part of the answer is about long-term financial planning. Rather than just dealing with the year in question and maybe the following year, we are looking at where we are trying to get to in three or four years' time. That is our aim, but it is not helped by the fact that we have a time-limited spending review. We can give boards an indication of what their budget might look like two or three years hence, but we cannot give them assuredness. We give them that at the earliest possible opportunity, but it is dependent on the spending review cycle.

We have the 2020 vision of where we are trying to get to, so the strategic direction is clear. The introduction of integrated budgets for health and social care will assist in bringing together the budget resource that can be used across that sector.

10:30

NHS Scotland's reliance generally on non-recurrent lines has been coming down. There is always non-recurrent flexibility in the system; the issue is whether it is being used on a recurring or a non-recurring basis. You made the point earlier about trying to create some investment space in the system. The way in which that flexibility is used is important.

We have a commitment to give boards as much clarity as possible on the amount of funding that is coming to them. With regard to the financial planning cycle, we have signed three-year plans with most territorial boards. The detail for years 2 and 3 is less rich than that for year 1, but we have that commitment in place.

We are focusing at present on a couple of boards—one is NHS Highland—and looking at their levels of recurrent commitments that are not funded through recurrent resource. We have put specific resource into NHS Highland to work with it on looking at the shape of the services that it provides. NHS Highland was an early example of health and social care integration, so it has potential for progression.

Colin Beattie: You touched on an important point that does not seem to have been highlighted in the Auditor General's report about non-recurring savings being used for non-recurring expenditure. Is that a valid point about some NHS boards at the moment? We are looking at boards that apparently have non-recurring savings that, on the face of it, could be a problem in the future because we just assume that they are made against recurring expenditure.

John Matheson: Mr Gray mentioned the overall performance of the NHS in Scotland. Against an £11 billion budget, the health boards were £23 million underspent. Of that £23 million, £10 million was due to NHS Glasgow deliberately underspending to allow it to cover the anticipated double-running costs in south Glasgow hospital. The move to south Glasgow hospital is due to happen at the end of this month. That fantastic project is on time and on budget but there will be double-running costs, so NHS Glasgow prudently put aside some money in recognition of that.

That accounts for £10 million of the underspend. A similar approach was taken to £3 million by Dumfries and Galloway.

The Scottish Government tries to manage the overall position within the totality of a £12 billion resource. The underspend within the health and social care directorates for 2013-14 was £4 million, which is landing the helicopter on a drawing pin. The aim is to ensure that we maximise the amount of healthcare that we can get from the available resources. That necessitates looking at the inevitable non-recurrent flexibility that there will be in a year and how it can be managed appropriately to ensure that we maximise the delivery that we can get from the totality of the resource. That requires flexibility between boards and between me and board colleagues.

Colin Beattie: I have one final question. We beat ourselves up here about targets and percentages and so on. Do we have any figures that show how we compare with south of the border or with other European countries on things such as waiting times? Do we have anything like that?

Paul Gray: Mr Hunter will be able to help you with that.

Alan Hunter (Scottish Government): Yes, we do. I will pick up on unscheduled care. Obviously, if any patient is waiting for any length of time, we want to address that. It is important to know the journey that we are taking.

I have been in the Scottish Government for about a year but prior to that, I worked in acute hospitals in the health service. When I worked in the health service, patients always waited for a long time in accident and emergency departments. At Glasgow royal infirmary 10 to 15 years ago, patients routinely waited for long periods of time. A collaborative programme was introduced back in 2004-05 to address that. Over the years since then, there have been significant improvements. There has been some reduction in those improvements and there are some challenges in the system at the moment, but it is important to put that into the context that Scotland is still ahead of its international and United Kingdom comparators.

Colin Beattie: Do we have the figures?

Alan Hunter: Yes. The figures are that 7.3 per cent of patients in Scotland who attended major A and E departments in September 2014 waited more than four hours. In England, 8 per cent of patients waited more than four hours, so there was a marginal difference between England and Scotland. In Wales, 16.9 per cent and, in Northern Ireland, 24.3 per cent waited more than four hours. In New Zealand, where they monitor a less ambitious six-hour target, 6.2 per cent of patients waited more than six hours. In Australia, 18.6 per cent of patients waited more than four hours.

That puts the situation into context. Although we need to do and will do more for the Scottish population, we are ahead of the game on the pressures, which are coming in because of an ageing population. There has been a 17 per cent growth in admissions over the past seven years and that is matched by the growth in the population aged more than 75 years.

There are significant challenges in the system, but we are working with the Academy of Medical Royal Colleges and other partners to try to identify where the next change in unscheduled care and other areas will come. With the other UK countries, we standardised 11 waiting time procedures. In nine out of the 11, Scotland was better than England and, in all 11, it was better than Wales and Northern Ireland. That is based on the latest published studies.

Colin Beattie: You clearly have quite a bit of information.

Convener, I suggest that it might be of interest to the committee to have the comparative figures that are available circulated to members so that we can see where we are.

The Convener: Yes. Can you facilitate that, Mr Hunter?

Alan Hunter: Yes, absolutely.

Mary Scanlon: We constantly hear about the ageing population and people being treated in a homely setting, but exhibit 13 on page 40 of the report tells us that, over five years, there has been a reduction in home care of 11 per cent. That is a total of 60,950 fewer people receiving home care. We also have a 10 per cent reduction in care homes and a 36,500 reduction in the number of residents in care homes.

We are always being told that people are older and need more home care, but the provision of the services is going in the opposite direction to the level of demand.

Paul Gray: Dr Keel will help us with the interpretation of those numbers.

Dr Keel: Mr Hunter will help us, actually, because he has the statistics.

Paul Gray: Right, sorry. I knew that I was being nudged from the side.

Alan Hunter: I looked at those figures as well and needed some interpretation so I got the position on them. Although there has been a decrease in the numbers of patients receiving home care, the spend and the number of complex care packages have gone up. That is in line with what we are trying to do: we are trying to keep more patients in their own homes—there are figures that I can share that show that that is the direction of travel—and there are more complex care packages doing that.

Mary Scanlon: Is it the case that, in terms of the eligibility criteria for home care, the barrier has been raised since the Parliament passed legislation on that in 2001?

Alan Hunter: I can come back to you on that, but our direction of travel is that we want to keep people in their home and more resource is going into that, which matches the figures. I can share that information with the committee.

Mary Scanlon: There are 61,000 fewer people receiving home care, which is an 11 per cent reduction. Therefore, people have to be more ill to receive home care. Is that the case?

Alan Hunter: We have patients who are in their home being looked after. That is the direction that we are going in.

Mary Scanlon: People's care needs have to be higher and more complex to receive home care than was the case 10 years ago. Is that the case?

Alan Hunter: The eligibility criteria have been changed, yes.

Stuart McMillan: Good morning, panel. My first question is a point of clarification. As a new member of the committee, I come to the issue with a fresh eye. We have received a clarification from Mr Gray on the £830 million backlog. His submission states:

"A further £97.6 million relates to properties which will be replaced with current redevelopment projects."

I am aware that NHS Greater Glasgow and Clyde is discussing the potential for two new health centres, in Clydebank and Greenock. When I read that comment, I was not sure which category those two facilities would fall into. Would it be the backlog or the figure for new projects?

Paul Gray: New facilities would involve capital investment, so that would not be a backlog issue. That would involve a decision about whether the board will invest money in new facilities.

Stuart McMillan: Okay—thank you.

A number of points struck me when I read the report. One was that there is something in it for all the parties that are round the table. Clearly, there are challenges, as our witnesses have said, but there are also positives, as the report indicates. With an eye to the future, it is obvious that there are challenges ahead.

One point that struck me is in case study 2, on page 14, which describes the situation in NHS Orkney and states that the board's spending on locum doctors increased by 30 per cent. The report points out that there are issues in trying to attract people to Orkney, although I do not know why, because it is a beautiful part of the world. What actions is NHS Orkney taking to encourage more people to go there to work? Does it have any flexibility to offer people incentives?

Paul Gray: As you say, the island boards can offer living conditions that are very attractive to the many people who like that kind of setting. Boards can offer incentives if they choose to do so within their overall pay arrangements and terms and conditions. However, what tends to make boards most attractive to people is if they operate on a stable and effective basis. That is why NHS Orkney is giving so much attention to responding to the section 22 report on it to ensure that it is seen as a good place to work and that it is running and delivering a viable health service, which in general it is.

Mr Matheson can say more about the support that we have given to NHS Orkney and the considerations that it has undertaken.

10:45

John Matheson: The other factor that will make NHS Orkney more attractive is the redevelopment of Balfour hospital, which will take place over the next two to three years.

NHS Orkney has clinical issues. There are a couple of factors there, the first of which concerns the point that Mr Gray made. The second relates to the potential that exists for NHS Orkney to redesign the services. A number of the islands have had general practioner-led services, and it is possible that a nurse-led service might be more attractive and might make it easier to fill vacancies.

In the section 22 report on NHS Orkney, we recognised that, because it is a small board, its level of technical accounting expertise needed a bit of enhancement. We sent up a colleague from NHS Fife to give it dedicated support around the time of the annual accounts, and some continuing support beyond that. We try to provide some central support when that is possible. I know that NHS Orkney has had support from and strong connectivity with NHS Grampian around communications and other aspects of the support services that it provides.

Stuart McMillan: Thank you—that is helpful.

Paragraphs 24 and 25 are about capital spending. When I read them, I immediately thought of the convener of the Local Government and Regeneration Committee, Kevin Stewart, who regularly says that it is not possible to legislate for common sense. Paragraph 25 suggested to me that a joined-up approach was being taken. Because NHS Grampian was not in a position to spend the money at the time in question, it wanted to put that back. I thought that it was a positive thing that NHS Grampian was working in tandem with the Government, but I could also understand why some people might want to challenge it. Will you provide a bit more information on what happened in that situation and the rationale for it?

John Matheson: Each year, in the capital programme, we deliberately overcommit at the start of the year. We do so because we anticipate slippage. There is a risk attached to that, but we work closely with boards in managing it. The level of overcommitment in the current year was around £20 million, but we still anticipate that the capital budget will come in on line.

We supplement the capital budget with capital receipts, which come from the sale of buildings that are no longer used or required for healthcare provision. There is obviously a risk attached to that as well, which relates to the timing of capital receipts, the timing of planning permission for developments and so on. That is a dynamic source of funding, but we work closely with

individual boards and on a pan-Scotland basis to make sure that we utilise the totality of the capital resource that we have available. That requires detailed discussions.

In that context, NHS Grampian is specifically mentioned in the report. It has had significant capital investment over the past number of years. It has the new emergency care centre at Aberdeen royal infirmary and an additional £120 million was recently committed to develop maternity and cancer services there.

When we talk about the balance of care, it is important that we talk about primary care investment. You made a point about the development of health centres in Glasgow. On the health service side, in addition to the development in Forres, a development in Inverurie is imminent. A significant amount is happening in the capital programme.

We recognise that, overall, Scottish Government capital funding has reduced significantly over the past few years, and we have tried to protect the health capital resource by transferring money from revenue to capital to supplement the capital resource that is available. Recently, we have had a major commitment in the form of the £824 million south Glasgow development. That is coming to the end of its investment programme, with a further £30 million of the £824 million to be spent in 2015-16.

We work closely with boards and, in that, we are ably supported by the Scottish Futures Trust. We talked earlier about long-term planning. If members are interested, we are happy to share with the committee our 10-year capital plan, which we have just produced and which has been agreed by the cabinet secretary.

Stuart McMillan: That would be useful. However, as a West Scotland regional MSP, I must put on the record that, although they are in the same health board area, Clydebank and Greenock are not in Glasgow.

John Matheson: I apologise. I was referring to the greater Glasgow and Clyde area.

Stuart McMillan: That is fine.

Has the process that is under way and which is set out in paragraphs 24 and 25 of the report been in place for some time, or is it a recent initiative between the Government and the NHS?

John Matheson: We have taken this approach for a number of years now. However, for the past three or four years, we have been focusing on a comprehensive asset management report on the state of the NHS estate, which has enabled us to quantify the outstanding backlog maintenance in the NHS. When we started that work in 2011, we split the maintenance into low, medium, significant and high priority. The total investment required was just over £1 billion.

For the past two or three years, boards have had a clear focus on the issue, and the commitment that has been given is that within five years all the high and significant priority backlog maintenance identified in the original report will be removed through either corrective action in the maintenance of the facilities or a recognition of the capital programme that we have in situ. For example, the opening of the new Dumfries and Galloway royal infirmary will enable a move off the existing site and will therefore remove the need to deal with the backlog maintenance on that site.

Stuart McMillan: Finally, with regard to paragraph 39 of the report, which refers to the co-location of staff, one of the carers centres in the west of Scotland—it is in the NHS Greater Glasgow and Clyde area—has a member of staff based at a hospital to assist people who have been discharged. This has happened within the past year and a half or two years, and I was supportive of the funding application for the proposal, because those involved felt, at least beforehand, that it would help people when they were discharged, and indeed the whole process. Would you encourage such moves? Would you be looking to do more of that, and with non-statutory partners?

Paul Gray: Yes. As we proceed along the path of integrating health and social care, it is important to ensure that they are integrated for the patient, the carer and the family so that they do not have to seek multiple sources of advice in different places. The more we can do to ensure that there is a single source of advice and that that source is near the patient, the carer and the family, the better. We are very supportive of the kinds of approaches that you have highlighted being taken forward.

Nigel Don (Angus North and Mearns) (SNP): Good morning, colleagues. I want, if I may, to think a bit further ahead. I am conscious that any audit report is, almost by definition, about what has happened historically, with some reference to current processes, but it seems to me that one of the current processes must be to look beyond 2020 to, say, 2030 or 2040.

The reason why I say that is that some of us, despite what our years might tell us now, are thinking of being around at that time, and the statisticians tell us that that is quite possible. Of course, from the health service's point of view, life is just going to get more difficult, and we all know that. I have not seen any discussion about how things are going to have to change on that timescale.

What level of thinking goes on and what is your current thinking on how we are going to cope with a significantly older population?

Paul Gray: At the beginning of this month, I set up the new directorate of population health improvement within the health and social care directorates because I am clear—and I am following the advice of senior colleagues—that tackling the overall health of the population is the way in which we will make a real contribution to addressing the future pressures that you rightly identify.

Advanced healthcare systems across the world can tell a reasonable story about how they have improved their efficiency and sustainability and the quality of the care that they provide, but I do not think that you will find an advanced healthcare system anywhere in the world that says that it has cracked the issue of population health. Scotland has particular characteristics in relation to population health that are long standing and that contribute significantly to some of the deep-rooted inequalities in Scotland. For that reason, I have taken the decision to establish the new directorate, which will draw in the best clinical advice that we can get in order to ensure that we make real progress on tackling population health. It will take a long time and it will be difficult, but I suspect that, if I get it right, you and I will be the beneficiaries.

Nigel Don: Yes. I am with you, but I challenge you—not on what you said, but on the consequence of that. If you and I and those around us live healthier lives for longer, that merely defers your health board problem. At some point, the old age effect takes over—none of us likes to think about it, but we have all seen it—and we then need the medical help that you are well placed to provide. If we stick around longer, it is worse when we get there; it is more complex and the comorbidities that Dr Keel spoke about are more evident.

We may defer it, and we will probably—nationally—have to spend less in order to get there, which is what we have to do first, but by the time we get there, it will be even more complicated and expensive. I guess that I am trying to get us to how on earth we are going to be able to handle that when we get there. That is probably a question for the Health and Sport Committee, but I suggest that what you are doing to think about it is a question for the Public Audit Committee.

Paul Gray: Indeed. I assure you that we are on our way in thinking about it, although I am not claiming to be finished yet. Dr Keel will have something to add in a moment.

The situation will inevitably be that end-of-life care will continue to be required and will be complex and acute. However, if we can shorten the period over which that is required, that will be beneficial to both the individual and the health service.

I always find it very hard, for reasons the committee will understand, to put an economic value on end-of-life care. It is a hugely important component of what we do. We need to get better at it and we are getting better at it.

Dr Keel will have some useful things to say on that point.

11:00

Dr Keel: First, before I come to the question, I note that in the discussion so far we have focused mainly on financial and performance management issues. They are important, but only as a means to an end, which is to improve clinical outcomes across patient care. The Audit Scotland report refers to those improved outcomes. If we look back over the past 20 years, expressed in rates of mortality, all-cause mortality has been reduced by 36 per cent, cancer mortality is down by 26 per cent, coronary heart disease is down by 69 per cent, and stroke mortality is down by 64 per cent.

How has that been achieved? It has been achieved through a combination of prevention and better treatment. Treatments have changed dramatically. When I started in medicine, if someone had a heart attack, they were kept lying on their back in a coronary care unit for nearly two weeks, but now people who have a heart attack are up and back home within a day or two. That is just one example of how things have changed, and they will continue to change.

From where I am sitting, it seems that what we need is to have more emphasis on prevention while maintaining the NHS's ability to deliver improved treatments as they come along. Why am I focusing on prevention? I would like to see the younger people who are coming through living longer, and living healthier lives for longer, so that they do not develop all the comorbidities that the current population are developing. They might get into quite late old age with only one or two, as opposed to half a dozen. In the end, less NHS resource will be required to care for them at the end of life. That is the aim.

We are doing a lot around prevention. We have lots of investment in the early years, for example. There is lots that we could talk about. The direction of travel is getting upstream of the health problems that the Scottish population face at the moment and stopping them developing in the younger generation.

Nigel Don: I think that I heard some logical answers in there, if I might put that kindly. If I

heard you correctly, you are suggesting that, if we live healthier longer lives—which has to be good, regardless—the process of dying is shorter and probably less complicated medically because we have not developed some comorbidities on the way. You are entitled to the view that, when we get to counting the beans, that end-of-life process is cheaper and therefore more manageable in health service financing terms, which are the terms in which we have to discuss it. There is a degree of logic in there that I understand and respect.

I return to Dr Keel's answer to the first question, which was about waiting times for out-patient appointments. I think you suggested that they are one of the effects of an ageing population, which I can entirely believe. Mary Scanlon talked about the comprehensibility of the numbers that are in front of us. I am not sure that I have seen many of these data broken down by age of the patient. I do not think that we want to break down everything—that would just create a much bigger spreadsheet—but some of the data could helpfully be broken down by age of patient, which must give us some clear indicators of why things are arising.

Dr Keel: That is a very helpful suggestion. It was already going through my mind that we need to have a closer look at what is in the data. Thousands of out-patient numbers are coming forward now. I suspect that those patients are very much in the older age groups, but we need to have a better understanding of the numbers.

The Convener: We have a brief supplementary from Stuart McMillan before I bring in Drew Smith.

Stuart McMillan: I am happy for you to take someone else first, convener.

The Convener: Carry on.

Stuart McMillan: Paragraph 69 of the report highlights the issue of longer-term financial planning, but there is a potential risk to that. As has been stated, there has been a reduced level of capital budget to the Scottish Parliament and Government, and it is anticipated that less money will come to the Scottish Parliament going forward. Dr Keel talked a moment ago about the ideal situation. How do you marry up the two? We know that there will be less money and cuts to the Scottish Government budget. How do you plan for that?

Paul Gray: In response to Mr Don's questions, Dr Keel and I were talking about something that is 10 to 20 years out in terms of delivery although, as Dr Keel said, we have made significant progress on quite a number of crucial conditions.

There are two things to say about the short term. One is that there is a 75 per cent correlation between delayed discharge and performance in accident and emergency. In other words, more delayed discharges will put more pressure on A and E departments. That is why tackling delayed discharge is an important short-term measure to improve the performance of the acute sector, as well as what happens in the home and in care homes. It is critical for patients that they are out of hospital as quickly as possible, but continuing on that path of improved efficiency is also one of the ways to address the financial pressures that we face.

We are running a programme on patient flow through hospitals to ensure that the flow is as smooth and predictable as possible. We have brought in a world expert in patient flow, because we think that the area is important. At a recent conference that I attended, he stated that, although many countries are talking about improving patient flow, Scotland is actually trying to do it. I will not claim success yet, but we are making a real effort in the area. We are doing things to improve the efficiency of the system as it stands while trying to marry that up with the planning for the long term, to which Mr Don has rightly drawn attention.

Short-term initiatives will make a difference. We are putting in place a six-point plan for the improvement of unscheduled care in hospitals. We have worked very hard with the royal colleges on that, as Mr Hunter mentioned. We are taking seriously the short-term improvements that we need to make as well as planning for the longer term.

John Matheson: I have three points on that. First, the protection that the health budget has been given, which is welcome and which mirrors the protection given by the Department of Health in England, gives us relative, if not absolute, protection, as we still have efficiency targets to face.

The focus of the committee today has understandably been on issues such as the increased resource and the budget consequentials. The challenge that we have in the NHS is to look at how effectively and efficiently we use the totality of our resource and not just the marginal increase each year.

Another point is that the progress on quality of healthcare, in relation to infection rates, readmission rates and so on, which has been identified and recognised internationally, is important in terms of the effective use of the £12 billion. When I talk about financial performance, I am talking about quality-driven financial performance. If we get the quality right, there is a better chance of the numbers being correct.

The final point is that, after staffing, the highest area of spend in NHS Scotland is prescribing. We

spend about £1.4 billion on drugs. One of our areas of focus is on national therapeutic indicators and performance indicators and how we use the drug budget as effectively as possible.

Drew Smith: A couple of members have referred to Mr Gray's helpful written submission on the issue of backlog, which is where I will start. The health service is a hugely complicated thing, because people are hugely complicated. However, on the issues primarily around buildings, I am interested to know why you are going to be a year later than forecast in clearing some of the backlog? Earlier, we talked about anticipated slippage in relation to something else. Do the forecasts take into account the fact that there is going to be slippage, or can we just give and take a year on such forecasts?

Paul Gray: Obviously, we would prefer to meet the initial targets that we set ourselves for backlog maintenance. One of the issues in backlog maintenance is that, once a maintenance programme is started, issues that were not visible on the surface are often discovered, so it takes longer. We are close to where we want to be, but we are not absolutely there. We predict that the high-risk things will be dealt with fairly soon and all but £150 million of the next level down will be dealt with by 2016-17. Mr Matheson is on top of the detail and can provide further information.

John Matheson: As I mentioned, the other thing that we are trying to do is to protect the formula capital budget, which is the source of funding for backlog maintenance. That is increasing between 2014-15 and 2015-16 from £146 million to £157 million, although it does not all go on backlog maintenance—it also covers things such as equipment replacement.

The commitment that we have given is that we will remove all high-risk and significant-risk backlog maintenance that was identified in the 2011 survey within five years. We will do that either through actioning and dealing with it or through the new capital replacements, such as the new sick children's hospital, the new Dumfries and Galloway royal infirmary and the new south Glasgow hospital, which will enable our colleagues in Greater Glasgow and Clyde to leave the sites at Yorkhill and the Victoria infirmary.

Drew Smith: I was on the Health and Sport Committee around the time that we discussed some of the issues in that survey. The written submission is encouraging. It gives us reassurance and I recognise that progress is being made. However, if we forecast something and do not meet it, and then are given a reassurance that it will be met in 2015 or 2016, our confidence in the ability to do that is taken away.

Can you say a word about the proportion of the high and significant maintenance that relates to surplus buildings that are unlikely to be used as opposed to those that are still key to the delivery of healthcare?

John Matheson: I do not have that detail to hand, but I will happily supply it to the committee.

Drew Smith: I turn to the issue of delayed discharge and the issue of people. We talk about delayed discharge, but when my constituents come and see me they do not refer to their relative as a delayed discharge. They tell me the story of an elderly person who is perhaps coming towards the end of their life and is experiencing a level of service from the health service that is often life limiting—it has made their condition or variety of conditions worse—and has made their experience worse. It has made the experience for that person at the end of their life and for the people around them not what we would want it to be.

I am interested in whether you believe that there is anything more that we can do to understand the personal impact on human beings of some of the problems around delayed discharge. We can measure the number of people who are delayed in leaving hospital because of a lack of a care home place or because of lack of adaptation at home, but do we measure the number of people whose health has been affected by that? Do we measure the fact that they are then back in contact with their GP and other specialists or back in hospital within a set period of time? Do we measure the fact that, if their life ends shortly afterwards, their family may feel that their life ended sooner than it needed to, because of the stresses of such things? Are any of those things measured?

Paul Gray: I have two things to say. First, I am not suggesting that you raise it here, but if a particular case comes through your constituency case load that you think should be drawn to our attention, I ask you to do that. The only way that we can fix problems is if we know about them. If you have particular issues, please raise them with us directly.

Secondly, on the impact on individuals, the key reason that we want people not to stay in hospital longer than they need to is not because of the money but because it is not good for the individual. I am absolutely clear about that. A person who stays in hospital longer than they need to will have a less good outcome. The impact will be felt in various ways. If someone has stayed in hospital too long, they may be unable to return home because they have lost the confidence and the facility to be at home. Their families, carers and friends will see that difference in the general way in which they conduct themselves.

11:15

The reason why we think that it is worth taking the issue seriously is precisely because we already know that outcomes will be better for people who get home, or to a home-like setting, at the right moment. We are focusing, therefore, on seeking to get people discharged within 72 hours—that is the ideal timescale. The two-week and four-week periods are important staging points, but 72 hours is what we are looking at in terms of getting people out.

We are working with the seven local partnerships that have the most significant challenges: Aberdeen, Edinburgh, Falkirk, Fife, Glasgow, Highland and South Lanarkshire. We have people working on that today to ensure that we do more. Glasgow is making good progress on something called discharge to assess. Rather than have someone wait in hospital to be assessed, they are discharged in order for the assessment to take place, as long as it is clinically safe for that to happen.

To respond to your point, I want to be clear that we know that keeping people in hospital for longer than they should be there does not produce good outcomes, and that is why we are serious about tackling the issue. Of course there are financial benefits to taking action on the issue as well as benefits in terms of the pressure on A and E units and so on, but the core point is that it is better for the individual.

Drew Smith: I was not trying to raise a specific case, but I think that we all know—from the cases of people we represent or from the cases of people we visit in hospital—that a bad experience in hospital towards the end of someone's life can destroy their confidence, make them not want to go back into hospital and make them give up. That is the experience of too many people. Do we attempt to measure that kind of experience? Some people will not experience any particular impact from being delayed in hospital—they will manage it fine and just carry on—but, for others, it might be another hurdle on the way towards the end of their lives that can be destructive for them personally, and stressful for family members who experience it alongside them.

Paul Gray: If there is a poor clinical outcome, that will be followed up through the hospital's clinical governance procedures. However—you might not expect me to say this, but I will—what is important is that, if patients, carers or families have a complaint about the way in which they or their family member was treated, they make that complaint at the time, when something can be done about it. People sometimes feel that they should not complain, or that it is not fair to do so. Of course, we like to be praised, but we absolutely need to know what goes wrong, as well.

The patient opinion website is an excellent website that is used across the United Kingdom and is being promoted by us in Scotland. From it, we get some great stories about people who have been well treated, but we also get some important stories about people who have not been well treated. One example—it happens to be from England, but I will use it—concerns someone who, after four years, only now feels able to come forward and say that something did not go as well as it should have done and talk about the serious impact that that had on them. They have had an excellent response. I have seen NHS Greater Glasgow and Clyde responding well to complaints and seeking to get in touch with the individuals concerned.

I want to keep in our minds the fact that, in the majority of cases, we are doing well. However, where that is not the case, it is important that we get the facts and the details from the families quickly, so that, if there is something that we can do to address the problem, we have an opportunity to do so and, if we cannot do anything, we can at least learn from what happened. That was one of the big lessons of the Vale of Leven inquiry. We discovered that there were things that could be done, and which we are now doing. We do not want to wait a number of years for something like that; we want to know now.

Drew Smith: There will be instances of complaint when specific things have happened and need to be resolved as appropriate. There is also the issue of systems, and the number of people who are subject to delayed discharge will be down to issues such as the lack of a space at a care home, appropriate adaptations at home or a care package to facilitate that person's return home. It is a matter of individual complaint, but it is a systemic problem that the resources are not in the right place at the right time for individuals.

My final question is about the extent to which Mr Gray, as the chief executive of the health service, can resolve those issues. What is your sense of the level of change that is required in local government? We obviously want to work in partnership, and that is our whole direction, but there are competing demands, competing budgetary pressures and competing decisions to be made. We are all aware of local authorities that will be making cuts to warden services and to the provision of care alarms and other things that people need at home. Ultimately, it is not within your gift to solve those problems.

Paul Gray: No. There are three things to say in response to that. First, I am perfectly clear that the health service cannot resolve the issue all on its own, but that brings me to my second point, because that is why the integrated joint boards are so important. The discussions in the past were

about whether the health service was putting pressure on local government and whether local government decisions were putting pressure on the health service. An integrated joint board with an integrated budget will see that picture as a whole, so in a situation where the health service can do something that might save pressure and cost on local government, there will now be an incentive to do that, because it will be a two-way incentive. The incentive for local government to reduce pressure on the health service will be equal, because there will be an integrated joint board with an integrated budget, so there will be a genuine budgetary and resource incentive for everyone to work in the most efficient way together.

At the risk of repeating myself, the third point is that we must continue to put the person at the centre. It is about a better service for people, so the thing that I am pressing at the moment with colleagues who are responsible for those areas is that, in thinking about governance, resources and money, we must continue to put the person at the centre of the decisions that we take.

Drew Smith: That relates back to the figure that Mary Scanlon highlighted about the 11 per cent reduction in people receiving care at home and the figure for delayed discharge bed days rising by 9 per cent. Is it too cynical to say that there is a direct correlation there?

Paul Gray: There is a simple correlation in so far as, if resource outside the hospital decreases, pressure in the hospital increases. On the other hand, if we get better at improving the health status—the overall health and wellbeing—of people who are leaving hospital, they will need less when they get out there. It is not a one-way algorithm. If we get better at improving people's health status, they will need less care when they leave hospital, and if they can self-manage and self-care, rather than being dependent on resources provided by the state, that is in the interests of the individual, because they have more control over what they are doing, and it is in the interests of the state, because it costs less.

It is a complex set of interactions, but we are working to ensure that we make the best of what is available in the health service and in local government to maximise the benefit for people.

The Convener: I call Colin Keir.

Colin Keir (Edinburgh Western) (SNP): Thank you, convener. Please accept my personal congratulations on your appointment.

Having looked at the report, some of my colleagues have picked up on the fact that not everything is doom and gloom in the garden. There are obviously challenges, but there are some good points as well. I will carry on from where Drew Smith was, with a question about care home provision.

You have pointed out the pressures on areas such as Edinburgh and Aberdeen, which I assume come from property pricing and all the rest of it, over which you do not necessarily have a great deal of power. Given the difficulties that have been pointed out in the report and elsewhere, including at the Health and Sport Committee, how do you expect the cost relations to develop? Are the boards learning from what has happened over the past few years, when provision in certain areas has become pressured? Is an end in sight? Is there a plan of action to ease the pressure by helping local authorities or whomever with the problem?

Paul Gray: You are right to point out that the causes of pressure in different areas—in different geographies, including towns and cities—are different, depending on the economic circumstances and the demography of each area. We are working with the areas that are under most pressure to ensure that they are thinking carefully about the solutions that are likely to work for them. Some solutions will work pan-Scotland, but other solutions, such as those applying to care homes and so on, will have to be tailored a bit more to the area in question.

John Matheson and I had a useful meeting yesterday with NHS Lothian's chief executive and his finance director about some of the options that they have for tackling the pressure that they face. Options include changing the way in which some beds are used, ensuring that step-down facilities are available and working with the local authority to ensure that, over time, facilities that we currently own can be transformed into care home places. Those solutions will have to work for specific localities. We are working hard on that.

At the health and social care management board, we are hearing a report every two weeks from the director of health and social care integration to ensure that we as a board are sighted on what is happening across Scotland, rather than focusing on particular geographies. We also have regular discussions with NHS board chief executives, to ensure that they, too, can learn from what is happening in other board areas.

Colin Keir: Other pressures that spring out at me relate to the problems with drugs, whether they are generic or patented. We have a new medicines fund—is it £40 million?

As for how all the new reforms that have come in are affecting the pressures that have been identified over the past year, how do you feel about the coming year? Will it be a bit more manageable when it comes to dealing with the

new drugs, appropriation and so on? Your comments on that subject would be helpful.

Paul Gray: I will ask Mr Matheson to say what we are doing on the budget for drugs.

The year 2015-16 will be another tough year. The demographic trends will not start going downwards next year or the year after. We will face demands on the health service. There is growing demand from the public for the services that they want to receive, and there is demand on the drugs budget, which Mr Matheson mentioned as being one of the most significant aspects of our budget. However, I know that boards are working hard to deliver local delivery plans that represent financial balance for them in 2015-16. I do not claim that that will be easy, but I believe that it is doable.

11:30

John Matheson: I have three points. We have a policy called prescription for excellence for our strategic direction and how we manage the pharmacy resource. It is not just about the drugs resource; it is about the relationship with community pharmacists and the drug companies. Our strategic direction is driven by our 2020 vision.

It is important for us to focus on the new drug pressures, but we also need to look at the totality and how we spend the existing drug budget of £1.4 billion. We have a good rate of prescribing generic drugs—at 83 per cent—but 80 per cent of our prescribing is repeat, so how do we manage that effectively? How do we engage with GPs and primary care teams on how prescribing is managed under the national therapeutic indicators for statins, inhalers and proton-pump inhibitors?

On the detail of the financial resource, we recognise the significance of drug pressures. In 2014-15, we have given NHS boards an additional £10 million in recognition of the in-year pressures that they face, and we have given them an additional £30 million for 2015-16.

Colin Keir: I am aware of the time, so I will leave it there.

Mary Scanlon: Although Drew Smith did not have an example, I feel that I can use an example because it was on television earlier this week, although I do not have the patient's permission. Debbie Michie was not kept in the Ian Charles hospital for 72 hours as a delayed discharge; she was held there for more than a year. I know that everyone is well aware of her case. Health and social care integration is supposed to solve all those problems, but although we have had that integration in the Highlands for two years, one patient there has waited for more than a year.

As an MSP for the Highlands since 1999, I know that people are scared to speak out or complain. They say to me, "Say something, but don't mention my name, where I live or my condition." Someone might have a list of complaints about all the cancelled operations at Raigmore last week, but they will ask me not to mention their name, because they are scared that they will get picked on or put to the bottom of the list. Mr Gray seems to understand that patients are scared to speak out, as are staff.

My next point is on what Stuart McMillan said about all the cuts from Westminster. The NHS budget at Westminster has been protected since 2010 and the witnesses have spoken about the additional consequentials that have come to Scotland and NHS Highland as a result of increased spending at Westminster. Instead of us listening to threats of cuts coming down the line—obviously, nobody knows what will happen in May—it would be exceptionally helpful if you told us what the real-terms changes have been in the NHS budget since 2010.

There are many figures in the report, but when it comes to a report card that is based on a policy of excellence, the biggest scare factor in the NHS occurs when a GP thinks that they cannot deal with a patient, so they send the patient for an out-patient appointment. For the 12 weeks that the patient has to wait for that appointment, they do not know what is wrong with them. That is a worrying time.

It is even more worrying that the section 23 report that is in front of us shows that, between March 2010 and March 2014, there was a 4,200 per cent increase in the number of patients who waited more than 12 weeks for an out-patient appointment. The figure went up from 157 to 6,754. There was also a 34 per cent increase in the number of people who were on waiting lists. If my GP refers me to a consultant, from that day forward I am worried about what the consultant will say. I repeat that there was a 4,200 per cent increase.

I just put those points on the record, convener. The witnesses might wish to respond in writing or orally, but I needed to make those points.

Paul Gray: What would be of assistance, convener? I offer to write to the committee to make clear the real-terms changes in the budget since 2010.

As for Mary Scanlon's point about out-patients, I note that the LDP guidance that we have issued says in response to this priority that

"Each and every NHS Board is expected to achieve the 12 week outpatient standard and the LDP should include a delivery trajectory. Long waits for outpatient appointments

are unacceptable and NHS Boards must also eradicate waits over 16 weeks which is the longstop."

Mary Scanlon: The report says that things are getting worse instead of better.

Paul Gray: We now want to make things better.

I will respond briefly to the point about patients being afraid to come forward. I place on record my genuine view that patients should have nothing to fear from coming forward. If they believe that they do, and if they have evidence to support that, I am happy for them to come to me directly. If the issue involves clinical care, the chief medical officer will review it, and if it involves administrative standards, I and my senior team will review it.

For staff, there is a confidential helpline, which although paid for by us is not run by us. There is the patient opinion website, where people can put up details anonymously, if they so wish. I am genuinely anxious to encourage everyone in Scotland who has a concern to raise it, and I give my personal commitment that I will take such issues very seriously. If any member around this table or elsewhere has evidence that individuals, whether they be patients or staff, are afraid to raise concerns, I want to know about it.

The Convener: This is my first meeting as a member of the committee, Mr Gray, and I have to say that I think that your approach has been open and transparent and that you want to continue in that manner. By way of background, it would be helpful to hear about some of your frustrations over the fact that some targets have not been met. Some of that will be down to poor management practices in boards; I do not want you to name any names, but will you share with us your concerns and frustrations? After all, we have put forward our concerns, and you must have frustrations that you convey in your internal discussions with board members and managers who, because of poor management practices, are not meeting targets that should have been met with the resources that have been made available.

Paul Gray: Let me make one or two points about that. First, I am keen for other boards to learn—and learn quickly—from NHS Tayside's excellent performance in delivering the A and E four-hour waiting time target, and Mr Hunter and others are actively ensuring that that is the case.

On 17 December 2013, NHS Healthcare Improvement Scotland produced a critical report on NHS Lanarkshire that pointed to certain management practices that were not efficient and to unclear governance structures. NHS Lanarkshire has taken that report seriously and tackled the issues, but I felt frustrated that some of the issues arose because of unclear management procedures and governance arrangements. I have asked other boards to take on board the lessons that were learned from Lanarkshire.

Committee members will be aware of the difficulties that NHS Grampian has faced. To begin with the positives, we had the annual review of NHS Grampian on Monday, and it was like a different place. However, although there have been significant improvements in NHS Grampian, I am of course frustrated that it has taken a lot of time and input to get us there. Malcolm Wright, the interim chief executive, has made a big difference, and I am seeing clinicians who were previously disengaged and unhappy—and who, in some cases, were behaving quite counterproductively—coming forward and saying, "We want to be part of the solution."

I am frustrated that at times we seem to operate in a way that leads to frustration in the health service, which then bubbles up in doctors, nurses and other professionals feeling the need to express themselves in the press. I am not seeking to inhibit people's right to speak up when they think that things are going wrong—quite the contrary, as I said in response to Mary Scanlon—but it frustrates me that we do not yet have the processes, procedures and governance in place to allow people to express their concerns and have them dealt with internally.

A great deal of excellence tends to go unnoticed in the health service, and it frustrates me that the public discourse is regularly about the few things that go wrong. Believe me—when things go wrong, we want to know about it, and we want to fix them. If we make mistakes or harm people, we should apologise for that without reserve but, as I have said, it frustrates me that all the discourse is about what is not going well instead of the many things that are going well.

I recognise that you and a number of other members are new to the committee or returning to it, and if you would find a private briefing from me, senior officials and senior clinicians helpful, we would be happy to provide it. I am not saying that I do not want to be on the record—I am happy to be on the record on all matters that are connected with performance delivery and accountability—but if such a briefing would be helpful we would be delighted to provide it.

The Convener: I am not claiming that poor management practices are exclusive to your organisation—they can happen in many organisations—but if, after it was brought to your attention that people had engaged in such poor practice and you had sought to reconcile matters and ensure that things were taken forward in a positive manner, we found when we revisited the matter that those people had not met the obligation that had been put on them, would you, as would be expected in any organisation, say that

those individuals should not continue in their positions? I am not asking for specific examples; I am simply taking it as read that that would be the position.

Paul Gray: The employers of most staff in the NHS in Scotland are of course the boards, but I have made it very clear to the chairs and chief executives of NHS Scotland boards that I expect high standards of performance. I also expect people who have not done well to have that drawn to their attention and to be given the opportunity to recover and redress the situation. My view is that if, having gone through a proper performance management process, any individual—not just in the NHS but in public service generally—cannot meet the required standards of the job, they must take a different job at a different level where they can meet the requirements or move on to something else.

The Convener: I thank the panel for its evidence and suspend the meeting for five minutes.

11:43

Meeting suspended.

11:48

On resuming—

Section 22 Reports

"The 2013/14 audit of the Scottish Police Authority"

The Convener: We come to agenda item 5. I welcome the Auditor General for Scotland; Gillian Woolman, assistant director, Audit Scotland; and Mark Roberts, senior manager, Audit Scotland. I ask the Auditor General to make a brief statement.

Caroline Gardner (Auditor General for Scotland): I wish the committee a happy new year.

I am presenting this report, "The 2013-14 audit of the Scottish Police Authority", under section 22 of the Public Finance and Accountability (Scotland) Act 2000. The SPA and the Police Service of Scotland came into being on 1 April 2013, and 2013-14 was the first year for which the SPA produced accounts. The SPA's accounts include the financial results of the Police Service of Scotland.

As the committee is aware, the process of bringing together the eight predecessor forces and the Scottish Police Services Authority was challenging, and I undertook to keep the committee informed about progress since my last report in 2013.

Significant progress has been and continues to be made. I would like briefly to highlight three key issues. The first is the pressure that the SPA's finance function was under during 2013-14, which was in part due to the substantial challenge of bringing together the finance systems of the eight predecessor forces and the Scottish Police Services Authority, and in part due to the fact that numerous finance staff left under the SPA's voluntary redundancy and early retirement scheme. In addition, there were protracted discussions between the SPA and the Police Service of Scotland to establish where responsibility for the finance function should lie, which led to a delay in appointing a permanent director of finance and generated uncertainty among finance staff about their future permanent roles and responsibilities. The SPA appointed a permanent director of financial accountability in 2014, which puts the SPA in a good position for the future.

The second issue arises from the pressures that the SPA's finance function experienced in 2013-14. The auditor—Gillian Woolman, who is on my left—gave an unqualified opinion on the SPA's

annual report and accounts for the year, but, unusually, she expressed a modified conclusion on the matters that she is required to report on by exception. She concluded that for certain areas adequate accounting records had not been kept during 2013-14, which meant that the audit was difficult to complete; more important, that limited the information available to support the decision making of the SPA and Police Scotland during the year.

Thirdly, the auditor assessed progress against recommendations in my November 2013 report on police reform. As exhibit 1 in the report before the committee today highlights, the SPA has made progress on or completed the majority of those recommendations. The key area in which work remains in progress is the development of a long-term—by which, for the avoidance of doubt, I mean into the mid-2020s—financial strategy that takes into account all the additional cost pressures that the SPA faces. Having such a strategy in place will provide a road map to help ensure a sustainable future for policing in Scotland. The SPA is continuing to develop the strategy based on its strategies for workforce, estate, fleet, information and communication technology systems and procurement. I have asked the SPA's auditor to continue to monitor progress on that work as part of the 2014-15 audit.

Alongside me are Gillian Woolman, who is an assistant director of Audit Scotland and the appointed auditor responsible for the audit of the SPA, and Mark Roberts, who is a senior manager with Audit Scotland and leads on our work in the justice area.

As always, convener, we are happy to answer the committee's questions. You will forgive me if I rely on Gillian and Mark more than usual, given the state of my voice today.

The Convener: Thank you for your statement, Auditor General. We have questions from Colin Beattie first of all.

Colin Beattie: The important thing is that the auditor gave an unqualified opinion, whose basis, I assume, was that, despite the deficiencies that she encountered, she was able to satisfy herself as to the SPA's accounts. Is that correct?

Caroline Gardner: Absolutely. I ask Gillian Woolman to talk you through what happened and how she arrived at a clean opinion, with the modification that I have described.

Gillian Woolman (Audit Scotland): That is clearly a very evident question to ask in the circumstances. At all times, the external audit was carried out in accordance with Audit Scotland's audit guide, so that we could see all the audit evidence and seek all the information and explanations that we required to reach a final audit opinion. The audit opinion on the financial statements was unqualified.

However, since 2010-11 there has been an extra part to the audit opinion that highlights areas that we may have to report on by exception. Consequently, the modification arises in that area, which relates to the adequacy of accounting records and information and explanations that we received in particular areas. I assure the committee that we undertook very much a full-scope audit, in order to reach the unqualified audit opinion on the financial statements.

Colin Beattie: That is a very important point to put on record.

The scope of the merger was almost unprecedented in Scotland, and it brought together nine different financial systems. Was the level of difficulty in the first audit commensurate with that?

Caroline Gardner: As I think I said in my opening statement, first, we absolutely recognise that complexity; there is no doubt that it was a very big merger in any terms. That would always have had an impact. Over and above that were the delays that were caused in reaching agreement about who had responsibility for the finance functions between the SPA and Police Scotland and the consequent delays in appointing key members of staff. Added to that were staff departures under the voluntary severance and early retirement schemes and the uncertainty that remaining staff experienced about what their jobs would be. All that added to the unavoidable complexity that Gillian Woolman and her team had to deal with.

Colin Beattie: I have a couple of specific questions on those inadequacies. In your report you state:

"adequate accounting records have not been kept."

Can you define that?

Gillian Woolman: Yes. I am happy to provide the detail in response to that question. The audit opinion highlights aspects of the accounting records in the areas of fixed assets, bank and cash and the supporting documentation for the calculation of key accruals in the balance sheet at year end. We discussed what we were looking for through the planning process, working closely with finance officers, and our expectations about what accounting records would be readily available in the course of the audit work during 2014.

In due course, there was a delay in the production and passing over of particular records relating to fixed assets. Although they were forthcoming after a period of time, they were not right up to date for the transactions for the year, but we worked closely with client officers to

determine where the transactions were recorded, which was directly into the financial ledger. Consequently, we revised our audit approach and did audit work that was additional to what we might otherwise have done.

That gives you an idea of that particular area.

Colin Beattie: It was not that the records were incorrect; it was that they were incomplete at that point—they were not up to date. Is that correct?

Gillian Woolman: Yes. We were seeking audit evidence for 2013-14. Normally for the audit of fixed assets, we would look at fixed-asset registers, which we would expect to be up to date. However, it was only at the end of August 2014, which was several months after the end of the year that we were auditing, that there was clarity that the registers had not been kept up to date but that the transactions had been recorded elsewhere—that is, directly into the financial ledger. It took time to receive explanations that enabled us to progress with the audit work—quite a bit later than would have been the case otherwise.

Colin Beattie: Okay. There were delays, and I imagine that there would be some cost involved in that. Can you quantify the cost?

Gillian Woolman: We are currently discussing with the client the additional time that was incurred and what that means in terms of cost.

Colin Beattie: Do you have a ballpark figure?

Gillian Woolman: We have not raised that directly with the client at this stage.

Colin Beattie: You are talking about property, plant, equipment and accruals. Was that the only problem that was encountered? It seems to be the main focus of what you are talking about, but were other aspects of accounting involved?

Gillian Woolman: We have produced a year-end report—an annual report—that has gone to members of the Scottish Police Authority. We also produced reports during the year and interim management letters, which went to the audit and risk committee. We highlighted weaknesses in the internal control systems. The full report at year end is quite extensive but, for the purpose of the audit opinion, we drew out the areas that we felt were of materiality to the overall opinion. Those were the areas that we homed in on.

Colin Beattie: I go back to my original question. Would you say that the deficiencies that you found were broadly commensurate with the complexity of the merger of nine different areas? Presumably, those areas were all using different systems. Although the accounting principles might be the same, physically bringing that all together within a fairly short period must have been quite difficult.

Gillian Woolman: The organisation that had responsibility for the preparation of the financial accounts was in no doubt as to the size of the challenge. As the external auditors, we were in no doubt as to the size of the challenge for the first year of the two new organisations. Nevertheless, over time, and over the period of the audit, additional weaknesses came to light. As well as our identifying findings that required amendment in the accounts between the draft and the final report, the client also identified additional information that came to light at the client's end that meant that changes had to be made to the accounts.

12:00

Colin Beattie: Would you say that the SPA finance people were aware of those deficiencies and were working on them, or were they unaware of them?

Gillian Woolman: There were changes in the personnel leading the finance functions over the period. Also, they had to work with a wider community of finance officers across Scotland to glean key pieces of information, and some of that information came late—that was to do with internal communications.

Caroline Gardner: To add to that, the underlying causes come back to the two things that I highlighted in my opening statement: the delay in agreeing where responsibility would sit, and the consequent turnover and instability of staffing until after the end of the first year. The posts have now been filled and people have much more certainty about their roles and responsibilities. However, in the period from before the establishment of the SPA and Police Scotland to after the end of the first financial year, the need to fill some key posts meant that there was a great deal of pressure on individuals and a lack of ability to make progress on the things that we would all agree are the basics for good internal control and financial management and reporting.

Colin Beattie: Ms Woolman, you said that you issued reports to the SPA on various issues. Have you had responses? Has the authority taken on board those reports and is it actioning them?

Gillian Woolman: It is part of our normal practice for any audit to issue interim management letters during the year. All our findings are discussed with officers before the finalisation of the report, and we get management responses on how it will take forward the actions. Such reports are discussed at the SPA's audit and risk committee, the members of which provide effective scrutiny to ensure that officers engage with the issues that internal and external audits

have raised. We are confident that actions are being taken to address the issues.

Colin Beattie: Will you continue to follow up on that?

Gillian Woolman: We will.

Mary Scanlon: My first question relates to the recommendations. As a member of the Public Audit Committee, I imagined that the recommendations would be about issues such as scrutiny and effective spend, so I was surprised that seven of the eight recommendations recommend that Police Scotland and the SPA "continue to work together". Do those bodies need to be reminded by the Auditor General and Audit Scotland to work together?

Caroline Gardner: It is worth reminding ourselves that the recommendations on which I am reporting progress appeared in my original November 2013 report on police reform. At that stage, there had recently been an agreement about who would play which roles in relation to the central services that are required. Clarity was emerging on who would take lead responsibility for which issues.

The recommendations date back more than a year, and we are now reporting on progress. I certainly feel that it is good news that, for most of the recommendations, the work is either complete or very much in progress. I bring them to the attention of the committee given the level of interest that there has been in the new service over the period of its life since April 2013.

Mary Scanlon: Given the public spend on the single police force, we would take it for granted that the two people at the head would work together.

My second question follows on from Colin Beattie's point. In the conclusion, paragraph 9 states:

"certain accounting records were not adequate".

It continues:

"and difficulties were encountered in conducting the audit".

I have heard the response about the accounting records of the different police authorities not being the same, but what difficulties were encountered on top of that in conducting the audit?

Gillian Woolman: The two were very much related. The issues were about trying to establish where the up-to-date accounting records were and who was responsible for them at the time, and gleaning sufficient audit evidence to pass over to the audit team to enable us to carry out our standard audit work and to reach conclusions based on the assurance that we could draw out. Again, that links to the fact that it was a period of transition for the finance teams as they came together. Some people departed, some roles were changing and some permanent roles and functions were not yet known.

Mary Scanlon: It is just that you say that apart from accounts being "not adequate", you encountered "difficulties". We will leave it there.

I understand that the ICT system is still under development and has been postponed again, this time to September 2016. Will you give us an update on that? I also understand that in certain areas the payroll is administered by local authorities but that there will be a single payroll system from March. Will you give us an update on whether those issues will lead to duplication and whether the delay will have an impact on the savings that we are all expecting?

Caroline Gardner: This report is not about doing fresh audit work on new areas. We did the work that was required for Gillian Woolman to sign her audit opinion and look at progress against the eight recommendations in my November 2013 report. Mark Roberts might pick up on the broader question of ICT and how we plan to look at that in future.

Mark Roberts (Audit Scotland): On ICT, some of my colleagues have been in discussion with Her Majesty's inspectorate of constabulary for Scotland about the work that will go on over the next few months to monitor and evaluate progress on the implementation of the i6 programme. As the Auditor General said, we do not have more detail, based on the report that we are considering. However, i6 is one of the key areas of ICT development in the public sector that we are interested in monitoring and assessing as work goes on.

Caroline Gardner: Gill Woolman might want to comment briefly on the payroll system.

Gillian Woolman: In the 2013-14 audit, on which we are reporting, we are right up to date with the payroll arrangements and the legacy arrangement with the local authorities that acted on behalf of the joint boards in that regard. Our interim management letter drew attention to the service level agreements and the period for which they would continue.

We have yet to find out more information, as we undertake our 2014-15 planning, to determine future arrangements for the payroll system. I have yet to glean that information, as the auditor.

Mary Scanlon: Is the system on target for March 2015? That is six weeks away, but you still do not have all the information. That is perhaps something that we can look at.

Gillian Woolman: As the external auditor I am not in a position to say whether the payroll system is on track for March 2015.

Mary Scanlon: Okay. Does Mark Roberts know whether it is correct to say that the IT system has been postponed to September 2016?

Mark Roberts: I do not know, to be honest. I will come back to the committee on that when I have spoken to colleagues. We had a meeting with HMICS to discuss the subject yesterday. I will reply to the committee in writing, if that is all right with the convener.

Colin Beattie: I will take the convener's guidance on this, but given that we have not had evidence on information and communication technology, payroll systems and so on, we really have no basis for discussing these matters.

The Convener: If the information can be provided by way of background, that would not be unhelpful. I do not think that we should seek evidence on the matter.

Mary Scanlon: It is in Police Scotland's corporate strategy.

The Convener: Yes—but I do not think that we are looking to take further evidence in that respect. We are working on what is before us today.

Nigel Don: I want to clarify my understanding of the words that are used. Forgive me if I make this too simple. Am I right in thinking that an organisation gets an unqualified report on its accounts if the numbers add up, and that the comments that Audit Scotland has made are, in essence, about the systems that it found? Auditors want to be convinced that all the stuff that they have not seen—because they never see everything—is credible.

Caroline Gardner: That is right. The audit opinion is a professional view that the financial statements give a true and fair view of the financial picture, in line with all the professional standards with which financial reporting and we, as auditors, have to comply. There is no question but that the financial statements give that true and fair view.

What the modified conclusion conveys to me as Auditor General, and on to the committee, is that the process of getting to that opinion was more difficult—because of the inadequate records during the year—than we expected, which is unusual. As Gill Woolman said, the requirement came in in 2010-11 and this is the first time there has been a modified conclusion. Given the level of public interest, I think that it is worth our while to draw that to the committee's attention, but I do so in the context of our also having acknowledged the improvements that are being made in financial management and financial reporting within both the SPA and Police Scotland.

Nigel Don: My colleague Colin Beattie made the point that one cannot really be surprised that there is some difficulty when nine organisations are brought together.

Turning to my second point, however, I note that you spoke about voluntary redundancies and the loss of what I presume were fairly important people in the context of the systems that we are talking about. I wonder whether anybody has reflected on the wisdom of that voluntary redundancy process and whether people have learned a lesson. My recollection from my time in industry is that voluntary redundancy was not made available to everybody because some people were plainly needed. I wonder whether that lesson has been learned in this context for public service in general.

Caroline Gardner: You are absolutely right about the general point. Our report on managing mergers in the public sector made the point about the need to be clear about the key people and key skills that are required, and the need to ensure that they are in place during the transition.

There were particular challenges in this case because of the number of bodies that were being merged—the eight former police authorities plus the Scottish Police Services Authority—the fact that they were dispersed around Scotland and the fact that part of the rationale for the merger was to make savings that would help to ensure sustainable policing. Those challenges were there anyway, but the delay in agreeing who would take which roles and therefore which staff would be needed made it more difficult to ensure that people were kept during the critical period, were available to build the new systems and—to be frank—were available to provide information to Gillian Woolman and her team when they did the audit. The genuine complexities of the work were made more difficult by the delays that were encountered.

I think it is worth our while to note again that, as well as making the audit more challenging—that is a fact, and I am grateful to Gillian Woolman and her team for the work that they put in in order to deliver a clean audit certificate—that also meant that the information that was available to Police Scotland and the SPA to inform their decision making was not as rounded and complete as it might have been during the year, which has an effect on how public money is used. That is part of the reason why I am bringing the report to the committee today while fully recognising the progress that continues to be made in resolving the issues.

Nigel Don: Thank you. On a simple point of information, are you going to go back for next year's annual report?

Caroline Gardner: Gill Woolman will be auditing the accounts of the SPA, including Police Scotland, every year. It is part of what we are required to do. My decision on whether to report to the committee and the Parliament will depend on what comes out of that audit, as it does in every other case. I am sure that at some point we will go back and have another in-depth look at the performance of Police Scotland, and particularly at progress in developing and delivering a financial strategy, but for now there are no firm plans for when that will take place.

Nigel Don: Thank you.

Drew Smith: I think that everyone recognises that it was always going to be a complicated business to bring together the eight forces and the SPSA. That was not a surprise, but it would also not be a surprise that somebody would need to be in charge of the finances and people would need to be clear about who that was.

We have seen the extraordinary spat between Police Scotland and the Scottish Police Authority being played out in public. What you show is the underlying reality of what that relationship between the two organisations created in terms of the flow of information and recording of information. You describe the negotiations to decide who was doing what as "protracted". It was a squabble, basically, was it not?

Caroline Gardner: You will understand, Mr Smith, that as auditors we aim to use language very clearly about what is going on, and we reported in full on the history of the merger in November 2013. I think that what we are seeing now is the legacy of the problems that were experienced in the early months leading up to the merger and the transition to the new arrangements.

There was uncertainly about whether the SPA or Police Scotland should lead on provision of support services. That took time to resolve, and eventually the Scottish Government moved in and brokered an agreement between the two parties. We are now seeing real progress, but we are also seeing the legacy of that delay.

12:15

Drew Smith: In order to have confidence that the arrangements that now exist will be successful, is it necessary to understand where the responsibilities lay between the organisations? Would you put it squarely that the organisations had different views about how the arrangements should work? Is the issue resolved, and is it now just a question of moving on? Was one organisation more overbearing than the other about how it wanted to do things? Was there a real difference in how they wanted to do the job?

Caroline Gardner: That was a core issue in the report that I published in November 2013. As is often the case with problems and situations that are to a great extent about the roles that individuals play and the different perceptions that they bring, it is not possible to say that one person or organisation was responsible. I said at that time that the lack of clarity about who would do what, which was inherent in the legislation and the wider planning, did not help, and that there may have been scope for the Government to help to resolve the situation more quickly.

That is a different point, however, and we are not looking to reopen those questions. What we are saying now is that there were consequences of the delays during 2013-14. In Gillian Woolman's view in particular, staffing has now reached a stable state, which is a good thing. We will continue to monitor how the people who are now in post are delivering what they are responsible for in terms of good financial management, good financial reporting and good use of public money overall to support policing in Scotland.

Stuart McMillan: In paragraph 9 of the report, you mention:

"the suppliers were paid in a timely manner".

How much of an issue was that? Was that a consequence of some bills or invoices not being paid during the previous financial year, which then carried forward to this year?

Caroline Gardner: Gill Woolman will answer that in detail. The point that I was trying to make in that paragraph was that the finance staff in the SPA and Police Scotland were working very hard to keep the show on the road. Inevitably, there was within that a process of prioritisation of the most important things to be done.

Gillian Woolman: As external auditors, we look at the financial accounts. In that paragraph, we are trying to provide assurances that the management accounting was being maintained throughout the year. Indeed, that was an important area for informed decision making to take place throughout the year. That paragraph was intended to give confidence that the finance staff who were in post were working very hard and that they knew that their priorities were at the interface for ensuring that supplies and payment were all kept up to date during the first year.

Stuart McMillan: On the particular part of paragraph 9 that I quoted, was there an issue?

Gillian Woolman: No—there was not an issue regarding payment of suppliers.

The Convener: We have discussed the process that was followed. We are dealing with substantial sums of money regarding what both organisations are responsible for. Obviously, you are playing an

important role in public scrutiny. In reaching your conclusion, you have made demands for information from the organisations, and you expect them to respond. Have you considered, on reflection, that more preparatory work should have been done to ensure that the information was provided, so that your job would have been much easier than it seems to have ended up being in the end?

Caroline Gardner: You are absolutely right, convener. Policing in Scotland costs about £1.8 billion a year, and it is a service that we all rely on and expect to be there when we need it. In my November 2013 report, the point that I was making was that, for a change of such a scale, the run-up period was quite short, for good reasons. The fact that some areas were left uncertain left open the potential for the delays that we saw in the agreements about who would play some of the key roles in managing and reporting on finances.

The committee has had the Scottish Government's assurance that the lessons will be learned for any such future moves. The underlying point that I would like to bring out is that for any organisation spending public money and delivering public services, having good financial information and good financial records is not something that we are interested in just because, as auditors, we are bean counters, but because it is one of the underlying ways in which we all, as citizens—and you as parliamentarians—know that public money is being properly used and accounted for.

I am very pleased with the progress that has been made within the SPA and Police Scotland, so I thought it appropriate to bring to the committee's attention the challenges that were experienced as a result of the delays during its first year of operation.

The Convener: Some of us are new to the committee, so we do not know all the background to this, but I wonder what lessons have been learned from the process. Significant public funds are involved. I can think of other organisations that receive significant public scrutiny that have been asked for information and see it as an absolute given that such information has to be provided or their organisations cannot continue to function.

You have highlighted some of the areas where information has been provided and that information has led to the report that you have given us today. My point, therefore, is that somewhere along the line the information has not been collated properly, or it has not been possible to collate it. What lessons have been learned to ensure that that has been dealt with in relation to the new organisation that has been created? I would expect it to have been dealt with in a robust manner to ensure that the significant public funds that have been spent are recorded properly.

Caroline Gardner: We are very confident that the foundations are now in place for good financial management in the future in the SPA and Police Scotland. The people are there, the roles are clear and the backlog of work in terms of pulling the information and the system together is well under way, in Gillian Woolman's estimation. We will continue to monitor that.

In relation to the bigger question of other such changes and mergers, the committee has the Government's commitment to ensuring that lessons are learned for the future. Change on such a scale does not happen often, which is one of the reasons why it is so challenging. However, where there are future mergers or reforms that bring up the same sorts of questions, the committee has my assurance that we will continue to look closely to make sure that lessons are learned early, and not just when the reform is complete, at the end of the process.

The Convener: I thank the Auditor General for Scotland and her team for their contribution today.

"The 2012/13 audit of North Glasgow College"

The Convener: Before we move to item 6, I advise colleagues that I was the constituency member for North Glasgow College up until 2011. I understand that I do not have to declare that as an interest, but I just thought that I would draw it to the committee's attention.

We have received responses from the Scottish Government and the Scottish Further and Higher Education Funding Council on the Auditor General's section 22 report on the 2012-13 audited accounts of North Glasgow College. There have been several changes in the committee membership since this was last discussed on 19 November. Members should note that North Glasgow College no longer exists, as it merged with Stow College and John Wheatley College on 1 November 2013 to form Glasgow Kelvin College. In addition, we have the submissions from the committee's consideration on 19 November and the Auditor General's report on Glasgow Kelvin College.

I invite members to comment on the submissions that we have received and any action that they propose we take.

Colin Beattie: The submissions that we have received do not change my opinion on this from the last time we discussed it. The way the whole thing has been handled is outrageous. The fact that the main college concerned no longer exists creates enormous difficulties. Reading through everything, I think that there seems to be every evidence that, at the very least, there should be some sort of investigation into negligence and

possibly even incompetence. I feel strongly that the whole thing has been badly handled. Some of the points that have been raised include the fact that the remuneration committee had not met for a number of years, that it received inadequate management support and that it was unaware of funding council guidance. All the paperwork shows that the case merits a proper investigation of how that happened.

The Public Audit Committee is not an investigating committee, but I ask your guidance, convener, on where we can take this matter next. If the entity still existed, it might be easier, but it does not, so where can we escalate the matter for further investigation?

Mary Scanlon: I totally agree with Colin Beattie. It is outrageous and a sad reflection on the auditing procedures. We are constantly being told that lessons have been learned and things are in place, that we now have merged colleges that in future will adhere to the public finance manual, and that the same thing will not happen again, but the fact is that it did happen and that individuals awarded themselves around £750,000 of taxpayers' money—thank you very much. Their defence was that they had not met for a number of years, that there was inadequate management support and that they were unaware of funding council guidance.

I read the funding council response and, to be honest, I really was not impressed by that either. It said that the guidance is on the website and that if only the college had looked at the website, everything would have been fine. It is gold-plated passing the buck. I do not know what the way forward is, but the entity does not exist any more, as Colin Beattie said. As an audit committee, we know that £750,000 is money that would go a long way towards home care and other things that are required in our public services, rather than being awarded to college principals and vice-principals. I do not know what we can do. It seems to me that they have probably got away with it.

I am pleased that the matter was brought to our attention by the auditors, Scott-Moncrieff, and I would like advice as to whether and how we can take it forward. I put on record that I fully agree with Colin Beattie about the very concerning information that we have had about these huge pay-offs.

Stuart McMillan: I have a simple question. In the light of the reports on North Glasgow College and the work that has taken place on the issue, is a similar piece of work going to be done on the other merged institutions?

Colin Beattie: On the final page of the submission from the Scottish funding council, it states:

"It should be noted that the Scottish Public Finance Manual does not affect the non-incorporated colleges".

How can we reassure ourselves that they are adhering to proper guidelines—if there are guidelines—to ensure that they do not encounter the same problems? They are publicly funded bodies, so there has to be some accountability. How are they accountable?

Mary Scanlon: We need an assurance that it cannot happen again. That would be helpful and Colin Beattie makes a good point.

The Convener: It is clear from those contributions that members feel strongly about the issue and believe that the response so far has been unsatisfactory. I suggest that we write to the Scottish funding council expressing our concerns and emphasising the fact that we are not satisfied with the latest response, and that we make it clear that we want to take the issue forward and seek a further response on that basis. Is that agreed?

Members *indicated agreement.*

Section 23 Reports

"NHS financial performance 2012/13"

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

12:29

The Convener: In item 7, we are invited to consider a further response to the committee's report on NHS financial performance in 2012-13 and the report on NHS waiting lists, published last June.

The committee considered the Scottish Government's substantive response to the committee's report on 5 November 2014 and agreed to note it. The response that members have before them today is the final outstanding part of that response. Members will note that the response explains the improvements in the terminology used to report on NHS performance. The Scottish Government intends to provide a focused set of priorities and standards, which are summarised on page 12 of the local delivery plan guidance.

I draw colleagues' attention back to the discussion that we had earlier today when we received evidence from Mr Gray, who gave a commitment to come back to the committee on the very issues that we are considering under the current agenda item. I suggest that, given that commitment to return to us, that would satisfactorily deal with this item. Is that agreed?

Members *indicated agreement.*

12:31

Meeting continued in private until 12:55.

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