The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Monday 2 February 2015

Session 4

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CONTENTS

PUBLIC AUDIT COMMITTEE
3rd 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:

Chris Brown (NHS Highland)
Garry Coutts (NHS Highland)
Nick Kenton (NHS Highland)
Elaine Mead (NHS Highland)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

Highland Council Chamber, Inverness

Scottish Parliament

Public Audit Committee

Monday 2 February 2015

[The Convener opened the meeting at 09:29]

Decision on Taking Business in Private

The Convener (Paul Martin): Good morning, ladies and gentlemen. I welcome members of the press and public to the third meeting in 2015 of the Public Audit Committee. We are delighted to be here in Inverness and I take this opportunity to thank the Highland Council for its hospitality so far. This is the second time that the committee has visited Inverness—I think that our previous visit was in 2005—and I thank you for making us feel so welcome.

I ask all members of the public to ensure that electronic devices are switched to flight mode or are turned off. We received apologies from Drew Smith and Stuart McMillan in advance of the meeting.

Agenda item 1 is a decision on taking business in private. Do members agree to take in private item 3 to allow the committee to discuss the evidence that it has received and to seek any technical advice from Audit Scotland?

Members *indicated agreement.*

Section 22 Report

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

09:30

The Convener: Agenda item 2 is an evidence-taking session with NHS Highland on the Auditor General for Scotland's report, "The 2013/14 audit of NHS Highland: Financial management". I am delighted to welcome our panel of witnesses from NHS Highland: Garry Coutts, chair; Elaine Mead, chief executive; Nick Kenton, director of finance; and Chris Brown, chief internal auditor.

I understand that Mr Coutts wishes to give a brief opening statement.

Garry Coutts (NHS Highland): Thank you very much, convener, and I welcome you and the committee to the Highlands. It is great to see you up here, and I am particularly pleased that you will be able to spend time with us this afternoon and see some of the great work that we are doing. I am immensely proud of a lot of what we are achieving. Groundbreaking work is going on in our partnership with the Highland Council, with which we have integrated health and social work, and we have made an absolute commitment to quality improvement and are working with acknowledged world leaders to transform our services by putting the individual service user or patient at the heart of all that we are doing. I hope that when you have the chance to hear about some of that work this afternoon you will share my excitement about the future.

That said, I am aware that, this morning, we are looking not at the future but back at last year's performance. I was as disappointed as anyone that we required an element of brokerage from the Scottish Government to achieve financial balance, and I was very disappointed that the Auditor General saw sufficient weaknesses in our planning and controls to publish the section 22 report.

NHS Highland values the audit process. We work closely with internal and external auditors and use their findings to help us to improve what we do locally. I assure the committee that we have reflected long and hard on last year's financial outturn and on the section 22 report. Today we will be able to report to you positively on the measures that we have put in place and our on-going work to ensure that we have more effective planning and better controls as we move forward, and I hope that that will give you confidence that we have indeed learned from this experience.

However, I think that it is important to look at our performance in context. In the 11 years that I have been the chair of NHS Highland, we have never

required brokerage. Given that, over the past five years, almost half of Scotland's health boards have required some brokerage at one time or another, seeking brokerage is in itself not an unusual occurrence. In fact, because boards have no capacity to keep reserves and will always seek to spend all their allocated resource, I think that it is sensible—if not inevitable—that NHS Scotland will want to retain some flexibility to support boards that might have slight overspends at year end. The alternative would be for us to be far more cautious and to have far higher underspends with money being returned to the centre and not used for the benefit of patients and the public locally.

The amount of brokerage that we required was relatively small; £2.5 million represents 0.3 per cent of our total budget. I am not making light of that. That is not desirable and is not something that I ever want us to repeat. However, that is a relatively modest amount from a budget of three quarters of a billion pounds.

The suggestion that the board was not aware of the financial position and was not involved in decisions about seeking support from Government was of major concern to the board. NHS Highland prides itself on its openness and the level of detail that we report in public. We webcast our board meetings. Not only does our board hold meetings in public; our committees hold meetings in public, too. That is not standard practice in all public bodies. The extent of our public reporting can be evidenced by press cuttings. I have with me a selection of press cuttings that report our underspend, which go back to August last year. If we were trying to be secretive, we were not very good at that.

On the back of the section 22 report, we commissioned our internal auditors from Scott-Moncrieff to review aspects of it, including our response to it. We are joined by our chief internal auditor, Chris Brown, who will be able to give his independent view of what he has seen. I hope that that will also give members confidence in us as we go forward.

I want to be absolutely clear: the board was fully aware of the financial situation. We made a judgment on the proposed management actions and came to the view that they were sufficient to bring us back into balance. Our financial position deteriorated because of unforeseen circumstances late in the year, and we were aware that there were on-going discussions with the Government about the position. That happens routinely. That was not the subject of specific reporting, but it was no surprise to board members; indeed, it was referenced in public meetings.

Although seeking brokerage was always a possibility, it was not agreed until 6 March and it was not signed off until 12 March. It was made public on the publication of board reports and press briefings less than a fortnight later and was formally reported at the next public board meeting six days after that. Again, when that was reported, there was no surprise for board members. We knew the system and the process, and the formal board and committee papers had kept us fully up to date. The suggestions that executives kept members in the dark are just not true. Those in our top team are among the most values-driven and transparent professionals I have ever worked with in 30 years in public life. I have 100 per cent confidence in their integrity and know that they could no more keep us in the dark than fly in the air. I hope that the internal audit report will give members confidence in that.

I reiterate that we are not complacent about the position in which we found ourselves. We do not underestimate its seriousness. We have learned the lessons and have worked since the start of the financial year to make improvements in our planning, financial controls and reporting. We have a team of executives, clinicians and managers who are committed to our quality approach to delivering services. We still have a way to go, but I am confident that we are on track.

We are working in a very difficult environment. Our view is that we have to develop a culture of continuous quality improvement that is led by staff on the ground who are empowered to work with communities, patients, service users, carers and families if we are going to deliver the type of health and care system that we all aspire to deliver. It will not be easy, but I genuinely believe that we are well placed to deliver, and we will use the hard lessons of last year to help us.

The Convener: Thank you for your opening statement, Mr Coutts.

You advised us that you are not complacent. Can you confirm that you accept the findings and conclusions of the section 22 report?

Garry Coutts: Absolutely. We have discussed the section 22 report with our auditors. As auditors do, the auditors gave a fair report of what they saw. We are working hard to ensure that we learn from the areas of weakness that were identified. We are content with that.

The Convener: Will you comment on the comments in *The Press and Journal*? You raised concerns about comments from the Public Audit Committee and advised that some of the conclusions were "unfounded".

Garry Coutts: There are three issues. There is the section 22 report. I am absolutely saying today that we accept what it reported, and we are acting on it. In that report there is no suggestion that the board was unaware of the financial position. There were some issues about the timing and I hope that

the internal audit report that we have provided as evidence gives some clarity on that.

Comments were made at the Public Audit Committee meeting on 5 November 2014 that we felt were not representative of what was said in the section 22 report and were unfair about the way in which my board had been informed of and discussed the issues. We were not at that meeting, so we did not get the chance to speak to you and your colleagues about what was said. If we had, and if we had been able to provide the evidence that is contained in our timeline and our internal audit report, you would have got some assurance that far from having been kept in the dark, we were working in an absolutely open way.

If I can make one more point—

The Convener: Please be as brief and succinct as possible in your responses.

Garry Coutts: I will, as much as I can.

The auditor looked at our board meetings. I do not believe that I was able to spend enough time with the auditor to ensure that they were completely aware of all the scrutiny that took place at all our committee meetings, which was vital to our governance. If I had been, the auditor would have been able to give you different advice.

The Convener: Colleagues will have questions on that later.

Ms Mead, can you clarify for the record who the accountable officer is for NHS Highland?

Elaine Mead (NHS Highland): For the record, I am the accountable officer, as chief executive of NHS Highland.

The Convener: For the record—we all want to be clear about this—reporting to the board is your responsibility as the accountable officer, and your responsibility alone.

Elaine Mead: It is absolutely my responsibility to report to the board.

The Convener: How do your heads of department—of which you have a number, I have no doubt—report to you?

Elaine Mead: I meet them regularly. We also meet weekly as a leadership team, and we meet formally as a senior management team, which is an audited meeting.

The Convener: Do they keep you informed of all aspects of the board's activities, including financial reporting?

Elaine Mead: They do. I keep very close to the detail, particularly on financial activity. I meet my chief operating officer, who in turn meets the director of operations regularly, so I am very close to the financial position.

The Convener: How do you expect those people to keep you informed? Do you expect them to keep you informed informally, or do you expect formal papers to advise you regularly with information that you would wish to receive on the board's financial arrangements?

Elaine Mead: Recently we have strengthened the reporting through a performance board, which I chair. Until that time, the discussions were more informal. As I said, I meet my colleagues weekly, but there are papers that go to our senior management team and then on to the board. My executive colleagues contribute to them, particularly the director of finance, who draws up the finance report for the board and the improvement committee.

The Convener: If your departments face financial challenges, would you expect to receive information on that from your heads of department quickly and formally?

Elaine Mead: Absolutely. I would expect to receive that very quickly.

The Convener: The board found itself in a position where it faced significant financial challenges and a brokerage was being negotiated. Given that you are the accountable officer, should you not formally provide information on that to the board members, in the same way as you expect your managers to provide information to you?

Elaine Mead: I would expect that, convener, and I did my best to provide that information by ensuring that the chairman was aware of our final decision to secure brokerage.

The Convener: We are not talking about the final decision; we are talking about the negotiations that were taking place with the Scottish Government, which were referred to in the Auditor General's report. To be clear, your responsibility as the accountable officer is to provide that information on an on-going basis, as you would expect from your managers.

Elaine Mead: It is, and I discussed our financial pressures with the board throughout the year. My board was quite clear—

The Convener: You advised the board formally.

Elaine Mead: Formally and informally.

The Convener: Are the discussions on the brokerage position detailed in the board papers?

Elaine Mead: The brokerage position was formally agreed only on 12 March.

The Convener: I understand that it was agreed then, but I seek some clarity. According to the Auditor General's report, there were discussions concerning board members' awareness that

brokerage was being discussed. At what stage was that advice given to the board?

Elaine Mead: Let me just look at the detail. I was about to take you through the timeline, convener. Would that be helpful?

The Convener: I think that we already have the timeline. We want to be clear that what you expect of your managers—your heads of department—is what the board members would expect of you. Is that correct?

Elaine Mead: It is, and I have done my best to keep the board informed, both formally and informally.

The Convener: Do you accept that that has been done informally, though?

Elaine Mead: I do.

The Convener: Advising board members at a development session that they are looking at the possibility of brokerage is unacceptable. Do you accept that?

Elaine Mead: I accept that that was done in an informal situation. I was speaking to the board about the challenges of our financial position.

The Convener: As the accountable officer, you have significant responsibility. You are paid a salary of £120,000 a year plus pension benefits, and those benefits are available to you because of the significant responsibility that is expected of you. Surely your board members would have expected you to provide formal information in connection with the financial management of the organisation—as you would expect your managers to provide such information.

Elaine Mead: I did my best to give that information to the board.

The Convener: I appreciate that you did your best, but it did not happen, did it?

Elaine Mead: It did happen. As soon as we secured the brokerage—

The Convener: I appreciate that it was secured, but do you accept that negotiations were taking place and that that information should have been provided to the board—as you would have expected your management team to provide it to you?

Elaine Mead: Yes, I accept that.

The Convener: Thank you.

09:45

Colin Beattie (Midlothian North and Musselburgh) (SNP): Good morning. I would like to explore one or two points that are raised in the Auditor General's report. The convener has touched on brokerage. In 2013-14, the brokerage was £2.5 million. Is there any prospect that brokerage will be required again this year?

Garry Coutts: I do not anticipate that brokerage will be required this year. We have publicly reported our position. We still have a gap in the last quarter to make up, to ensure that we break even, but I am confident that we will be able to do that. That is the position. I certainly do not expect brokerage to be required this year.

Colin Beattie: So, at this moment, as reported to the board—as far as the board is aware—there is no requirement for brokerage.

Garry Coutts: The board is working on the assumption that our management plans to break even will come to fruition. As always, we are reporting our monthly position regularly to the Scottish Government, and there is no plan in place to require brokerage.

Colin Beattie: The brokerage of £2.5 million is repayable over three years, so that has to be factored into your plans.

Comment is made elsewhere that two thirds of the current savings—the savings that are highlighted by the Auditor General—are non-recurring. You cannot make non-recurring savings every year; they are not sustainable. How will you tackle that?

Garry Coutts: We want to get into recurring balance. Indeed, if you turn the clock back to 2010, you will see that we managed to get the board into recurring balance. That is where we want to be. We need sustainable service redesign to make sure that we get the balance of our activity correct so that we get back to that position. However, we cannot do that overnight. It takes many years to get the full benefits from a lot of our redesign, given the level of public engagement that we have to get involved in to get service change agreed, so we will have to rely on non-recurring elements until we get the recurring elements coming back out.

As a board, we are aware that requiring a high level of non-recurring funding is not sustainable. Therefore, we want to convert that to recurring funding as quickly as we can, and that is what our targets are based on.

Colin Beattie: Is there a plan in place for that?

Garry Coutts: Indeed. Our board meets tomorrow and will look at the plan not just for the coming year but for a 10-year period, which involves significant levels of service change that we will need to be able to deliver. Obviously, we do not just have a 10-year plan; we have a one-year plan, a three-year plan and a 10-year plan with more strategic elements. That will be fully

discussed at our board meeting tomorrow, the papers for which are available online.

Colin Beattie: Does that 10-year plan replace or update an existing plan?

Garry Coutts: I have been around for a while, and people have traditionally looked very much from year to year. In the past few years, however, when resources have been tighter and there has been less ability to use existing resources to fund change, the reliance on longer-term plans has been essential. We have a number of longer-term plans for parts of our business, be it adult social care, acute care or primary care, and we need to ensure that they are refreshed. In short, this is a refresh of those plans, but it builds on the work that we have been doing in the past.

Colin Beattie: Will it not be a challenge to keep achieving these non-recurring savings? Paragraph 12 of the Auditor General's report says that in 2013-14 £11.4 million of the savings were non-recurring. How sustainable is that?

Garry Coutts: Recurring savings are far more sustainable and ensure that we get into financial balance, but non-recurring elements will always arise in a budget of three quarters of a billion pounds. What is an acceptable level of non-recurring savings in a budget of three quarters of a billion pounds? Personally, I think that the answer is £5 million or £6 million; that is probably a recognisable level. We certainly want to halve the amount of non-recurring savings that we use, and that is our plan.

Elaine Mead: Our plan going into next year is indeed to reduce our dependence on non-recurring savings in line with the Auditor General's advice. We think that that is good advice; we absolutely need to do that, and it will help us as we go into the next financial year.

Colin Beattie: In the section of the Auditor General's report entitled "Financial management", paragraph 6 says that although

"NHS Highland was forecasting that it would break even at the end of the financial year"

and monthly reports to the board forecast break even, the actual figure showed significant overspends. How could that have been?

Garry Coutts: This is where confusion might have arisen, but the board is absolutely clear about this. At the start of the year, we know our financial position and the savings that we have to find in that year if we are to break even. We report that we expect to break even on the assumption that we will make savings of a certain amount during the financial year, and we have plans to achieve those savings that crystallise during the year. We know that we will want to achieve certain savings in the acute sector—in hospitals—and that we will want to make certain savings in primary care. We know what the plans are, and our operational units scrutinise them to ensure that they are deliverable and acceptable as we move forward.

We therefore report the scale of the challenge of achieving the savings that we need to make to break even, the plans that we have in place to achieve that aim and what we have delivered under those plans. For example, last August, we reported to the board that we still required to make around £12 million of savings in the financial year. That was publicly reported and clearly stated, and our plans to make those savings were not just carefully scrutinised by us but reported widely in the local press. The board did not do that secretively in any way.

Colin Beattie: The Auditor General says that there were insufficiently

"detailed plans to bridge the gap between"

the

"deficit ... and"

the

"forecast break-even position."

Garry Coutts: I accept that if the plans had been sufficiently detailed and robust we would not have required brokerage at the end of the financial year. However, if you look at NHS Highland's history, you will see that we have delivered a break-even position year after year after year. The past financial year was an exception for us; as I have said, it was the first time in 10 years, at least, that we have required brokerage. I do not know whether we have even required brokerage in the past, but that was certainly the first time that we have required it in the 11 years that I have been chair of NHS Highland.

We as board members had to judge whether the plans were robust enough to deliver, and we believed that we had robust plans. Clearly on that occasion and in that year the plans were not robust; if they had been, we would not have required brokerage. However, despite the scale of the challenge and the fact that at the start of the year we had to make £20 million-worth of savings to break even and that we required £2.5 million in brokerage, a lot of our plans worked.

Colin Beattie: Paragraph 8 states:

"Poor financial management was a major factor in NHS Highland needing brokerage".

Although Raigmore hospital was a part of the reason, do you agree that it appears that poor financial management in general was an issue?

Garry Coutts: I have to agree. We would not have required brokerage if our financial

management had been sufficient. We are talking about a budget of more than three quarters of a billion pounds that involves hundreds of cost centres, lots of independent contractors and lots of individual managers managing budgets. It is our responsibility as a board to make sure that there are sufficient plans and controls to ensure that all of those deliver so that we deliver break-even overall.

Last year, that financial management was not sufficient. I am telling you that that is not acceptable to my board. We are revising our controls and our planning to make sure that that does not happen again. I can do nothing other than accept that our plans and controls were not sufficient last year.

Colin Beattie: Where does the responsibility for that lie?

Garry Coutts: It lies with the board. The board is charged with the responsibility of making sure that we break even and that we have controls in place. I do not want to go into everything in microdetail, but I would be happy to go into detail on where the underspends and overspends were across our budget.

Colin Beattie: In connection with that, a follow-up report by the internal auditor in May 2014 highlighted a lack of progress on the recommendations of the 2013 report. How did that come about?

Garry Coutts: We asked for those reports.

Colin Beattie: Why were the recommendations not implemented?

Garry Coutts: We had a change in the management team at Raigmore. We believe that we now have much more robust management there but, during the period of change, it was not possible to implement the full level of management actions that we would have wanted to take. It was not until January 2014 that we managed to get in place the new team, which—with the support of the director of finance, the chief executive and others—worked out the extent of the controls that were required. It put in place the new management regime that we are confident will deliver the performance that we require.

Colin Beattie: In paragraph 15 of the report, the Auditor General reports that

"NHS Highland's financial position will remain challenging for the next five years."

That is assuming that you break even and that recurring savings are made. Even then, there are other challenges to face. Are you satisfied that the planning process and the financial controls that you have in place are sufficiently robust to take you forward, given all the challenges that you face?

Garry Coutts: Yes. I meet all my colleague chairs in NHS Scotland regularly. None of them tells me that the situation will be anything other than challenging. There has been good news about accelerating the process of bringing us up to the level of NHS Scotland resource allocation committee share that we should be getting. That will mean additional resources, which will help us. I am absolutely confident that the approach that we are taking to eliminate waste and to focus on the quality of care for patients and members of the public who require our services will deliver a sustainable NHS Highland in the future.

Colin Beattie: My final question is on agency staff. The cost of agency staff increased by 83 per cent between 2012-13 and 2013-14. Are you still relying heavily on agency staff? It is clear that they account for a substantial element of the budget.

Garry Coutts: That is right. We still rely heavily on agency staff. We look to eliminate that cost as much as we can by getting substantive positions in place, but there are times when agency staff are useful in helping us through peaks and troughs. When change is being made, it is sometimes good not to fill posts permanently until the service has been reconfigured in the desired way. However, the level of agency staff is far too high, which is not a good place to be.

Colin Beattie: Is the number still at such a level?

Garry Coutts: No—it has come down. We are managing that process. Elaine Mead might have specific information to provide.

Elaine Mead: The locum costs were a particularly significant element of the agency costs. They had a full-year effect in 2013-14 of £9.7 million. We fully recognise that we have some of the highest locum and agency staff costs in Scotland. There are three reasons for that.

First, it is difficult to recruit some specialised doctors. I welcome the opportunity that we will have to discuss that in more detail with the committee. It is particularly difficult to recruit hospital doctors. There are some links with training numbers in the UK. In addition, the generalist jobs in our rural general hospitals are not as attractive as they were. There is a one in three on-call rate for those posts and they are very difficult to sustain, so we are still having to replace them with locum doctors.

The board has a role to play in taking on responsibility if we are unable to recruit general practitioners to practices. We have had some difficulties in a number of practices in the past 12 months. For example, there was a cost of nearly

£500,000 for maintaining a salaried GP in a team in Thurso. We are working on all those things to try to reduce our reliance on locums and the vast expenditure on them, but there are challenges for us.

10:00

Tavish Scott (Shetland Islands) (LD): This is not a court of law, although it might feel like that. We would normally all be sitting on the same level for a committee meeting. I know that you all have cricked necks from having to look up at us.

I have a number of factual questions on the Auditor General's report. First, the report suggests that the financial challenges that you had in the financial year that we are discussing were mainly due to an overspend on the operating costs for Raigmore hospital. Is that true?

Garry Coutts: That was a significant proportion.

Tavish Scott: What is significant in that sense? What was the percentage?

Garry Coutts: The percentage for Raigmore was about—I will look to Nick Kenton for the figure.

Nick Kenton (NHS Highland): The overspend at Raigmore for the financial year 2013-14 was £9.6 million.

Tavish Scott: With regard to its significance, was it 75 or 90 per cent of the problem in terms of the costs of the rest of the board?

Nick Kenton: If we ignore the brokerage, the overall overspend was £2.5 million, so the costs were in excess of the brokerage figure. In effect, the rest of the board was underspending, collectively.

Tavish Scott: So Raigmore was the problem.

Nick Kenton: Yes. There were other pressures, but it was the key problem.

Tavish Scott: Mr Coutts, you have already accepted that, as the Auditor General said, there were weaknesses in the financial management at the hospital. Is it fair to say that the problems were in the hospital rather than with the rest of the board's functions?

Garry Coutts: Yes, largely.

Tavish Scott: Mr Beattie asked about an internal audit report of April 2013 about Raigmore. It highlighted several weaknesses in governance, including in budgetary control. Is that correct?

Garry Coutts: Absolutely.

Tavish Scott: Mr Beattie asked about the follow-up report of May 2014. It highlighted a lack of progress. Is that correct and fair?

Garry Coutts: It said that there had been progress but that it was not sufficient.

Tavish Scott: What would you regard as being insufficient?

Garry Coutts: After the original report, a lot of training was put in place with budget holders on their budget management, which is work that is paying off. There were other issues. The board's improvement committee, which holds meetings in public that scrutinise underperformance, had regularly asked to see the management actions that were proposed in relation to Raigmore to ensure that we would see the improvement that we were looking for. Management plans were in place, but they did not turn out to be as well founded as we had expected.

However, as I said, we have seen changes in the senior management team in Raigmore. We will continue to use internal audit to back up our assumptions, but I believe that we now have a much better regime and process in place to ensure that we have got over the problem.

Tavish Scott: In hindsight, given that we are discussing a report about something that happened in a previous financial year, do you—particularly as the chairman—feel that the non-executive board members challenged your executive team hard enough on all those factors?

Garry Coutts: Yes—they did. As well as the audit committee and the board, we have two other committees that scrutinise. We get the plans for each of the areas where savings are intended, and they are challenged. We assess whether the impact of the management action is as predicted and whether it is not sufficient.

In Raigmore's case, management actions were detailed for us during the year, but they did not deliver the scale of savings that we wanted. We asked for those to be revised. We had particular issues in Raigmore that made it harder for us to put in the strength of management actions that we would have wanted and that we would have taken in other areas, but I do not want to go into the details of that here.

Chris Brown (NHS Highland): The follow-up report in May 2014 was done at the request of the board's audit committee. It was the non-execs who asked us to follow up on the actions that came from the previous report, because they were concerned about that.

Tavish Scott: That is entirely fair. However, if the challenge was good enough, I do not understand why the wider public—you have said quite a lot that you report all this in a wider public sense—were constantly being told that you were going to break even and that everything was fine, although you were actually not at all breaking even

and were running a deficit, and you ran a deficit right through the year.

Garry Coutts: We absolutely made the position clear. We reported to the public our belief that we would break even and, with sufficient management actions, close the deficit gap. We said that from August 2013 onwards.

In August 2013, a *Press and Journal* editorial said that we would have a £10 million gap if we did not have in place the management actions. Mary commented that we had to make the savings, but she was—rightly—concerned because she did not want the savings to impact on patient care.

The Convener: Are you referring to Mary Scanlon?

Garry Coutts: I am sorry—yes, I was referring to Mary Scanlon.

Mary Scanlon (Highlands and Islands) (Con): My comments are being used in evidence against me.

Garry Coutts: We made it absolutely public that we still needed significant management actions to be taken to ensure that we bridged the gap.

Tavish Scott: It is a source of some regret that the Auditor General found that

"there were no sufficiently detailed plans"

to support the contention that you have just made.

Garry Coutts: I have to accept that the plans were insufficient.

I ask you to bear it in mind that we had a £2.5 million gap at the end of the financial year, compared with a £20 million deficit opening position. A huge effort was made to close the gap. The rest of the board managed to close it despite specific problems at Raigmore hospital, which resulted in a £9 million overspend there.

An awful lot of very good action by an awful lot of dedicated and committed executives was taken to close the gap. However, you are right. I wish that we were not here; I wish that we had bridged that last £2.5 million.

Tavish Scott: I really get the point about the rest of the board. However, what I am slightly struggling with is that, if Raigmore was such a key problem for the board, were I the chairman or a board member, I would have had that as a standing item on the agenda. I would have been looking at and all over the top of the issue at every board meeting, because that is where the problem was.

Garry Coutts: The figures on Raigmore were reported at every operational committee meeting, improvement committee meeting and board meeting. All those meetings were in public.

Tavish Scott: When the chief executive and the director of finance met the Government to discuss the brokerage, I presume that that meeting was to discuss the fact that Raigmore was the financial hole in your plans and that you needed the brokerage money to square that off—Mr Kenton alluded to that.

Elaine Mead: Indeed. We made it absolutely clear to the Scottish Government that we had concerns about the financial management in Raigmore hospital. When we met on 13 December 2013—that was for our half-year review—we discussed the risk of our break-even potential with the Scottish Government. At that point, our potential deficit was £6.5 million.

The position improved when we got to month 9. We had plans in month 9. We did not want to secure brokerage at all, because we understood that paying that back would cause us more difficulty, which Mr Beattie alluded to. At month 9—that is the December 2013 figures—we were forecasting a £5.6 million deficit. We reported that to the February 2014 board meeting, along with elements to close the gap. I think that you are asking me about them, so let me identify what they were.

In the last quarter of the year, we expected Raigmore hospital to show an improvement of £1 million. In the event, that was not the case, but that was our plan. At the time, we were securing an additional £1 million from Highland Council. We expected a benefit of £2 million from our asset life plans, which my colleagues can discuss in more detail. We were looking for the remaining £1.6 million to come from further management actions, including vacancies and additional procurement benefits.

On 4 February 2014, we were comfortable that we had plans in place that would deliver the financial break-even. When the month 10 figures—for January 2014—were published on 18 February, I expected us to be in a forecast position of about £4 million. Instead, we found that Raigmore had moved to its detriment by £400,000, rather than improved its position. That proved to be a significant risk to our financial balance plan.

Tavish Scott: You said, helpfully, that you reported the December 2013 discussion to the February 2014 board meeting. At no time prior to December was the board formally told that you were entering into negotiations over brokerage.

Elaine Mead: We did not enter into brokerage negotiations at that time. We did not enter into such negotiations until much later, which was after I had received the month 10 figures.

Tavish Scott: When did brokerage negotiations formally begin?

Elaine Mead: I asked the director of finance to open the discussions about brokerage with the Scottish Government after the month 10 figures became available.

Tavish Scott: That was in January.

Elaine Mead: It was after 18 February.

Tavish Scott: Into March.

Elaine Mead: Yes, into March.

Tavish Scott: Thank you.

Garry Coutts: To be clear, although the figures were not provided at the board meeting, they were at the committee meetings within the cycle. The improvement committee and the operational committee units had the figures.

Mary Scanlon: A section 22 report is very serious; indeed, there has not been one in my four years as a member of the committee. This is a very serious situation. As the convener has said, the committee has not been in Inverness for 10 years, when it was the college that was overspending.

I want to go back to the convener's opening point. NHS Highland has agreed the factual accuracy of the section 22 report, and it has agreed with the auditors from Audit Scotland who are sitting behind the witnesses. The report, which you have agreed, states:

"The chief executive and director of finance"—

Elaine Mead and Nick Kenton—

"discussed the board's financial position with the Scottish Government in December 2013 but did not formally advise the Board at that time about the possibility that NHS Highland might not break even at the year-end."

Do you agree with that? From what I have heard you say to my colleagues, you tend to muddy the waters on that point. Do you agree that you discussed your financial position with the Government in December 2013 but that you

"did not formally advise the Board at that time"

that

"NHS Highland might not break even"?

Elaine Mead: I absolutely discussed with the Scottish Government on 13 December what I described to Mr Scott. At that point, we were not discussing or seeking brokerage at all, Ms Scanlon.

Mary Scanlon: What did you discuss?

Elaine Mead: We discussed our plans and the risk to our plans for a break-even at the end of the year as part of our half-year review with the Scottish Government.

Mary Scanlon: Were you overconfident in your recovery plan? As Colin Beattie has said, what Audit Scotland tended to find was an insufficient recovery plan and weaknesses in it. Were you confident with the Government, but perhaps not so confident with your own recovery plan?

Elaine Mead: We were confident with the Government and with our own plan, should it all have gone to plan.

Mary Scanlon: Why were you confident in December, but then had to ask for money eight weeks later in February?

Elaine Mead: Because of the changes in the month 10 position that were reported, particularly from Raigmore. Two items were different at that point. The first was a £400,000 deterioration in the Raigmore position when we had expected an improvement, and the second was a reduction in the amount that we expected to get from the asset lives work. Those two things made me recognise that we were unlikely to be able to deliver a break-even without support.

Mary Scanlon: You did not expect either of those spending requirements.

Elaine Mead: Not at that point. We invited an independent assessor—Douglas Griffin, who was the previous director of finance for NHS Greater Glasgow and Clyde—to come in and review our position. Over that December, he looked at our plans, interrogated us, discussed our position with us, spoke to colleagues who are now the new management team at Raigmore hospital and was able to give us confidence in the way forward. He felt that, if the way forward went to plan, we would break even. That was at that point in time.

Mary Scanlon: Most of Mr Coutts's opening statement was about brokerage and the fact that other health boards have received it. However, those other health boards, apart from NHS Orkney, have not been told so often that they have poor financial management. Is that why you are sitting here today? Do you feel that you have overcome all the criticisms, that you are now on a path forward with a recovery plan and that you do not require brokerage for this year or in future?

Elaine Mead: We absolutely accept the Auditor General's comments and fully accept the section 22 report, Ms Scanlon.

Mary Scanlon: Okay. *The Press and Journal*, which has diligently covered this issue, says that on 3 December—in other words, before the Government intervention—Elaine Mead was "absolutely confident" of breaking even at the end of the financial year. However, despite an injection of £6 million of Government money on 12 January—I think that you are using £3 million this year and £3 million next year—the board papers

for tomorrow show that the board is £2 million short. This committee is looking to be assured that you are confident that you are in control and that there is no longer poor financial management at NHS Highland. I am certainly still extremely concerned, and I am not confident that you are in control.

Garry Coutts: It is important to recognise that NHS Highland has an extremely good track record of delivery. As for our requirement for brokerage, last year was the first time in 10 years that we have looked for it; I do not know the last time we had to do that. I do not think that it is accurate to take just one snapshot.

This is an important issue. We are not complacent about it, and we are putting everything in place to ensure that we get this right for the people of the Highlands.

10:15

Mary Scanlon: Brokerage is not the point, and NRAC is not the point. Other health boards have been underfunded or funded below their target funding and have required brokerage, but what is important—and the reason why we are here today—is the fact that Audit Scotland saw fit to draw the Public Audit Committee's attention to the accounts of NHS Highland because of poor financial management.

As I have said, brokerage is not the point; it was designed to fix a problem. The main point is poor financial management, and I want to leave here today in the hope that we do not have to come back and ask, "What are you doing this year and next?" I am looking for that confidence, but I do not have it yet.

Garry Coutts: It might be useful if I explained some of the things that I have put in place since the end of the last financial year.

The Convener: As briefly as possible, please.

Garry Coutts: One example is the programme board that was established to consider specific pieces of work across NHS Highland. In the past, those were reported to us at a high level, but now they are reported to us in significant detail. Non-executive directors who have project management experience sit on the programme board with our executives and then report back to the board. That is a significant improvement in the way that we do things. The programme board has been reporting all year and will continue to do so.

We have learned lessons and put improvements in place. If you want details about what we have learned, we can provide them.

Mary Scanlon: One issue is the completely and utterly unfounded claims that have been made, and the Public Audit Committee would be failing in its duty if it did not respond to Audit Scotland's section 22 report.

Your internal audit contains a recommendation to

"improve the timeliness of financial information",

which means that that was not being done. Secondly, it says:

"The financial management issues that directly caused the need for brokerage could potentially have been avoided",

which means that that was not being done. It talks about ways in which

"NHS Highland can enhance current processes and make financial reporting more robust going forward",

which it says involves promises made by you. It also refers to issues that are

"partly due to poor financial management"

and says that you

"could have been clearer about the assumptions made and the related risks."

I am looking for an acknowledgment that the section 22 report on poor financial management is accurate and an assurance that the issues that were raised have been remedied.

Mr Coutts, you have been chairman for 11 years. I have been in the Scottish Parliament since 1999, and I remember discussing with your predecessor, Caroline Thomson, the high percentage of non-recurring savings, which Colin Beattie has referred to. It was an issue more than 10 years ago, and in that regard you are still the highest by far in the whole of Scotland. I need you to give me confidence about how you are addressing poor financial management.

Garry Coutts: Okay. If you want details of all the steps that we have taken, I can provide them, but I cannot do that briefly. I am also quite happy to ask the director of finance and others to come forward with details—

The Convener: It would be really helpful to get that information, and we can correspond on the matter.

Garry Coutts: I am happy to provide that information. As for non-recurring savings and the discussions that you have had on that, I note that, when I became chair of NHS Highland, we had had extraordinarily high levels of non-recurring savings and that, as a board, we brought the level down to zero.

Mary Scanlon: It is currently 62 per cent.

Garry Coutts: But we brought it down to zero. Was that in 2010?

Nick Kenton: It was in 2009-10.

Garry Coutts: In 2009-10, we brought it down to zero. It has increased again, and there are a number of reasons for that. Making the changes that we are trying to make requires us to use elements of non-recurring savings, but the board knows that it does not want to be in that position and it has plans to reduce that. It is not true to say that, for all of that period, we had the highest level of use of non-recurring savings. We brought the level down to zero and it has accelerated again.

Mary Scanlon: The issue was raised in Audit Scotland's overview of the national health service in Scotland.

Colin Keir (Edinburgh Western) (SNP): Good morning. I am intrigued about how you decide which items go into formal board papers and what it is acceptable to discuss at informal meetings of the board.

Garry Coutts: The board makes all decisions, and any decision making will be done fully and publicly at a board meeting, or it will delegate that work to its committees, which also meet in public. The board also considers the formal performance reporting, whether on financial matters or activity, clinical governance reports on infection control and so on. All those things are raised in public at the board meetings.

Furthermore, as advised in good governance practice, the board meets informally to ensure that it has training and development and that it fully understands and is enlightened on new healthcare initiatives. It will also look at things that do not require decisions but which might well become issues in the next six months, nine months or five years, so that we are apprised of things that are in development. I can assure you—and I have been around committee meetings in the public sector for a heck of a long time—there are no secret, private meetings at which decisions are made about NHS Highland's activity.

Colin Keir: So the board makes the decisions about what is on the agenda.

Garry Coutts: Yes. Ultimately, the agenda is the chair's.

Colin Keir: Allowing for that, do you think that the board really meets expected standards of public accountability, particularly in relation to discussions about financial arrangements, given the position with informal meetings, which allow no opportunity for the public to be assured that effective scrutiny is taking place?

Garry Coutts: All the financial reporting goes to public meetings of either the operational units or the board.

Colin Keir: I am thinking about comments that we heard earlier from the likes of the convener and Mr Scott, and the difficulties with informal meetings that were highlighted by members in earlier questions. Things have not come across clearly at public meetings, and we would not be here if we did not think that there was a problem. Having sat on boards, I know exactly what I would expect. Your board has been criticised for the actions that you have taken.

Garry Coutts: I have met the Auditor General and our auditor. I entirely take responsibility for this, but the audit team in Audit Scotland changed, and we went from one team to another. We had been working with the previous team for years on our governance reviews and the way that we planned our governance. If we had had a complete change of auditor—if another firm of accountants had become our external auditors—I would undoubtedly have got very close to them to ensure that there was an absolute understanding about the way in which our governance works, the interrelationships between all our committees and the board and the way in which they have delegated responsibility, but I did not do that when the audit team within Audit Scotland changed.

I have now spoken to the Auditor General and to Stephen Boyle, our auditor, to ensure that we have such meetings and that there is a clear understanding of how our committees and our governance work together. I believe that our governance and reporting of financial matters are as transparent and open as any organisation that I have worked with. Indeed, I am confident that that is the case. I am more than happy to discuss the position further with our auditors, and if there are improvements to be made, we will always make them.

Colin Keir: Given that you appear to have accepted that there were some problems, why would any member of the public who is sitting here today take your word that things are going to change? What can you say to the general public, not just to the committee, to reassure them that accountability will change, that financial problems will be reported, seen and discussed fully at the board meetings and that they can have some degree of happiness that you are on top of the game?

Garry Coutts: Through our publicly reported board meetings and committee meetings, we are absolutely transparent about our position. The timeline for reporting and the report from our internal auditors about the way that we report in public should give you a lot of confidence about that. If there are improvements to be made, we are more than happy to look at them continuously.

In the past 18 months, we have started to webcast our board meetings to give more people

the opportunity to scrutinise what we do. We are always going to look for ways to improve such things. I also ask members of the public to look at our performance over time. NHS Highland has had a very good track record in delivery for a long time, and we have very good satisfaction rates among the people who use our services and comment on the way in which we deliver them. I am absolutely committed to working with our local public, to give them what assurance and comfort we can, and we will continue to look for ways of doing that.

Chris Brown: Can I make a point, convener?

The Convener: Briefly, please.

Chris Brown: One of the main reasons for our most recent internal audit review was the desire to look at how well informed the management kept the board on the financial position. We met a lot of the non-executive board members, and from reviews of the board papers and discussions with those non-executive members we determined that they were kept fully informed of the financial position all the way through 2013-14 and that they continue to be kept well informed.

As for the issue of informal board meetings that has been raised, the board development sessions that we are talking about are meetings of the full board including all the non-executive members, the executive members and senior management. They are not official board meetings, but they are pretty formal.

Colin Keir: I am sorry, but it is public accountability that I am interested in. I do not doubt that the information was put forward; I am talking about public accountability and how the public can have confidence that the information that goes into the board's agendas will be discussed fully at board meetings.

The Convener: I think that it is unhelpful for panel members to recycle comments that have already been made. Can you keep your answers as succinct as possible? I want you to have the opportunity to respond to questions.

Mary Scanlon: When the Auditor General came to the committee to present the report, she said:

"One of the reasons why the report on NHS Highland is before the committee is that the way in which the situation was handled means that there is no formal record of papers to the board or minutes of decisions taken."

That is not acceptable audit practice. Do you agree? Those are the Auditor General's comments in the *Official Report*. She said that there was

"no formal record of papers to the board or minutes of decisions taken."—[*Official Report*, *Public Audit Committee*, 5 November 2014; c 38.]

You can be as informal as you like but, as Colin Keir said, you are accountable to the public for three quarters of a billion pounds and the effective delivery of a high-quality health service. Secrecy is not acceptable.

Garry Coutts: There is not any secrecy. I accept—

Mary Scanlon: There is "no formal record".

Garry Coutts: Can I finish my comment, please? I accepted entirely what Mr Martin said earlier. We accept the section 22 report. The comments that you have just read out are not in the section 22 report—

Mary Scanlon: They were from the Auditor General.

Garry Coutts: Mrs Scanlon, I understand that, and I accept that that is what the Auditor General said. If you look at all our public agendas and the minutes of discussions that took place, and if you go back and look at the webcasts, which are still available online, you will see that the issues were fully discussed at our public meetings. That is absolutely and categorically the case.

The Convener: It is important to clarify for the record that the statement that Mary Scanlon read out is in the report.

Garry Coutts: Can you refer me to that, please?

The Convener: It is in paragraph 7.

Mary Scanlon: It says:

"Officers did not formally report the brokerage agreement ... to the Board until ... the end of the financial year."

10:30

Garry Coutts: Exactly. We have already discussed the point that the brokerage was discussed with the Government only in March. That specific comment is about brokerage, and the discussions on that took place in March. Mr Keir's questions were about routine reporting and routine assurance that performance was properly scrutinised by our board, and it was.

David Torrance (Kirkcaldy) (SNP): Mary Scanlon has covered most of the issues that I was going to ask about. However, to refer back to the board development sessions, is it good management practice for there to be no records or minutes of those?

Garry Coutts: I have two or three points on that. Following the publication of the report, I will now ensure that, for every board meeting, the topics that have been discussed informally will be minuted in our formal minutes, and a note will be produced on the topics. About 14 months ago, the board brought in an expert on corporate governance to run a training and development session—we do that regularly. That expert was

clear that it is good practice for the board to get together informally, just for team dynamics and to ensure that the members operate effectively together as a team. We will continue to do that, but I will ensure that there is public reporting that it has taken place.

David Torrance: Can you reassure me and the general public that transparency, which is a word that you have used, will now apply to everything that you cover?

Garry Coutts: Absolutely. I am confident that we are, and have been, transparent in the publication of information on our performance, whether that relates to finance or activity. We publish that publicly, and decisions and discussion on that performance take place in public. I am sorry that there is a perception that important things take place outwith the formal board meetings, because they do not. They take place at those meetings—I give an absolute assurance on that. I will now ensure that we formally record the occasions when the board meets informally, whether for training or development, to take advice from clinical experts or whatever.

The Convener: On the informal development sessions, did the corporate governance organisation or adviser recommend that an issue as serious as negotiating possible brokerage with the Scottish Government should be discussed informally?

Garry Coutts: We were having a training session on general governance principles, which is an issue on which all boards regularly refresh themselves. As part of that regular training session, we had a discussion about the development sessions and how they were applied, but there was no discussion about specific items. The board is fully aware of the process that if, towards the end of the financial year, there is an increased risk that the gap will not be closed, there will be discussions between our chief executive and director of finance and the Scottish Government. We do not have the option not to break even, and the board was fully aware that those discussions would be taking place.

The Convener: I understand that the board was aware of the budgetary challenges that it was facing, and such discussions probably take place in boards across the country. However, you are saying that the word "brokerage" was never discussed at that informal session—

Garry Coutts: Well—

The Convener: None of the board members will write to us either formally or informally on this issue and no one from the board will provide any evidence to suggest that there was any discussion at that informal session about the negotiations that were taking place in connection with brokerage.

Garry Coutts: There were discussions, not negotiations.

The Convener: And brokerage was mentioned.

Garry Coutts: Yes. One of our board members who had previously served on a board in another part of the United Kingdom that had regularly required brokerage asked whether at that stage it would not be sensible to look to brokerage instead of continuing to try to find the savings in year in that financial year. The suggestion was made during that session, but that is my only recollection of a specific discussion about brokerage as opposed to the requirement to break even.

The Convener: Before I bring in Nigel Don, I want to get more of a picture of the informal development session and the kinds of discussions that took place at it. We understand that development needs to happen and that informal discussions can, on occasion, be part of good governance, but was there any reference to that informal development session at any further point when the board was discussing the possibility of brokerage? Did anyone say, "Well, we actually discussed this at the informal session, so it has been debated and discussed with board members"?

Garry Coutts: No.

The Convener: So it was never used as a reference point in order to say, "Yeah, we've discussed this issue with the board."

Garry Coutts: Not in those terms, as far as I can remember. I am trying to be very careful here, because I do not want to say anything that misleads the committee. The substantive discussions about our wish, our desire and our efforts to achieve a break-even position during the financial year all took place at our board meetings and at no time did the board discuss the requirement for brokerage until we got the January—or month 10—figures in February. We told our chief executive and our director of finance at the January meeting that they had to take whatever action was required in finding savings to ensure that we broke even. Inevitably, given the stage that we had reached in the financial year, there were formal discussions with the Government about brokerage in March.

Nigel Don (Angus North and Mearns) (SNP): Good morning, colleagues. I would like, if I may, to address the issues around Raigmore hospital. I note that your internal report mentions an overspend of £8 million, but I have some figures from the Auditor General that suggest that in October there was a financial gap of £8.2 million for the whole board and £6 million for Raigmore. I do not want to fight about those numbers, as they come and go from month to month, but the operation is clearly significant, and it has been

identified as being a very large part of the deficit that has caused you the problem that we are talking about. Given that any large operation has three costs—people, who are the staff; buildings, which you know about; and consumables, which in this context are medicines and such things—how can your budget be anything other than fixed? How can you vary things in the context of running a medical operation, given that you need staff, buildings and medicines? How is that sort of thing susceptible to financial management?

Garry Coutts: A number of things provide opportunities to generate efficiencies in our way of working to ensure that we can spend more money on direct patient care and care in general. For example, the rotas for our consultant colleagues are developed to ensure that they focus on the work that only they can do rather than on work that perhaps other professionals who are not as expensive could do. That kind of modernisation work takes place all the time.

We continuously look to try to ensure that all our prescribers use generic drugs where possible and advisable. We have initiatives on that and on other procurement. We want to ensure that all our professionals—whether they are nurses, allied health professionals, doctors or healthcare assistants—are working to the top of their licence, rather than doing things that could be done by other people, so workforce planning is absolutely essential. We want to eliminate waste: the whole ethos of the way that we want to improve services in NHS Highland is focused on eliminating waste. That includes things such as ensuring that we do not have overprovision—that we are not re-ordering tests. We have heard a number of times in the past of a series of tests being carried out routinely on people who have gone into hospital, without reference to whether the same tests had been done before.

All that stuff creates efficiencies. We have seen a dramatic reduction in bed days because we have reduced infections in hospital, which makes savings that we can redeploy elsewhere. That is the way that we want to do it.

Nigel Don: You have given me some of the practical management answers, which I accept, and I am conscious that this is not the Health and Sport Committee—I am not trying to turn it into that. However, I am still unsure about how those issues are subject to financial management. What you do is add up the cost of the things that you have done. Financial management means proactively deciding what you are not going to do in order to save money. All the things that you have talked about are things that you are going to do anyway, and then you will work out the costs afterwards.

Garry Coutts: We are going to plan financially with our management to do those things more efficiently. We have done that in significant areas of our work over the past five years and we will continue to do it. If you look at the increase in our activity as an NHS board, you will see that it far outstrips any increase in the financial resources that we receive, because we are doing things more efficiently and effectively. We will continue to drive that. We manage that financially, to ensure that when we make changes we get the cash out to reinvest elsewhere.

Nigel Don: Forgive me, but I will press the point. Although I accept everything that you have said, I do not see that as financial management. All that you will do is, afterwards, add up the costs of what were good management decisions. That is not financial management; that is people and buildings management. Actually, the costs will be whatever they will be.

Chris Brown: One aspect of our internal audit review looked at how that issue is dealt with in the hospital: how do budget holders and service managers translate the activity that is going on in hospital into the financial budget and financial position?

One difficulty that we found was that there can be huge fluctuations in the cost base at the hospital, because some drugs are very expensive and it is almost impossible—at least, it is very difficult—to predict how many of those drugs will be used from one year to the next. It is difficult to develop a budget for those drugs.

In addition, demand for services in general in the hospital is hard to predict. An increase in demand must be met by additional staff costs, so the hospital has to employ more consultant time to keep waiting lists down. Waiting lists are dependent on demand for services in the hospital.

Budget holders need key financial management skills to predict what that demand will be and translate it into a financial budget. There can be huge fluctuations in the costs of drugs and staff time because of those demand issues.

Nigel Don: I entirely accept that, but I stick to my point that that is not financial management; it is practical hospital management. The finance is just the costs when you add them up; there is no financial management in anything that you have talked about.

Chris Brown: The two things cannot be taken apart; they are inextricably linked. Management of operations or activity must be inextricably linked with financial management. There is no way that budget holders and service managers can make operational decisions without understanding their financial and budgetary implications. They must be

linked together. That absolutely is financial management.

Garry Coutts: At the start of every year, each of our operational units and each of our managers knows exactly what their budget target is for that financial year, and that is cascaded down to budget holders. We train and support them and expect them to be able to manage their budget within that target. When there is increased expenditure and increased activity, as there has been in a number of areas, we have to be able to manage that from other areas. That process of financial management takes place day in and day out; it is led by Elaine Mead's team.

Nigel Don: Are you confirming that there are things that you do not do because you do not have the money to do them?

Garry Coutts: If you wanted to give us a lot more money, there are things that we would do, but we must ensure that we deliver the health service that the Government wants us to be able to deliver for our people. I believe that we can achieve that within the resource that we have, but that means that we must completely redesign the way in which we do things and continuously improve the service that we are working on. That is what our Highland quality approach is based on.

The Convener: I call a brief suspension until 10.55.

10:45

Meeting suspended.

10:58

On resuming—

The Convener: I reconvene the meeting following the suspension. Mary Scanlon will continue the questioning.

Mary Scanlon: Paragraph 14 of the section 22 report from Audit Scotland states:

"The auditor has highlighted that the cost of delivering adult social care services in Highland ... continues to pose a financial risk to the board."

I thought that it was probably worth asking about that because we have a few Highland councillors in the public gallery today. I appreciate that we will take evidence from Audit Scotland later, but that will be done in a private evidence session whereas this one is on the record.

I was very supportive of the lead agency model—in fact, NHS Highland and Highland Council have led the way in Scotland on the integration of health and social care. If there is a risk, I think that many people will be worried about that. Can you explain what the risk is and what is being done to address it?

11:00

Garry Coutts: There are risks in any change that we embark on. Making transformational change in how we do things is a risky process. I sometimes feel that the easy thing to do would be to keep your head down, not make any changes and be conservative in how you run organisations. If we had done that, perhaps we would not have ended up here today. However, I believe that we have to change dramatically if we are to have the sort of health and care system that we want for the future, and which I want for myself for the future. I am unashamedly a huge supporter of the work that Highland Council and we have done to bring about change, which is showing results.

A lot of the people in the room will know that one of the biggest challenges that we faced a couple of years ago was getting care-at-home services for people. We had an awful lot of people who were assessed as requiring care at home but were not getting packages for it. In the past couple of years, through an integrated team of healthcare professionals working with social workers and social care professionals, we have reduced that deficit hugely. That effort has included moving to pay the living wage to all home-care workers in Highland, whether they work for us, the private sector or the voluntary sector, which has made recruitment and retention so much easier. We pay an increased fee for that, but it gets directly passed on to the workers who are doing the work.

We have therefore managed to turn a corner in the care-at-home deficit, but such work takes time. We now want to move on to working with our care home providers, which will mean that we will be able to get people who are currently blocking beds in our hospitals out much more easily into care homes. Once we get that working effectively, we will be able to show dramatic change.

When we embarked on integration, we and the council were quite clear that we would not see the full benefits of the work for at least five years. The lesson that we took from looking at other places around the world that have tried to make a change on the same scale is that they look for it to take five to 10 years before they get the full benefits. We are at least three years down that path, and the rest of Scotland has yet to start on it. The work is challenging, but we are managing it very closely and we think that we will get the benefits from it.

Mary Scanlon: Well, it is a serious risk. I will just go through some of the figures. The Scottish Government allocated additional funding of £1 million in 2012-13 to the integration work and another £1 million in 2013-14. Highland Council and the board of NHS Highland have agreed that the council will provide £4.5 million this financial year, £4.3 million in the next financial year and £4.7 million in the following year. Those are huge

transfers from the council. I have always been very much in favour of health and social care integration, because I thought that it would mean the end of delayed discharge, which is a serious problem in Highland, as is finding home carers. I have raised with the director general of health and social care the case of Debbie Michie of Nethy Bridge, who was in the Ian Charles community hospital in Grantown for a year because there were no home carers. I recently visited a care home over on the Beauly Firth that gets seven phone calls a day asking for placements.

What I had hoped would happen through health and social care integration has not yet happened, although I am still a huge fan of it. I am concerned about delayed discharge, the lack of home carers, there not being enough residential care home places and the fact that Audit Scotland has highlighted integration as a risk going forward. To be honest, you could apply that to almost any health board in Scotland, but I was hoping for better from NHS Highland.

I have heard what is coming from the council, but I thought that the whole idea was to take resources from the acute sector out into the community. Perhaps you could address that in your answer.

Garry Coutts: I am delighted to do that. Elaine Mead will talk about some of the specific numbers for delayed discharge and say what it is that people are waiting for to get them out of hospital.

You are absolutely right to say that increased costs for social care are happening across the country. We can clearly identify the increase in the resources that Highland Council is giving to adult social care in Highland, but local authority spending across Scotland on social care is increasing. I saw figures recently that showed that the very substantial increases in social care spending were to the detriment of other services that local authorities are running. We are therefore seeing cuts in other services while spending on social care is increasing, so that situation is not unique to us.

I do not think that anyone in Scotland is yet in a position to talk about what the appropriate level for spend for social care should be. We are looking for the joint improvement team and others to work with us on that.

One of the major services that we are taking out of hospitals is geriatric care. We have just appointed an additional three geriatricians, who are working in the community with GPs so that people do not end up in hospital. All the medical reconciliations and all the medical care are given to people in their own homes or in care homes, rather than their being admitted, which is what would have happened.

The big pressure point that we have in Highland relates to care homes. As many people in the room will know, we have lost a lot of capacity in care homes. In other parts of the country, there have been significant new developments and a significant increase in care home provision, but we have seen a reduction. The people who are currently delayed in Raigmore and our other hospitals are not people who need care at home; they are people who are waiting for a place in a care home. Care home places are difficult to turn on and off. Facilities have to be built, staffed up and registered. We are working with providers to get the situation much more in balance, and I am confident that in years to come we will do so.

We have never pretended that we would turn the position round in a year or a couple of years; we have always said that it would take time. I am confident that the track that we are on will deliver benefits. Elaine Mead might want to give you the specific numbers on delayed discharge.

The Convener: Can you be as brief as possible, please?

Mary Scanlon: As Nigel Don said, we are not the Health and Sport Committee, but one of the main reasons for delayed discharge has been the shortage of home carers. We are looking at freeing up capacity in the acute sector, but I need you to address the point that Audit Scotland made in the section 22 report, which was that the cost of delivering adult social care services in Highland

"continues to pose a financial risk to the board."

That will be a worry to many people in the Highlands. I seek an assurance on what you are doing to address that, rather than being told that it is a problem elsewhere in Scotland. You are a step ahead of elsewhere in Scotland. The Parliament has brought in legislation to make sure that all health boards do what you are doing.

Garry Coutts: I thought that I had covered many of the things that we are doing to minimise that risk. We are doing work to ensure that we have the care-at-home workers that we need. We have worked with the sector to ensure that they are paid—

Mary Scanlon: You say that you have enough care-at-home workers, but there are people who have been staying in hospital for a year.

Garry Coutts: We have increased the care-at-home workforce dramatically. The big pressure point that we face is with care homes, not care at home. I ask Elaine Mead to give the committee the figures.

Elaine Mead: As of today, we have 33 patients waiting in Raigmore hospital as a result of delayed discharge. A significant proportion of those will be waiting for care home placements. As the

chairman of the board has described, that is now the pressing need. We need to develop the sector for care in the community. We have invested an additional—

Mary Scanlon: The fact that those beds are occupied by delayed discharge patients has resulted in quite a few hundred patients from the Highlands having to go to Glasgow and elsewhere in Scotland.

Elaine Mead: There are 61 delayed discharge patients in total, if I include the number of patients in the community hospitals. We are increasing and developing that sector by supporting additional care workers. We are working with schools and at university level to develop vocational training for the sector. I think that that will be necessary across the whole of Scotland. Importantly, to answer your question, we have invested an additional £1.5 million from health money this year in the sector to support the flow of patients out of hospital into the community. That is the critical transformational part of integration.

Tavish Scott: I will try a different line of questioning. I would like to understand how the internal audit process worked in the year that we are asking about.

Chris Brown, how long have you been the internal auditor for Highland Council? Who do you report to? Do you report to the board, the chairman or the chief executive?

Chris Brown: We are in our fifth year as the internal auditor at Highland NHS Board. We report to the audit committee, which is a non-executive committee of the board.

Tavish Scott: What happens on a monthly basis?

Chris Brown: We have monthly liaison meetings with the director of finance, Nick Kenton, and the chief operating officer.

Tavish Scott: Would those meetings include a monthly assessment of the financial position of NHS Highland?

Chris Brown: No—that is not what we do as internal auditor. We do not monitor the financial position on a monthly basis.

Tavish Scott: The director of finance and the chief operating officer would not raise with you what was happening each month—whether the board was in deficit or in surplus.

Chris Brown: They would not routinely do that, but they have raised that issue in the past. It was the management who asked us to do the first review of Raigmore hospital, because they were concerned about the financial position at Raigmore. That was an issue that came up at one of those monthly liaison meetings.

Tavish Scott: Forgive me if this is not in your remit, but is internal audit not about assessing month to month what is happening financially in NHS Highland?

Chris Brown: No, we do not do that on a month to month basis. We look at the control frameworks and the controls that are in place in NHS Highland to monitor the financial position.

Tavish Scott: What gave rise to the April 2013 report? Did you, as internal auditor, decide to commission that, or were you asked to commission it?

Chris Brown: We were asked to do the review by the director of finance.

Tavish Scott: Why?

Chris Brown: Obviously, this is going back a couple of years now.

Tavish Scott: Yes—I apologise for that.

Chris Brown: At one of our monthly liaison meetings, Nick Kenton raised concerns about the financial position at Raigmore. At that point, it had been known for a year or two that the hospital was overspending. There was a recognition by management that that was unsustainable, and they wanted to understand why it was happening.

Tavish Scott: Do not let me put words in your mouth, but you produced a report that highlighted the governance and the budget as the two main significant issues that needed to be addressed.

Chris Brown: Yes. The main issue was the culture in the hospital. There was not a strong culture of very tight financial management. That was partly because, until fairly recently, the hospital had had enough money—as the chairman said, in 2010 the hospital was in recurring balance. Therefore, until fairly recently, there had not been a need for very tight financial management. However, over the past few years, because of increasing demand and increasing costs in the hospital, there was an increasing need for tighter financial management.

Tavish Scott: So things had got a bit lax and a bit easy because money was okay and no one was too worried about it.

Chris Brown: People were making decisions in the best interests of patients in the hospital but without enough consideration of the financial implications of some of those decisions. That goes back to the point that Nigel Don made that there can be major fluctuations in cost, depending on the decisions that clinicians make in a hospital. Clinicians were not monitoring the budgetary implications of some of the decisions that they were making as closely as they could have done.

Tavish Scott: Your report found that there was not enough challenge of that from above, which I guess means the operational executive team and the board.

Chris Brown: It was the hospital management team, primarily.

Tavish Scott: But who was challenging the hospital management team? Who were they accountable to?

Chris Brown: They were accountable to the central management team in the health board and, ultimately, the health board itself.

Tavish Scott: Did you find that that process was not working effectively? That was part of your recommendations.

Chris Brown: Yes, absolutely. The governance and accountability were not as strong as they could have been. We made quite a few recommendations on that in the report.

Tavish Scott: A year later, you found that not enough significant progress had been made. As internal auditor, you must have been pretty fed up with that.

Chris Brown: The audit committee asked us to do a follow-up review, because it was concerned about the issues that we had raised in the initial review. One of the challenges that the hospital management had was that a culture change was needed. It was not just a case of changing a few controls and improving the situation; it was about changing the attitude of the budget holders. Those budget holders were primarily clinicians and were making clinical decisions. That is what they are trained to do and what they are used to doing. The hospital management had the challenge of trying to make them understand the financial implications of the decisions, which takes a bit of time.

Tavish Scott: That is helpful.

Were you at any stage asked to give a view on the need to go to the Scottish Government to ask for money? We call it brokerage, but basically it is a bung of money to allow a health board to get through a position of deficit. Were you involved in those discussions?

Chris Brown: No, I was not.

Tavish Scott: Do you think that internal auditors should be involved in such discussions, given that you are there to internally audit what is going on?

Chris Brown: We are asked to look at the controls that are in place in the health board to manage the financial position, so we would not expect to be asked about tactics that management should take. That was an operational management decision on how to bridge a gap. It was about whether to reduce services to stop spending money or to ask for more money to continue services at the existing level. That was an operational management decision and an issue for negotiation with the Scottish Government. We would not expect to be consulted on that kind of decision.

Tavish Scott: I am grateful for that evidence. However, just so that I can be clear, will you confirm that, during the year that we are looking at, the internal audit function was not asked to keep a monitoring view on the financial position, given all the financial pressures that are now so evident from the section 22 report?

Chris Brown: We were not asked to do that. We would not expect to be asked to do something like that, because that is basically a management job.

Tavish Scott: That is absolutely a management responsibility.

Chris Brown: Yes. What we do is to look at the controls that are in place in the health board to do that job.

Tavish Scott: That is great. Thank you.

The Convener: Mary Scanlon has advised me that she has a 30-second question, so I will allow her to ask it.

Mary Scanlon: I am just concerned that Mr Brown is concerned about clinicians making decisions in the best interests of the patient but not taking the cost into account. Do you feel that managers, rather than the clinicians, know best about what the budget should be and what would be in the best interests of the patient?

Chris Brown: No, I am not saying that at all. The clinicians and the managers need to work together to make decisions that are in the best interests of patients, but then to understand the financial implications of those things.

11:15

Mary Scanlon: Did you feel that the clinicians and the management were not working together? Is that one of the issues that you addressed?

Chris Brown: Yes. That is one of the issues that we identified.

Mary Scanlon: Okay, and you feel that that has improved.

Chris Brown: Yes, that has improved dramatically in the hospital.

Colin Beattie: Several members have touched on the informal meetings. I feel that they have been a little bit obscured by references to training and development meetings, which are a bit different from the point that has been made. The

question is whether it is right that discussions about the financial position should be taken at informal meetings of board members. Does that comply with the expected standards of public accountability?

Chris Brown: You are looking at me, Mr Beattie. No—it would not comply if those discussions took place exclusively at informal meetings. If your question is whether the discussions should take place only at informal meetings, the answer is absolutely not. However, from our review of the papers that went to the board and to those meetings, the only reason why that discussion happened at an informal meeting was that a board meeting had not come round yet. Board meetings happen every couple of months. If there is an opportunity for management to inform the board members of the financial position at an informal session, they will take that opportunity rather than wait until the next formal board meeting.

Colin Beattie: Given the gravity of the situation, would it have been appropriate to have an emergency board meeting rather than wait for the normal cycle?

Garry Coutts: The board had met in December, and it was following that meeting that the deterioration in the position that led to the view that brokerage was desirable took place. The board, at its public meeting, knew what it had to do. We had instructed our chief executive and director of finance that break-even was essential, and they were working on that.

The discussions with the Scottish Government started when we saw the month 9 figures. They were circulated to board members at the same time as the executive management team got them, as the financial monitoring pack that comes out is circulated to everybody. It was a matter of only about a fortnight before the formal papers came out, which formally reported that position to the board and indeed the public.

I have members who come from the Mull of Kintyre and Skye, so it is difficult to get them all together at short notice, but even with hindsight I do not think that I would have called an emergency or special board meeting for that, looking at the overall position of the board and the scale of the brokerage that was being looked at as a proportion of our budget.

Elaine Mead: As we have said, we had some discussion at the improvement committee. That is a sub-committee of the board and the minutes go to the board. However, the issue is one of the things in the Auditor General's report that we have taken heed of. We are now working with our colleagues in audit to try to change the timing of the publication of the in-month figures so that we can report to the board in a more timely way. We are trying to concertina that down. One of the difficulties that we had at that crucial time was the timing of the improvement committee and board meetings and the publication of the in-month figures. I hope that we will now have those tied together much more tightly.

Colin Beattie: I have a final, brief question about the note from internal audit summarising the findings from the section 22 review. The top paragraph on page 2 of that note says:

"One of the key actions relates to accountability of budget holders."

I am astonished that budget holders were not already being held accountable for their budgets. The paragraph says:

"The Raigmore Head of Finance has developed a Budget Holder Register and implemented several new controls".

That does not sound very positive. The note refers to "several new controls", but I hoped that there would be a lot more controls. It refers to a "Budget Holder Register". I hope that a process is already in place that holds budget holders to account. How effective will those new measures be?

Chris Brown: As I said, one of the key issues that we raised in the internal audit report was the lack of accountability of budget holders in the hospital. If budget holders had been held fully to account for overspending on their budgets, the hospital would not have overspent by millions of pounds.

Colin Beattie: That was in your 2013 report.

Chris Brown: Yes.

Colin Beattie: The results of that were not implemented, of course.

Chris Brown: They have been gradually implemented since April 2013. When we did the follow-up review in May 2014, we found that there had been progress, albeit slow, on implementing the recommendations. As I have said, a cultural change is required in holding people to account.

You are right that those controls are fairly fundamental management controls that should have been in place at the hospital, but they were not. The financial management in the hospital is now much stronger than it was when we did the review in April 2013. The controls that should have been in place are being put in place.

Colin Beattie: As an internal auditor, will you say to what extent the non-implementation of the 2013 recommendations contributed to the problems that came out in 2013-14? If those recommendations had been fully implemented promptly, would that have ameliorated the financial impact?

Chris Brown: Yes, it would have, because I presume that the hospital would not have overspent by as much as it did. However, it had overspent for a while on an annual basis at around the same level, and that position had been managed internally. In effect, the rest of the health board managed the position. The overspends in the hospital were managed by making compensations elsewhere in the health board. The fact that the controls had not been addressed or improved did not mean that there was no way in which the health board could have managed the situation, as it had done that on an annual basis until then. However, the full and prompt implementation of the recommendations definitely would have made things easier, because there is a real challenge.

A bit of additional activity was commissioned internally in the hospital right at the end of the year without a recognition of the financial implication of that decision. The financial implication came through the following month, by which time it was too late to make any amendments to the budget. If the improvements that we recommended in April 2013 had all been implemented, such a situation would not have arisen. The same management decision, which was basically to treat more patients, might still have been made, but the financial implication would have been recognised more clearly and it would have been reported internally more clearly, so quicker decisions could have been made about what to do in respect of brokerage.

The Convener: I want to conclude with a couple of questions. My first, which is to Mr Coutts, is connected with our earlier discussion about the signing off of the brokerage arrangement. What month did you say you presented that to your board in?

Garry Coutts: That was formally announced to the board on 1 April. The papers for that were published a fortnight before then, so the board's awareness of it was clear.

The Convener: How many board members do you have?

Garry Coutts: The total board membership is about 25, but there are about 10 independent members. I do not have the exact figures, but it is a large number.

The Convener: So, in response to that paper being issued two weeks prior to the board meeting, did you receive any informal or formal responses from board members asking why the brokerage deal had been signed off and why they had not been informed?

Garry Coutts: I had numerous discussions with board members—

The Convener: There is a difference between discussions and questions. Did someone call you and specifically ask, "Why were we not informed?"

Garry Coutts: Every single one of my board members knew that, if we were not going to be able to break even, we would be seeking brokerage.

The Convener: That is not an answer to my question. To be clear, I am asking whether anyone phoned you to ask why they were not informed. I would have expected at least one member of the board to do so.

Garry Coutts: I would have expected a board member to phone me up if they had not known that that was the inevitable consequence of what we were doing, so I am going to say no—

The Convener: I have given you an opportunity to answer all the questions. You have been open in answering some of them but, on others, more clarity is required. My question is, when the board members were advised of what was happening, two weeks prior to that meeting of the board, did members of the board call you and say, "I am concerned that we were not informed"? Yes or no.

Garry Coutts: No.

The Convener: None of them called you to say that they were concerned.

Garry Coutts: Not to my recollection, for the reasons that I have explained.

The Convener: Not one member.

Garry Coutts: For the reasons that I have explained, not to my recollection.

The Convener: Ms Mead, did any members of the board call you to express concerns about the fact that they were not informed that the brokerage arrangement was being signed off? Mr Kenton, did anyone call you?

Elaine Mead: No, they did not ask me that.

The Convener: So there was no correspondence on the issue. Nobody emailed you to ask, "Why are we doing this? What are the consequences of this?"

Elaine Mead: I have no recollection of any emails or correspondence about why we were taking the action.

Chris Brown: One of the issues in our internal audit review was to ask board members whether they felt that they were kept informed. They all said very clearly that they were. None of them said that what happened was a surprise to them.

The Convener: Okay.

Discussions took place and there was an agreement to sign off the brokerage arrangement

with the Scottish Government. Ms Mead, what would have happened if the Scottish Government had said that it would refuse the arrangement? Would there have been job losses or a loss of service?

Elaine Mead: We have a statutory responsibility to break even, so we would have had to ask how we could manage services in order to reduce activity between that point in time and the end of the financial year. That would not necessarily have resulted in job losses—

The Convener: It could have, though.

Elaine Mead: We would have had to look at how we could have reconfigured our services in the short term in order to—

The Convener: "Reconfigure" means possible job losses. Is that correct?

Elaine Mead: Well, some of the expenditure would have been on additional payments, so that would have reduced our costs on supplementary staffing. For example, if we had not increased a ward area or not kept a ward area, that might not have resulted in job losses. It might have resulted in some people not being paid for doing extra hours or extra duties. That would have been different.

The Convener: Let me play this out, then. You have had to consider the possibility that the Scottish Government would say that it would not sign the brokerage agreement. Were papers developed that discussed the possibility of job losses as a result of the arrangement not being signed off? Do documents exist that say, "Let's look at the possibility that the Scottish Government says that it can't give us a brokerage arrangement"? It could have said that.

Elaine Mead: It could have said that, Mr Martin, but the national health service has a no-redundancy policy, so we would not have been in a position to make people redundant, if that is what you are asking.

The Convener: But there would have been a reduction in services across the board.

Elaine Mead: Inevitably, there would have had to be a reduction in services.

The Convener: Was a paper presented that detailed the kind of loss of service that there could be?

Elaine Mead: There was not a paper in that way.

The Convener: Why not?

Elaine Mead: Because, at that point in time, we were looking to deliver break-even through the management actions that we had asked people to take. We were confident that we would deliver those, until we saw the deterioration in the Raigmore position, which made us have to go back and reconsider our financial end point.

The Convener: We need to accept that the scenario could have been that the Scottish Government could have said, "Very sorry, but we don't have this money to provide to you." In that case, you must have had some sort of plan B. Was there no plan B?

Elaine Mead: There always has to be a plan B, and our plan B—

The Convener: So, was there one?

Elaine Mead: It would have had to have been to reduce services in the short term.

The Convener: So you had a paper prepared for that scenario.

Elaine Mead: We would have had some background papers in which we considered what would have been the impact on our other statutory requirements to deliver targets.

The Convener: So, as a result of poor financial management, there could have been a reduction in services, and that is the kind of discussion that you had to have.

Elaine Mead: Only in that last month of the year.

The Convener: So the scenario could have been that the kind of services that we all take for granted could have been at risk.

Elaine Mead: In that last month of the year, in which we have a statutory requirement to financially break even, that could have been a risk.

The Convener: Can you give me one example of the kind of service that could have been lost during that period?

Elaine Mead: In that period, we might have been unable to implement additional waiting list initiatives that would have enabled us to deal with more patients who needed operations, and those patients might well have had to wait.

The Convener: Could appointments have been cancelled and so on?

Elaine Mead: The appointments associated with those operations might not have needed to be made in the first place.

The Convener: I thank the panel members for their time this morning. I appreciate that it has been a long session.

11:30

Meeting continued in private until 11:55.

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