The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 26 October 2011

Session 4

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PUBLIC AUDIT COMMITTEE
6th Meeting 2011, Session 4

CONVENER

*Hugh Henry (Renfrewshire South) (Lab)

DEPUTY CONVENER

*Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Mark McDonald (North East Scotland) (SNP)
Tavish Scott (Shetland Islands) (LD)
*Drew Smith (Glasgow) (Lab)
*Humza Yousaf (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Mr Robert Black (Auditor General for Scotland)
Barbara Hurst (Audit Scotland)
Tricia Meldrum (Audit Scotland)
Sarah Pollock (Audit Scotland)
Mark Taylor (Audit Scotland)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

Committee Room 6

Scottish Parliament

Public Audit Committee

Wednesday 26 October 2011

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

Decision on Taking Business in Private

The Convener (Hugh Henry): I welcome everybody to the Public Audit Committee's sixth meeting in the fourth session of Parliament. I remind members and everyone else to ensure that all electronic devices are switched off—says he, searching desperately for his phone.

I welcome to the meeting Joanest Jackson, who is from the National Assembly for Wales and is here to observe our proceedings.

I have apologies from Tavish Scott, but I do not think that there are any other apologies.

Before we move to item 1, which is a decision on taking business in private, I will remark on the announcement that Robert Black, the Auditor General for Scotland, made about his imminent retirement. We all have cause to be grateful for the contribution that Mr Black has made to the Parliament as Auditor General since he was appointed and we value the work that he has done. Of course, he has had a long and distinguished career in public life. He worked in local government and, I think, was associated with one of the health boards at one point. Is that correct?

Mr Robert Black (Auditor General for Scotland): No, convener. I was chief executive of Tayside Regional Council and, before that, Stirling District Council when a certain Mr McConnell was a member of it.

The Convener: You were also a stalwart of Strathclyde Regional Council for a number of years.

Mr Black: I was indeed. I had an excellent 10 years there.

The Convener: It has been a long and distinguished career. We will be sorry to see you go and we value the work that you have undertaken. I am sure that, in the months leading up to your retirement, you will continue to play a valuable role in supporting the committee and the Parliament. I thank you for all your efforts over the years.

Mr Black: Thank you for your generous statement. Valedictories are a bit premature because all that I have done is to write to the Presiding Officer saying that, after 12 years, I would like to retire from the post. I am sure that it will take the Parliament a few months to appoint my successor and I intend to continue to fulfil my duties fully throughout that period, so you are stuck with me for a little while longer. I wish to go at a time that is convenient for the Parliament.

The Convener: Thank you very much.

Does the committee agree to take items 5, 6 and 7 in private?

Members *indicated agreement.*

Section 23 Report

"A review of telehealth in Scotland"

10:02

The Convener: Item 2 is "A review of telehealth in Scotland", on which I invite Mr Black to brief the committee.

Mr Black: With your agreement, I ask Barbara Hurst to introduce the report.

Barbara Hurst (Audit Scotland): The report was published on 13 October. It examines how health boards use telehealth, what impact it has on patients and boards, and whether there is potential for it to offer better value for money than more conventional models of care. When we introduced our forward work programme to the committee back in June, some members were quite interested in the report.

It might be helpful if I briefly explain what we mean by telehealth. A recent overseas newspaper article about our report said that we were recommending telepathy, but we are actually recommending telehealth. To put it simply, telehealth is the provision of healthcare to patients at a distance using technology such as mobile phones, internet services, videoconferencing and self-monitoring equipment in patients' own homes. Examples include using videoconferencing to carry out a consultation between a doctor and a patient at different locations or diagnosing a patient's condition using images that are sent electronically, such as digital photographs of skin lesions.

Telehealth can help the national health service to treat patients in new ways. It is popular with patients, and nurses and doctors who have been involved in its use also find that it is good. It has the potential to help boards to deliver a range of clinical services more efficiently and effectively. However, it is important to say that it is not appropriate for all patients and all conditions.

As part of the audit, we looked at how the health service has developed telehealth. The Scottish centre for telehealth was set up in 2006 to support the health service in that work, but it had relatively limited impact in its first three years. It has now been integrated into NHS 24 to provide more focus and direction and it has published its first strategic framework, which focuses on developing telehealth on a national scale in four priority areas—stroke, paediatrics, chronic lung conditions and mental health.

As you can see in exhibit 3 on page 14 of the report, telehealth is used throughout Scotland but particularly in the north. That might not be surprising. However, developing and investing in the area has not been a high priority for most boards. We estimate that 70 telehealth initiatives have been introduced since 2006, but most are relatively small scale and cover few patients. Some 60 per cent are still at the pilot stage, are delivered informally or have been discontinued. The remaining 40 per cent are now part of the routine service delivery of the health board. We found that initiatives have often been developed in isolation and are not clearly linked to boards' wider strategic priorities or long-term financial planning.

As I mentioned, telehealth offers a number of benefits to patients, staff and the health service. Exhibit 4 on page 16 highlights some of the benefits, which include reducing travel, providing a quicker diagnosis and avoiding outpatient appointments and unnecessary hospital admissions. As the use of telehealth in Scotland remains small scale, there are limited opportunities for staff to gain experience in the area. There will be a need for increased training for doctors and nurses as it is rolled out more widely.

Of the 70 initiatives that have been introduced to date, only about 40 per cent have been fully evaluated. Although the results from those evaluations identified benefits from telehealth, the results from three current large-scale United Kingdom projects involving at least 37,000 people will further improve the overall availability of evidence. The first of those, which covers more than 6,000 patients in England, is due to publish its findings later in the year.

As part of the audit, we carried out some interesting and detailed economic modelling to assess whether telehealth can help the health service to provide services more efficiently and manage increasing demand for services. We modelled the costs of using telehealth to monitor patients with chronic lung conditions in their homes. Although there are some uncertainties due to the lack of reliable cost information, which is a recurring theme for us, we estimate that telehealth management of those patients at home could help NHS boards to avoid costs of about £1,000 per patient each year. The saving comes mainly from lower hospital admission rates. As well as creating potential for savings, home monitoring of patients with long-term conditions can benefit the patients by helping them to understand how to manage their condition—with health service support, obviously. Patients clearly value the opportunity that that gives them. There are therefore quality benefits as well as efficiency savings in the area.

The report makes a number of recommendations for NHS 24 and health boards, which are summarised on page 5. We recommend that health boards consider telehealth as an option

when they introduce or redesign services. We have developed a list of questions to help them to do that, which can be found in appendix 4.

We are happy to answer any questions.

The Convener: Thank you. What are the main barriers to more extensive use of telehealth in the health service in Scotland?

Barbara Hurst: The team might come in after my answer. We found that many of the initiatives are developed by enthusiastic doctors. When a doctor is really keen to develop a service and to roll it out more widely in order to provide patients with access from a distance, that is when such services have been most successful. As doctors and other supporting health service staff get more comfortable with telehealth, that should help.

We surveyed medical directors to see what the barriers might be. Sarah Pollock will talk about the survey.

Sarah Pollock (Audit Scotland): We surveyed the medical directors in the 14 territorial NHS boards and found that clinical preference is an issue. Not all clinical staff like the telehealth approach—they still want to see patients face to face and to have a physical interaction with them, and they really do not want to do that through videoconferencing. Another message that came through in the survey is that much of the work of the Scottish centre for telehealth had been done on quite a small scale and had not been rolled out more widely. The initiatives were quite small and some of the medical directors felt that there had been a lack of national direction on telehealth, particularly in the period when the SCT was being established. In many ways, that has now been addressed through the Scottish centre for telehealth integrating into NHS 24.

The Convener: Barbara Hurst said that it is down to enthusiastic individuals and you are talking about small-scale initiatives. Are you suggesting that there is a lack of strategic willingness, understanding or commitment? Would a more strategic approach help to develop what you seem to be suggesting is a beneficial initiative?

Barbara Hurst: We found some fantastic examples of where telehealth is being used to great advantage. Through the report, we are trying to push the idea—and we are already having some success—that telehealth is not something that should be at the behest of individual doctors but a strategic issue for the health service. Of course, we need doctor buy-in, but we also need buy-in from managers in order to develop different ways of delivering services and to manage demand in increasingly pressurised areas. Sarah Pollock could give you more detail on the situation in NHS Lanarkshire. That is a fantastic example of how, even in the central belt, telehealth can be used to increase the speed at which patients receive treatment according to priority.

The Convener: Before I open up the debate, I will ask a specific question about chronic obstructive pulmonary disease. You say that there are more than 100,000 people in Scotland who have the condition and that monitoring patients with COPD could avoid costs of around £1,000 per patient per year. Do you know whether all those 100,000 people would benefit from that? If they did, we would be talking about saving £100 million a year, which is staggering. If there is a potential saving of around £1,000 per patient even in this limited part of the health service, why is more work not being done on it?

Barbara Hurst: We could have aggregated that figure up and claimed a massive saving from monitoring patients with COPD, but we were pretty cautious in the economic modelling because of issues to do with the reliability of some of the data. We were trying to use it as an example of the savings that could be made. The modelling was a detailed exercise involving experts from across the range of COPD services and we are pretty confident that it is as robust as it can be, but we did not want to make huge claims about the savings that could be made, because telehealth might not benefit some individual patients among those 100,000.

The Convener: Even if only a very small percentage of patients—only 1,000, say—would benefit in the way that you suggest, telehealth could still result in savings to the health service of at least £1 million. Even in a worst-case scenario, substantial savings could still be made, so why are we not seeing more commitment to using it?

10:15

Barbara Hurst: We agree that there are savings to be made, which is why we did the exercise. NHS 24 has been very interested in this area of work and now that it might be driving some of the work, it may well try to promote the benefits of the approach more widely.

Tricia Meldrum (Audit Scotland): COPD is one of the priority areas for the SCT and NHS 24 in the SCT's strategic framework. As Barbara Hurst said, four areas have been identified in which the SCT wants to prioritise, pushing more national projects as well as more projects across the country, and COPD is one of those priority areas.

Mark McDonald (North East Scotland) (SNP): It strikes me from reading the report and from the discussion with the convener that this is very much a spend-to-save initiative. Obviously, there would be up-front costs in establishing telecare—sorry; I

mean telehealth, as telecare happens at a local authority level, of which more later, I am sure. However, when telehealth is up and running, savings can clearly be achieved.

I have two questions. I notice that on page 13 of the report, you talk about

"resistance or uncertainty among clinical staff".

There is often resistance to change, but is the block to broadening the use of telehealth resistance among clinical staff or a lack of understanding at the board and senior management levels? Obviously, decisions on the deployment of resources come from the top down. Is the problem as simple as resistance among clinical staff, or is it about a lack of understanding at board level?

Secondly, on page 14 you identify what appears to be a clear north-south divide, apart from a couple of exceptions, in the use of telehealth. We might explain that by reference to the remote communities in Highland and Grampian, but the Borders and Dumfries and Galloway have remote communities, too. I do not think that the explanation is that cut and dried. What is the rationale behind the reluctance to roll out telehealth in some of the other board areas that have remote communities to serve?

Barbara Hurst: I shall kick off and then, perhaps, I will ask Sarah Pollock to come in.

On your second question, part of the explanation might be no more than that the Scottish centre for telehealth was initially based in NHS Grampian and was seen as a way of giving people in rural and remote areas more ready access to services. Clearly, however, boards such as NHS Greater Glasgow and Clyde also provide services to people on the islands. As the benefits start to become obvious—we are getting some interesting examples from the central belt—people will see that telehealth is not just an issue for rural and remote communities. Things should improve.

On your first question, we agree that the block is about both clinical resistance and the need for managers to buy into the idea. An individual enthusiastic doctor can go only so far; the approach must be properly embedded in the work of the health board. We are very keen on the idea that, when boards are looking into different ways of delivering services, they should always consider telehealth. It might not be appropriate in all cases, but it should be part of the strategic thinking about how to change and redesign services.

Murdo Fraser (Mid Scotland and Fife) (Con): Let me follow up on Mark McDonald's question, looking again at the map in exhibit 3 on page 14. It is interesting that there seems to be no pattern at all in the development of telehealth. Some areas have a wide range of telehealth initiatives, such as Grampian, Highland and Argyll, as we might expect, and also greater Glasgow and Clyde and Lothian, but other areas that we might have thought would have benefited more—Tayside, Dumfries and Galloway, and the Borders—do not. The pattern seems to be completely piecemeal. Is that a fair characterisation? It seems that there is no particular logic to the development of telehealth and that it is very much ad hoc.

Sarah Pollock: That is a very good point. That is probably true, and it reflects how initiatives have been developed. There has not been huge national direction or a huge national drive in the early years, as there was no national strategy for telehealth. It was really for boards to say, "Here's an area in which telehealth might work for us and, more locally, here's an enthusiastic clinician looking for an area in which they think it could add value for patients."

Murdo Fraser: That is interesting.

The redesign of services is covered at paragraph 30 and onwards. Paragraph 30 says:

"Telehealth is not generally considered as an option when NHS boards are planning or redesigning the way a service is delivered."

The clear message from the report is that it should be considered as an option, as it can result in patient benefits and cost savings.

Paragraph 32 is about the Scottish Government's efficiency and productivity framework for the NHS. Is there sufficient impetus from the Government or the NHS nationally to drive forward that framework?

Sarah Pollock: There is probably more impetus now than there was a few years ago, and there is probably much greater understanding. I think that the evidence base is starting to be strengthened and that it will be strengthened much more by the three large-scale initiatives that are being run in the UK. One of the difficulties in the early days has been that there has not been the evidence base to say that telehealth is the right way to go, that it will result in benefits in the longer term, and that it will be cost effective. Very little work has been done that shows that, from a financial perspective, it is more cost effective to go for a telehealth initiative than conventional care.

Murdo Fraser: I am very interested in the checklist in appendix 4 for NHS boards that are considering redesigning services and bringing in telehealth. Will you be encouraging the audit function in the NHS to consider how it is being followed?

Sarah Pollock: The checklist will be applicable at many levels. We are mainly thinking about a clinician who might want to introduce an initiative

working with management—they can say, "Here are some of the things that we need to think about before we can put in place a telehealth initiative." The checklist gives the questions that need to be asked to evaluate whether telehealth has proved to be more effective than carrying out the service through conventional care.

The Convener: Would you clarify something that you said to Murdo Fraser? You said that there was no national strategy. Is a national strategy now in place?

Sarah Pollock: Yes. When the Scottish centre for telehealth and telecare came under the wing of NHS 24 in April 2010, it put in place a strategic framework that in essence is now the national strategy for telehealth. That covers the four priority areas of COPD, mental health, strokes and paediatrics, which are the areas that NHS 24 is considering prioritising over the next few years.

The Convener: Have there been any significant improvements since that strategic framework was put in place?

Sarah Pollock: The report highlights the work that has been done on strokes in particular and the successful development of telestroke throughout Scotland. I refer members to case study 1, on page 9. We looked at telestroke specifically in the south and east of Scotland, but it has been rolled out nationally, and NHS 24 has very much been behind that development. It has done work on developing a strategic framework for mental health, and it is driving forward home monitoring initiatives, which we talked about earlier, in the area of COPD. It is also increasing opportunities to put in place pulmonary rehabilitation classes for patients. I refer members to the third case study in exhibit 4. Patients with COPD in Pitlochry had to travel to Perth royal infirmary for rehabilitation classes, but that facility can now be provided in their local community hospital. NHS 24 is working nationally to roll out that approach in other areas.

Colin Beattie (Midlothian North and Musselburgh) (SNP): The report is very useful. One aspect that jumps out at me is the potential for the duplication of services. I recognise that there is a difference between telecare and telehealth, but there seems to be a lot of crossover in the functions that are carried out under each heading. I am aware that, in my area, East Lothian Council and Midlothian Council have spent millions on a telecare system that may or may not be able to slot into a telehealth system. That is an area that would benefit from more exploration. I think that Barbara Hurst touched briefly on the possibility of duplication, but I wonder how much exploration was done of that in developing the report.

Barbara Hurst: When we first scoped the report, we wondered whether we should broaden it to include telecare. However, we decided that we would do telehealth initially because it would give us a clear way in to look at potential efficiencies. Since we started the work, the strategic oversight of telecare has moved from the Scottish Government to NHS 24, which will now have oversight of both telehealth and telecare. Part of its support role will be to try to help health boards and councils to integrate some of the systems, although it is very early days for that.

Telecare is a gleam in our eye for possible investigation. However, we want to wait to give telehealth a little time to bed in before we come back and review what is happening in the area and expand that to look at telecare services. Colin Beattie is right that some of the monitoring could cover everything. We are keen to look at telecare services, but we want to do it as part of our second look at telehealth.

Colin Beattie: I am pleased that you are thinking about looking into telecare, because millions must be getting poured into telecare services right across Scotland as part of the effort to deal with the ageing population and avoid expenditure on care homes by keeping people in their own homes, which is all commendable. However, there must be considerable potential for duplication. We need to be alert to that. I hope that you will audit the area at an early point.

Barbara Hurst: I am not quite sure what "early" is, but—

Colin Beattie: Soon.

Barbara Hurst: We have certainly got it in our medium to longer-term plans. Sarah Pollock has been doing some work on the issues that we might examine when we bring it forward.

Drew Smith (Glasgow) (Lab): Paragraph 4 of your report refers to the Health and Sport Committee's 2010 report "Clinical portal and telehealth development in NHS Scotland", which said that no significant progress was being made although there were good examples, which sounds similar to the result of your report. That led me to think about what has changed since the 2010 report, and the obvious thing is the integration of the Scottish centre for telehealth with NHS 24. That sounds great, but paragraph 24 of your report states:

> "Half of medical directors felt that the integration of SCT and NHS 24 had no impact on the delivery of telehealth within their board."

Can you expand on what you heard from medical directors about that? If the Health and Sport Committee were to take another look at telehealth this year, would it just publish the same report again?

Barbara Hurst: I ask Sarah Pollock to talk about the survey of medical directors.

Sarah Pollock: The survey highlighted the way in which telehealth has evolved in Scotland through small initiatives and enthusiastic clinicians. We found that much of the interface was between those individual clinicians and the SCT. Strategically, medical directors perhaps did not have oversight of what was happening in their boards around telehealth. In addition, there was no national strategy for telehealth in the early days between 2006 and 2010.

The SCT was integrated with NHS 24 in April 2010. When we did our audit, we were looking at the situation less than a year after that integration, so it is fair to say that it was quite early days to evaluate what NHS 24 was doing more generally on a national level to drive forward telehealth. It has started to put in place initiatives such as the champions network, which brings together clinicians from across Scotland to share best practice, and it now has a much greater focus on the evaluation of initiatives and what can be learned and shared by NHS boards. Progress has been made, but it is still quite early days.

10:30

Drew Smith: I accept that the integration is new, but we are talking about established organisations, so I would have expected to see a bit more progress, given the sums that the convener mentioned could be saved.

You said that it was enthusiastic clinicians who were pursuing telehealth. That says to me that there must be enthusiastic clinicians out there whose small-scale projects are not being developed because they are meeting barriers. Did you get much of a sense of what the frustrations are for those people?

Sarah Pollock: With some of the small initiatives, we found that there probably was some frustration, because a number of initiatives have been discontinued. In some cases, that may have been for clinical reasons. We looked at an initiative in Fife on eye conditions where the quality of images was not good enough, so it was discontinued on information technology grounds. It is often the case that clinicians manage to get funding for a small-scale pilot, which they run for two years or so, after which it is discontinued. That might be because it did not fit with what the board was doing more widely, on a strategic level. A clinician might have developed an initiative but then not engaged with other people to find a way of taking it forward.

Drew Smith: In paragraph 22, you say that only half of boards' local delivery plans refer to telehealth. Did you get the sense that that will change? As a result of the strategic framework, is the Government now being clear with boards that telehealth needs to be part of their local delivery plans?

Sarah Pollock: It is hard to be definitive about that. Boards are starting to see the benefits of telehealth. When the evidence comes through from the large-scale initiatives that are being run just now, particularly the whole systems demonstrator programme, that will strengthen the evidence base, but NHS 24 will still need to provide considerable drive to promote and encourage the use of telehealth, which will involve working and engaging with boards.

Humza Yousaf (Glasgow) (SNP): I recently visited the Glasgow School of Art, which has a digital media hub in Glasgow's digital quarter. It has Europe-leading laser scanning technology, on the use of which it is linking up with Greater Glasgow and Clyde NHS Board. It is looking to generate income from that, in partnership with the health board.

Did you get a sense from any of the health boards that they see telehealth as an opportunity to generate income? Patient care must, of course, be at the centre of everything, but the great thing about a lot of telehealth initiatives is that their potential is not restricted to Scotland. Experts who are based in Scotland could treat conditions all across the world. Did you get a sense of that potential? I did not get any sense of it from the report. Maybe it is early days because the technology is still to be developed and we are talking about small initiatives, but you would think that that would be worth exploring.

Barbara Hurst: The focus of our work was to look at the specific benefits to patients and the efficiency savings. Income generation was not a focus. I do not think that we asked any questions about that, so I am afraid that we cannot answer your question.

Humza Yousaf: Do you think that it might be a motivating factor for some health board chief executives? It would be interesting to look at that.

Do any of the health boards have data on the uptake of telehealth initiatives by patients? Do you have any data on that, or do you know of any health boards that have such data?

Barbara Hurst: We certainly have data on how many patients were involved in each of the initiatives but, as we have said, they are relatively small-scale initiatives, so we are talking about only 30 or 40 patients per initiative.

Humza Yousaf: Okay. It would be interesting to see such data. Do you think that the health boards would have that information?

Barbara Hurst: I am sorry—I just need to check something with Sarah Pollock. Do we have the detail of how many patients were involved in each initiative? If so, we could provide members with it.

Sarah Pollock: Yes. We found information on 70 initiatives that have been put in place since 2006. From that, we know how many patients were involved. The average figure was about 34, but some initiatives involved slightly more patients and others involved as few as five or six patients. Therefore, we know how many patients were involved in the telehealth experience in those initiatives.

Humza Yousaf: Did you notice any discernible pattern? I am making a complete assumption, but I assume that perhaps people in a younger demographic would be slightly more willing to take part in telehealth initiatives, although it might well be that people from an older generation would need the service more because of mobility issues.

Sarah Pollock: It is interesting that the perception is that, particularly among older people, there may be more resistance and fear around the use of technology, but a number of the initiatives were around home monitoring of patients with chronic conditions such as COPD. It is interesting that patient satisfaction with the initiatives was very high. There was initially some concern along the lines of, "Will I be able to use the technology? Will it be difficult? Will I have problems?" However, problems did not happen because a lot of the home monitoring equipment is very simple to use. It came through strongly in the report that age was not a barrier to people feeling that they could use the technology.

Humza Yousaf: That is good to know.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): My attention was drawn to page 18 and case study 3, on the national videoconferencing project, which began in October 2009. With reference to my colleague Mark McDonald's comments, there seems to be a focus on the northern health boards in the early stages of that scheme, which might explain the difference between the north of Scotland and the south of Scotland in engagement with telehealth services.

Do you get the sense that, as we develop telehealth in Scotland, the public are fully ready to embrace it? I note with interest your comments about the use of broadband for delivery of some of the services. We can all talk about access to and the availability of broadband and broadband speeds throughout the country. Do you think that we are geared up and ready for telehealth and that the public are more ready to engage with it as a means of improving their own health?

Barbara Hurst: It is hard to speak for the public, but patients who see the benefits for themselves are positive about telehealth—I am thinking of benefits such as a patient not having to travel from the island to the mainland for an out-patient appointment or being reassured in their own home that what is happening to their blood pressure is not a cause for real concern. The more that the health service can do around promoting such initiatives, the better.

I suspect that it is only when you need telehealth or you can see the benefits to yourself that you become very positive about it. It is a difficult issue. I imagine that there may be some scepticism, but that would be quite easily dispelled when the benefits were considered.

As Sarah Pollock says, once we get the evidence from the large-scale evaluations, that will give us a much more solid evidence base on which to go out and say, "This can really deliver benefits to you as patients."

Willie Coffey: Can you clarify the experience that a patient has with telehealth? Is it with a local health centre or hospital? Do patients experience a direct link from the home to the telehealth service?

Barbara Hurst: Home monitoring equipment is used, but for videoconferencing—Sarah Pollock can come in with more detail—the patient would need to go to a health facility. In some ways, if someone is having a consultation, they want to be in a health facility, because if anything comes up through the consultation that they want local healthcare support on, they want to be able to access that.

Clearly, people do not all have videoconferencing facilities in their own home. I am not a technical person, so I have no idea what will happen in five or 10 years' time, but at the moment there are real benefits from the technology, which we think could be used better, or more effectively.

Willie Coffey: The application of technology can easily deliver that technology now—a person can receive some advice and some services directly at their home rather than via a local health centre or even a hospital that is distant from where they live. Perhaps that is a wee glimpse further into the future.

My second question is on evaluation. You made some comments about that. I know that there is a low number of pilot studies and so on, but even within that, the amount of evaluation is quite low. Is there a reason for that? Have some boards not done any evaluation of telehealth services? If so, why not, given that there is a national strategy in place to assist with the delivery of telehealth?

Barbara Hurst: Perhaps that takes us back to Mark McDonald's question about whether

telehealth is properly integrated into the management of services locally. Individuals who are doing things with telehealth might evaluate them, but they might not be bought into locally as a way of redesigning services. We are pushing appendix 4 to our report hard and saying to boards, "Please use these questions every time you think about redesigning services, because it might help patients and save money."

The Convener: I call Mark McDonald.

Mark McDonald: Thank you for allowing me to come back in, convener. I had a minor epiphany when Colin Beattie asked his question, because I recall that, when Audit Scotland outlined its work programme, I raised a point about the auditing of telehealth and telecare separately and asked whether it would not be better to integrate them in an audit. You appear to be saying that, had you known then what you know now, you might well have looked at doing a combined audit, given that telecare appears to have moved since then.

However, telecare is in your longer-term programme—I assume that you are talking about years rather than months—so might you consider publishing an overarching report on both areas of work? That would allow you to revisit some of the issues that are covered in the telehealth report and would provide for a more holistic audit, rather than your auditing telecare and then having to go back and audit the two areas of work together at some point in the future. Is that something that you would consider?

Barbara Hurst: Yes. On whether we could have focused more widely in this report, we would probably still have gone for telehealth, because it was a definite decision that we wanted to look at efficiencies in the health service. When we revisit the area, there is a strong possibility that we will want to look at telehealth and telecare together, particularly given the drive towards more integrated health and social care services for older people. It strikes me that that would be a good way of considering the integration of those systems.

The Convener: I thank you and your staff from Audit Scotland for contributing to an interesting and full discussion. Telehealth clearly has the potential to make a contribution not only to the quality of healthcare in Scotland but to financial savings. It will be fascinating to see how much commitment is made to it in the future.

Section 22 Report

"The 2010/11 Audit of the Scottish Government Consolidated Accounts"

10:43

The Convener: We move on to item 3. I invite Mr Black to contribute.

Mr Black: The report that you have arises from the audit of the Scottish Government consolidated accounts for 2010-11. It was published on 3 October. I give an unqualified opinion on the accounts, but the report brings to the attention of the committee and the Parliament some transactions that are reflected in the accounts that relate to the loss of European funding to Scotland.

I will start by mentioning the background to the issues that are highlighted in the report. There can be no doubt that Scotland benefits from a significant amount of European funding, which helps to support public spending on economic development, farming, the rural economy and fisheries. The amounts of money for those areas are included in the Scottish budget and the associated income and expenditure are reflected in the Scottish Government's consolidated accounts.

Within the broad policy framework that is established by the European Union, the Scottish Government has some discretion over how the funding is applied, but it must comply with detailed rules about the checks that must be done on the eligibility of applications for assistance under European programmes and the payments that are made.

10:45

The European Commission conducts its own audits to determine whether the required checks are in place. If it finds that they are not in place, it can withhold funding, leaving the Scottish Government to meet the costs from its own resources. The Commission does that through applying what are known as financial corrections, which are, in effect, a form of repayment. The system is designed to protect the European budget against the risk that ineligible expenditure has been charged to it. It also provides a strong incentive to ensure that national Governments and their agents have in place the management and control systems that are required under European rules.

My report highlights that as a result of such financial corrections, £51 million of European funding for programmes running between 1994 and 2006 has been repaid. The report also states

that further repayments are likely to be required in relation to other European funding programmes over the years since 2000. At the moment, those further repayments are also estimated to be around £51 million.

I consider that all those repayments represent a loss of European funding to Scotland. They arise because Scottish Government procedures have not been meeting the standards required to ensure that the use of funds complies fully with European legislation. Under the accounting rules, the Scottish Government consolidated accounts include provisions for those repayments based on the best estimates of the final amounts before they are finally settled. Once the amounts are settled, they are met from those provisions. The relevant transactions are reflected in the 2010-11 accounts.

There is a fairly long time period—it runs over many years—between the European Commission identifying issues and settlement finally being made. In part, that is due to the time that the European Commission takes to conduct its investigations, but it is also the result of the time required to discuss and negotiate the amount to be repaid. During that time, the Scottish Government is able to undertake additional checks and provide further eligibility information relating to the payments that it has made. If the Commission accepts that, it will limit the final amount that it seeks to recover.

The Scottish Government has undertaken a significant amount of work, which has had the effect of limiting the settlement for previous European structural fund programmes to the £51 million. Those amounts are now agreed and settled.

A similar approach is being taken to the European agricultural guarantee fund. Discussions with the European Commission about that are continuing and, until they are concluded, the amount that will be recovered by the Commission will not be finally confirmed. The timescale for that is uncertain, but I am hopeful that discussions are nearing completion.

The Scottish Government has made some important changes to the way that it manages European payments since the time of the original audits. Those arrangements will be tested through an on-going programme of European Commission audits. I will continue to monitor progress through the annual audit.

I have highlighted in the report two other issues relating to more recent audit findings. Both relate to concerns about the checks that are being done by the Scottish Government on other aspects of European funding payments. In one case there has been an interruption in regional assistance payments, which in effect means that the flow of funds has stopped coming through for a period, but that issue is now resolved. In the second case, the issues are subject to a current European Commission audit and remain unresolved.

Looking to the future, I think that it is important that the Scottish Government continues to address concerns about the management and control of European funding programmes. The Government must ensure that it learns the lessons from its experience of previous programmes and applies them in the future.

I have with me my colleague Mark Taylor, who leads the team that audits the consolidated accounts. He will help me to answer any questions that you might have.

The Convener: Clearly this is a matter of concern, not only because £51 million had to be repaid but because it is estimated that there will be a further likely repayment of £51 million. To put it in context, are you able to give us a total figure for how much was received in European funding for that period? What kind of percentage do those payments represent?

Mark Taylor (Audit Scotland): We have tried to do that and to give a feel for scale in the report. Total structural funding during the period was well over £1 billion and we have quoted figures in paragraph 13 to give a feel for scale. Because of the timeframe, it is difficult to match up two periods, but we have given a feel for scale that less than 5 per cent of the programme was repaid through these financial corrections. We have also tried to give a feel for the annual scale in relation to annual budgets in table 1 in the report. It is fair to say that the proportion is relatively small, but the absolute amounts are still significant.

The Convener: I am aware, over the years, that many countries have had similar problems with repayments of European funding. How much of this was a failure by Scottish Administrations to apply the rules properly and how much was it a failure by the European Commission, first to clearly explain the rules and parameters within which the funds should operate, and also to monitor and audit what was happening? It seems strange that the problems have built up over many years and yet nothing seems to have been done. How much was this a failure by Scottish Administrations and how much was it a failure by the European Commission to explain properly?

Mr Black: It is difficult to apportion responsibility. European regulations set out clearly the criteria for the award of any assistance and there is no doubt that the controls that the European Commission expects to see in place are testing ones. At the same time, as the report indicates, there has been clear evidence that the controls being operated within Scotland do not

measure up to that standard. You are right, convener, that Scotland is by no means alone in this; the Auditor General in England has reported on expenditure down there, and there have been issues in Northern Ireland, too. We are not unique in Scotland in having these problems, but nevertheless we think that the issues are significant enough to draw them to the attention of Parliament.

The Convener: At what level did the problems arise? Was it at a Scottish level, through the Scottish Executive or Scottish Government, or was it in the programmes and the applications made by the local programmes?

Mark Taylor: The short answer to that is both. On the structural funds programmes, it was a case of oversight and direction from the Scottish Government; the way in which, at the time, bodies called programme management executives also applied those controls; and the interface between those two. Of course, the buck stops with the Scottish Government and that was clearly understood. The European Commission auditors, in reporting on that, made the point that it was an oversight issue for the Scottish Government. It is fair to say that, on structural funds, it was a mixture of both.

The payment agency for agricultural funds is the Scottish Government and there is no intermediary in the same way, so responsibility for that lies with the Scottish Government.

The Convener: I realise that the rules are complicated, but, as Mr Black said, the European Commission lays down a very detailed set of rules and expectations. Are these problems that could and should have been avoided?

Mr Black: Essentially, I think that the control environment should have been stronger from the outset. We all have to recognise that hindsight is a wonderful thing and, with the benefit of hindsight, it is unfortunate that the controls were not as strong as they should have been in order to comply with European requirements. Having said that, I can say that the Scottish Government has been paying close attention to this over recent years and the audit team is confident that it has been strengthening the controls that have applied.

Mark McDonald: The control environment is an interesting angle from which to come at this issue. The date to which the problems relate predates devolution. Was the control environment that was inherited from Westminster at devolution deficient? Was no effort made at that time to consider whether the control environment needed to be made more robust or altered in any way? Was it simply inherited and continued with, despite the deficiencies that existed?

Mr Black: The largest financial correction relates to the European social fund for the period 2000 to 2006. It starts on the cusp of devolution and runs to 2006. As I mentioned in my on-going remarks, there were still outstanding issues relating to the next programme of work, running from 2007 to 2013; so, this has been an issue over a significant period. The audit that we are discussing is confined to the consolidated accounts for 2010-11. Over a number of years, however, the audit team has commented in the final audit report on the risks associated with the control environment. The risks have been known for some time and the controls have been subject to attention and improvement over a number of years.

Willie Coffey: I note, in table 2 in the report, that some of the figures date back to 1994, which was 17 years ago. I know that things sometimes move slowly in Europe, but that is a long time to catch up on some of the issues.

Systems of financial control and so on are surely not new. We are familiar with those audit principles when we engage with ERDF and EU structural funds management. Why were the issues not raised at the time, during the progress of some of the programmes, so that compliance could have been corrected and delivered as we were working through the programmes? Why have we waited five, six or seven years to be handed a bill requiring us to pay money back? Why can the corrections not be made while the programmes are in progress?

Mr Black: I am sure that Mark Taylor can help you with that. You must recognise that the European Commission applies its audit resources to the programmes after the event—it goes back to examine previous transactions. It must then make a judgment on whether there have been breaches of the rules and controls that are required. After that, there is an extensive period of checking within the Scottish Executive—latterly, the Scottish Government—and a period of negotiation with Europe on the matter. In the case of the £51 million that I highlighted, it has been possible to reduce the amount of the repayment to that level as a result of the negotiations. It is perhaps understandable that these things can take a number of years.

Mark Taylor may want to add some detail on that.

Mark Taylor: Yes, just to be clear on the timing of the audit process. The audits that the European Commission conducts are real-time audits that look at, and report on, the controls that are in place at the time. The delay happens as a result of that. All payment agencies and national Governments are able to demonstrate that any weaknesses in controls did not lead to ineligible

expenditure, and that is what takes a lot of time. The audit takes place when the controls are in place and on the controls that are in place at that time. I will use an example to give members a sense of the timeframe. The audits relating to structural funds were carried out broadly between 2003 and 2005. It has taken until this year for the issues to be resolved, but the controls were assessed at that stage. The Scottish Government seeks to learn from that in order to improve and strengthen its control framework, which it has done in the case of structural funds.

On the agricultural funds, the issues at stake run right up until 2009 and early 2010, which is when the audits were done. Audits are carried out close to the controls, and it is the discussion and negotiation after that which take time. The system allows a national Government—in this case, the Scottish Government—to make every effort to show that it has looked at the cases, gathered evidence and tested it. Once it has presented that evidence, there is a negotiation of the ultimate figure.

11:00

The Convener: The sums that we are talking about are large. Will you give us a feel for the type of problem that is causing the issue? Is it overpayment on individual projects, or individual projects engaging in activities that were not relevant?

Mark Taylor: Part of the problem is the range of issues that are subject to such financial corrections. In relation to structural funds, there are potentially five separate cases and, in relation to agricultural funds, there are potentially six separate cases. I will give you some useful examples. The most accessible of them concern agricultural funds.

Part of the process for claiming the single farm payment—area-based aids, to use the technical term—is that the Scottish Government must have in place an inspection process to ensure that the land that is in receipt of those subsidies conforms to the rules and requirements. Inspectors are in place to check a sample. The European Commission's auditors came along and reperformed the checks. They found some deficiencies in initial checks, which meant that ineligible features in land—for example, bracken or lochs, which are not eligible for subsidy—had not been identified in the initial inspections. Therefore, they raised concerns about the inspection process, which was subject to further investigation.

I will give another example from the same area. One of the tools that the Scottish Government uses is a database of fields in Scotland that are eligible for subsidies. Again, the Commission's auditors identified concerns about the quality of information in that database, how eligibility was recorded in it, the extent to which features such as lochs and bracken were recorded in it and simple matters such as which maps had been used and the measurements on them.

Those are the most accessible examples. In relation to structural funds, the issue was, again, the checking of eligibility. A common example concerns additionality. Support is available only when additionality can be proven—in short, the project could not be funded any other way—and the European Commission auditors determined that that was not being checked properly.

The Convener: Is that additionality in terms of the outcome or the funding that was made available to support the European project?

Mark Taylor: I will oversimplify, because the complexities in the regulations on additionality are significant. The basic principle is that, if somebody else could fund a project, it is not down to Europe to fund it. In short, Europe funds business propositions that would not receive normal business funding.

The Convener: Over the years, I have been aware that there were tensions whenever colleges applied for European funding. The issue was whether the local authorities in the past or, subsequently, the colleges themselves, through the Scottish Government, should fund the projects concerned. Often, it was at the margins and quite complicated.

Colin Beattie: I have a couple of basic questions. Paragraph 13 of the Auditor General's report mentions that the repaid income that is shown in table 2 arises

"from the findings of European Commission audits undertaken between 2003 and 2005,"

which is years after the event. Is there no time bar on how far back the EU can go to investigate and recover money? Any Government that goes that far back into the past must have great difficulty in retrieving the proper records. That is just a fact of life. It must sometimes be difficult to justify the expenditure or to find the pieces of paper that are needed to justify it. That may be part of the problem; I do not know.

My second point concerns items 1 and 4 in table 2. They occurred prior to the establishment of the Scottish Parliament, but the Scottish Parliament is reimbursing the money. Would it not be more appropriate for the money to come from the Westminster Government, given that the Scottish Parliament did not exist during the relevant period and the money came from a different budget?

Mr Black: On the latter point, when the Scottish Parliament came into existence, it took over responsibility for everything that is reflected in the consolidated accounts of what is now the Scottish Government. As a result, the financial benefits were being achieved before devolution but the consequences have flowed through to post-devolution. The system is the same; it is just that responsibility has been devolved from the UK Government to the Scottish Parliament.

Mark Taylor will pick up on the time bar issue.

Mark Taylor: Under the closure process for each of the programmes, the audit results are resolved. When that happens, the programme is closed and the Commission moves on to the next. That is a normal part of the European process. On the question whether there is a time bar, there is no hard-and-fast limit to the length of time that the process might take. However, when each programme is closed, the next is considered and investigated.

With regard to structural funds, the Scottish Government is working with Commission auditors on the closure of the structural funds programmes that ended in 2006. That process is nearing conclusion and this work has been done to allow that to happen.

Colin Beattie: Just for clarification, is it the case that there has to be an active audit for each programme in Scotland and that it is not simply a matter of saying that, if it is not challenged within five or 10 years, everything is okay and we can move on?

Mark Taylor: The audit arrangements are very well defined and involve a number of parties. However, the arrangements for structural and agricultural funds differ. In essence, the European Commission oversees the audit but, with regard to structural funds, the Scottish Government is required to engage its own independent audit and appoints its own internal audit service to do that work, whereas with agricultural funds Audit Scotland does that work as part of a consortium arrangement. The findings from the on-going audits feed up into what the European commissioners are doing and, as a result of those findings, they might decide to undertake additional work or investigate a completely different area.

The important point about the regime is that there is not a lot of discretion in its application. Again, its workings and the role of individual auditors are all defined in the European regulations. I point out, though, that we talk to one another about these things and have been in communication with Commission auditors on certain agricultural issues, most recently as a result of their recent visit.

The quite defined audit process that is in place allows issues to be identified as we go along and I think that it would be wrong to characterise the process as one in which we look back a long time and find problems that arose years ago. Such problems are identified; however, it is taking a long time to resolve the financial consequences.

Humza Yousaf: Table 2 sets out some of the European Commission's concerns, including

"Insufficient quality and quantity of verifications of expenditure ... Quality and volume of financial checks"

and

"lack of control".

Some oversights seem quite serious, while others are less so. Are you confident that since 2006 the more serious failures have been addressed? Indeed, can you give an example of how those more serious failures have been tackled? Are there still gaps and, if so, is the Government working on them?

Mark Taylor: For a number of years, the Scottish Government has been working hard to fix the more significant problems; in fact, we have recognised some of those improvements in the report. I realise that they are no longer called structural funds, but one good example concerns the structural funds programme for 2007 to 2013. As part of a new management and control mechanism that has been agreed between the Scottish Government and the Commission for checking payments, 15 per cent of each case is checked individually for compliance. That system is up and running; indeed, the interruption that has been mentioned was caused because the checks were not in place earlier in the year. However, they have now been introduced.

We are very much aware of the improvements that have been made to the inspection process. As I said earlier, we know that a good training programme for inspectors has been introduced; claimants are being educated on eligibility; and work on developing information from the land parcel identification system is on-going.

We sought to recognise in the report that significant effort has been made to address the historical problems and to highlight that there are still on-going issues in particular areas. The interruption, which has been addressed, was a recent example of that. The question in that regard was whether the new checks were in place. There are also on-going pressures with agricultural payments. The important point, as the Auditor General said, is that the Scottish Government is able to learn from its experience over the past years when it designs the compliance schemes. There is an issue around projects being approved at one stage but expenditure being made on those projects for a number of years afterwards. Projects

take a while to run and if the controls are not up to scratch at the start, it is difficult to dig oneself out of that two or three years down the line. The Scottish Government has put a lot of effort into addressing that to get ahead of the curve and be able to deal with the issues for future programmes. That is what a lot of the auditors' discussion has been about.

Humza Yousaf: In a sense, you are saying that there is an evolving process but that it does not really matter what controls the Government applies or when it applies them because difficulties will probably always arise because of the nature of the funds.

Mark Taylor: There will always be rigorous checks and tests on whether the expected controls are in place, but I do not agree that it is impossible for the organisation to ensure that those controls are in place. In particular, the Government has learned about the need to pay close attention to the requirements when designing the initial systems. Our audit was unable to look back and give detailed reasons why compliance failure had happened, but it is apparent that close enough attention was not paid to the rules when the initial systems were set up and the initial applications and schemes were examined. I know that the Government has learned that lesson for its approach in the future.

Murdo Fraser: I want to follow up on Humza Yousaf's final point about how we ensure that compliance failure does not happen again, because that is a key focus. The Auditor General's summary refers to procedures being evolved to try to deal with the problem, which seems to suggest that there is still concern about whether procedures that are being put in place will, in fact, meet European Commission requirements. Is there no way of getting greater clarity about that to ensure that there will be no repetition of compliance failure in the future?

Mark Taylor: I referred earlier to the well-defined audit process that is in place. As auditors, we will consider the issues in agricultural funds soon and report back to the European Commission on them, so they are on our radar. We felt that it was important to bring attention to the current pressures, although we will do on-going work to see how the improvements are put in place. We remain to be convinced in some areas, which may be because we have yet to look carefully enough or because controls have yet to be identified. The on-going audit process will test and review that.

Murdo Fraser: It sounds as though there is still a risk that more sums might have to be repaid in the future.

Mark Taylor: The Scottish Government recognises that risk in its accounts; provision is made for additional sums and in its contingent liability disclosures in the accounts. Indeed, the permanent secretary, in his statement of internal control, recognises that there is an on-going risk as the issues continue to be addressed.

Murdo Fraser: I have a final question for clarity about the agricultural funds. I presume that those are moneys that have been paid out over a period of time to individual farmers. Is there any question that they will be asked to repay moneys, or is it a Government debt that it will have to pay to Europe?

Mark Taylor: It is the latter of those two: it is a Government debt. There are policy questions for the Government about how it would deal with some of those issues going forward, but in terms of the financial corrections, the transaction is between the Scottish Government and the European Commission.

Mr Black: It is perhaps worth saying that there is absolutely no question of there being a risk of the final recipient being asked to repay money—it is between the Government and Europe.

Mark McDonald: That leads me on to my point, which Murdo Fraser touched on. The Government receives the funds from Europe and they are, by and large, disbursed to agencies, organisations and individuals. Controls can be strengthened at the centre, but there are key issues to consider otherwise—for example, in point 5 of table 2 in the report:

"Ineligibility of costs incurred by intermediate bodies".

The disbursal of the funds relies on controls being in place not just centrally, but where the funds are disbursed to. What guarantees are there that that aspect is being looked at? For example, when the Government hands out money to an intermediate body, what guarantee is there that it has the appropriate controls in place to ensure that it has no ineligible costs?

11:15

Mark Taylor: I mentioned earlier that one of the findings was about the Scottish Government's oversight of such bodies. There are strong responsibilities on the Scottish Government to oversee that process rather than to say, "Well, we've handed out the money and it's up to you guys to manage it properly." There has been a strong education programme with intermediate bodies around the rules that they need to apply and the work that the Government needs to do in overseeing the application of those rules. The Scottish Government is much stronger on that sort

of thing at the moment, but that will be tested through the on-going programme of audits.

The Convener: Thank you for your contribution to the discussion.

Section 23 Report

"Transport for health and social care"

11:16

The Convener: Agenda item 4 is consideration of a section 23 report. The committee has received correspondence from the Scottish Government and the Convention of Scottish Local Authorities. Do members have any comments to make?

It seems that there are no comments. We can either note the correspondence or refer it to the Health and Sport Committee and request further information, although I do not think that that would be relevant. I suggest that the Health and Sport Committee might be interested in the matter and that we refer it to that committee. Is that agreed?

Members *indicated agreement.*

Mark McDonald: I note that the Government has advised that it will update us about the healthcare transport framework once the revised one is published. In the meantime, we should pass the matter lock, stock and barrel to the Health and Sport Committee.

The Convener: Okay, thank you for that. We move into private session for item 5.

11:17

Meeting continued in private until 11:57.

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