OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit and Post-legislative Scrutiny Committee

Thursday 14 November 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

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CONTENTS

PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE
26th Meeting 2019, Session 5

CONVENER

Jenny Marra (North East Scotland) (Lab)

DEPUTY CONVENER

*Liam Kerr (North East Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Bill Bowman (North East Scotland) (Con)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Alex Neil (Airdrie and Shotts) (SNP)
*Anas Sarwar (Glasgow) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Joanne Brown (Grant Thornton UK LLP)
Bruce Crosbie (Audit Scotland)
Caroline Gardner (Auditor General for Scotland)
Leigh Johnston (Audit Scotland)
Fiona Mitchell-Knight (Audit Scotland)
Edward Mountain (Highlands and Islands) (Con)

CLERK TO THE COMMITTEE

Lucy Scharbert

LOCATION

Committee Room 5

Scottish Parliament

Public Audit and Post-legislative Scrutiny Committee

Thursday 14 November 2019

[The Deputy Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Deputy Convener (Liam Kerr): Good morning and welcome to the 26th meeting in 2019 of the Public Audit and Post-legislative Scrutiny Committee. I ask everyone in the public gallery to switch off their electronic devices or switch them to silent mode so that they do not affect the committee's work.

We have received apologies from the convener, Jenny Marra. I welcome Edward Mountain MSP, who is attending for item 2.

The first item of business is a decision on taking business in private. Do members agree to take items 3 and 4 in private?

Members *indicated agreement.*

Section 22 Reports

"The 2018/19 audit of NHS Highland" and "The 2018/19 audit of NHS Tayside"

09:00

The Deputy Convener: Item 2 is consideration of the section 22 reports, "The 2018/19 audit of NHS Highland" and "The 2018/19 audit of NHS Tayside". I welcome our witnesses: Caroline Gardener, Auditor General for Scotland; Fiona Mitchell-Knight, audit director, Audit Scotland; Bruce Crosbie, senior audit manager, Audit Scotland; Leigh Johnston, senior manager, Audit Scotland; and Joanne Brown, partner at Grant Thornton UK LLP. I invite the Auditor General to make an opening statement.

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

I have prepared these reports under section 22 of the Public Finance and Accountability (Scotland) Act 2000. With your permission, convener, I will start with NHS Highland and move on to NHS Tayside when you are ready.

This is the second consecutive section 22 report that I have provided to the Parliament on issues of financial sustainability in NHS Highland, and the fourth in six years. The report sets out NHS Highland's continued difficulty in meeting its financial targets and reaching a financially sustainable position. The report also sets out the organisational and governance problems that NHS Highland faced in 2018-19, including leadership changes and the issues set out in the Sturrock report.

In 2018-19, the board delivered £26.6 million of savings, but still required brokerage of £18 million from the Scottish Government to help it achieve financial balance. The board forecasts that brokerage of £11.4 million will be required in 2019-20 and a further £6.1 million in 2020-21, with financial balance being achieved in 2021-22. I consider these forecasts to be unrealistic given NHS Highland's past performance in identifying and achieving savings.

NHS Highland's financial difficulties coincide with a time of significant organisational challenge. There have been several changes to the senior management team and board, together with recruitment difficulties for some key posts. NHS Highland's culture has also been a focus of concern. The Sturrock report, which was published in May 2019, found that, for many people, NHS Highland is a great place to work, and there are thousands of well-motivated, caring and supportive staff. However, it also found that

incidents of bullying or inappropriate behaviour had occurred.

In conclusion, given the board's past record in addressing problems and the current leadership and organisational difficulties that it faces, I have concerns about its capacity to bring about the necessary change. The board will continue to need extra support in 2019-20 to develop and implement a clear plan to achieve a financially sustainable position and address the organisational issues that it faces. The focus now must be on longer-term sustainable reforms, rather than short-term reactive changes.

I am joined today by Joanne Brown, who is the appointed auditor for NHS Highland, and Leigh Johnston, from Audit Scotland. Between us, we will do our best to answer the committee's questions

The Deputy Convener: I am very grateful, Auditor General. Members have cross-cutting questions on both reports. Could you give your opening statement on NHS Tayside at this juncture?

Caroline Gardner: Certainly.

The second section 22 report is, as you say, convener, on NHS Tayside. This is the fifth consecutive report that I have provided to the Parliament on NHS Tayside highlighting a series of significant concerns covering financial, performance and governance issues.

The external auditor has highlighted improvements in the board's financial management and governance arrangements in the year. However, she reported that more progress is required with the transformation of services to secure the board's financial sustainability.

For the past seven years, the board has required brokerage from the Scottish Government to help it achieve financial balance. In 2018-19, the board delivered £32 million of savings, but still required brokerage of £17.6 million. NHS Tayside has received £67.8 million of brokerage since 2012-13, of which only £4.3 million has been repaid. In October 2018, the Cabinet Secretary for Health and Sport announced that the Scottish Government will not seek to recover the outstanding brokerage at 31 March 2019.

The board still has significant financial challenges. The high-level, three-year plan shows the board breaking even by 2021-22. The board's transformation programme will be key to reducing its cost base. However, it has taken longer than anticipated to approve the strategy, and the detailed transformation programme that is required to deliver the identified level of savings has still to be developed. As at June 2019, there was still only limited evidence of sustainable service redesign and transformation. Effective leadership is critical to delivering the transformation required and several key vacancies are still to be filled.

In conclusion, there are still considerable challenges ahead. NHS Tayside continues to have an expensive operating model, and a significant level of brokerage was required during 2018-19. The achievement of a balanced financial position depends on the successful delivery of the transforming Tayside change programme. Alongside the development of detailed plans, NHS Tayside needs to put in place the necessary organisational capacity.

My colleagues Fiona Mitchell-Knight and Bruce Crosbie head the audit team for NHS Tayside, and again Leigh Johnston will provide cross-cutting support for me in answering the committee's questions.

The Deputy Convener: I am very grateful, Auditor General. I shall ask the first question, which is a general one.

When the committee heard from you last year on the section 22 reports on NHS Highland and NHS Ayrshire and Arran, you told the committee:

> "All boards are struggling with balancing the three sides of the triangle—finances, waiting times and the quality of care."—[*Official Report, Public Audit and Post-legislative Scrutiny Committee,* 1 November 2018; col 4]

Can you tell the committee whether that is still the case for all health boards?

Caroline Gardner: Yes. The committee took evidence from me recently on my report, "NHS in Scotland 2019". In that report, we were able to set out evidence of increasing pressures on finances, but also on boards' ability to deliver the national standards that they are held to account for and to maintain the quality of care that we all expect when we need the NHS. That is partly a result of continuing financial pressure, but just as important is the demographic challenge that Scotland faces, with more of us living longer with complex health problems that cannot be treated and cured but which instead need longstanding support. NHS Highland and NHS Tayside are showing particular instances of those pressures, but they are pressures that affect the health service across the country.

Colin Beattie (Midlothian North and Musselburgh) (SNP): As the convener said, there are cross-cutting issues here. The one that concerns me most is that of leadership. It seems to be a common thread for NHS Tayside and NHS Highland that there are difficulties in retaining and identifying the right calibre of staff at a senior level. There also seems to a problem in getting the right mix of non-executives. That problem does not seem to be confined to NHS Tayside and NHS Highland; it appears to apply right across the NHS,

with people double-bunking on jobs and goodness knows what else. Where are we going on this? What is the solution?

Caroline Gardner: You are right: those are challenges for these two boards and for the NHS more widely. It was one of the major themes in the "NHS in Scotland 2019" report that I recently brought to the committee. We are seeing that it is increasingly difficult not just to retain but to attract and recruit people to those jobs. That is partly because the jobs themselves are getting harder. We see evidence of people in the second tier of management wondering whether it is worth taking the extra step up, with the profile, exposure and responsibilities that that brings. In Scotland, we tend to pay less for those roles than the NHS in England does, which can make it harder to recruit people externally.

Colin Beattie: Is the pay difference significant?

Caroline Gardner: Leigh Johnston is on top of the detail on that.

Leigh Johnston (Audit Scotland): I would have to look at the detail, but there is some difference in relation to certain positions. However, we have been successful recently, with NHS Shetland, NHS Highland and NHS Tayside all recruiting people from down south.

Something else that we have mentioned many times to the committee is project lift, a Scottish Government programme to manage talent that is coming through the system and provide better appraisal and support to the leaders and senior people who are already in place. Its purpose is to retain leaders but also to identify the leaders of the future.

Colin Beattie: Is the shortage restricted to Scotland or does it apply across the United Kingdom? Is getting the level of talent that is needed a common problem?

Caroline Gardner: We do not have the same level of detail about the NHS in other parts of the UK as we have for Scotland, but that sense of stretch and difficulty in recruiting and retaining people is a common one. In some ways, it is exacerbated in Scotland by the remoteness and rurality of some parts of the NHS that we are recruiting to. There is no doubt that it is a challenge. That is not to say, as Leigh Johnston has said, that the Government is not doing some things to counter that challenge, but we are seeing significant vacancy levels across the NHS, and some of them are quite longstanding.

Colin Beattie: Given the history of NHS Tayside and NHS Highland, it is a bit like a poisoned chalice. How do you persuade someone to come in, take over and run such boards when the risk is so high?

Caroline Gardner: It certainly brings its own challenges. As Leigh Johnston said, we have seen new appointments to both boards over the past year, and those people will need support to be able to do what are very significant jobs with a lot of transformation required and no likelihood of short-term improvements—the changes will take a significant amount of time.

Colin Beattie: Let me latch on to the idea of short-term improvements. NHS Highland is having trouble recruiting to key posts. Given the situation there, what options are there to provide the stability and capacity that are needed to move NHS Highland forward. It will not move forward without those things, will it?

Caroline Gardner: I ask Joanne Brown, as the appointed auditor to NHS Highland, to talk you through that.

Joanne Brown (Grant Thornton UK LLP): The NHS Highland leadership team was running with a number of interim posts, and over the period 2018-19 and into early 2019-20, the board has filled those posts on a permanent basis, including a permanent human resources and organisational development director and a permanent medical director. The posts are 100 per cent NHS Highland-only roles.

NHS Highland is still struggling with the recruitment of a permanent director of finance. As the report sets out, the board has tried unsuccessfully to recruit to that post on two occasions.

To support the board of NHS Highland, which is at level 4 of the Scottish Government escalation framework, the Government has put in place a finance turnaround director for the next 12 months. However, it is recognised that the director of finance role will be key in ensuring stability and the delivery of the transformation programme. The post has recently been readvertised and the board is hoping to fill it this side of Christmas, if possible.

Colin Beattie: The section 22 report says:

"NHS Highland was the pilot for a review of governance ... in NHS boards",

but

"there was limited progress in several areas".

Can you describe some of the areas where there has been limited progress and, if possible, say why?

Caroline Gardner: NHS Highland was the subject of the first review under "NHS Scotland: Blueprint for Good Governance", which is a peer-review process. Its review was led by the chair of NHS Greater Glasgow and Clyde, John Brown—in 2017, I think. I ask Joanne Brown to talk you

through the progress that has been made since then.

Joanne Brown: Following the pilot and the recent survey, which took place in February 2019, the board has had a good governance action plan, which includes 14 actions, of which it has completed four. Four others are work in progress, and the board has not yet started looking at the remaining six. It should be recognised that the circumstances behind that include the appointment of the new chief executive, who started only in February 2019, along with changes to the interim board and the chair of the board.

The board recognises that it still has to focus on a number of areas. For example, as a board, it needs to consider risk management, particularly at a strategic level, and to look at how to mitigate strategic risks and better understand risk management and the board's role in that regard. Alongside that is consideration of the governance structure that is in place, looking again at the finance committee as a sub-committee and the flow of information round the committees and through to the board. There has been a delay, which is partly down to the change of interim board chair and the recruitment of three new non-executive board members, which happened in July. The board recognises that the action plan is important and it has set out steps to progress the 14 actions and deliver them by the end of the financial year. Obviously, we will look at progress in that regard as part of this year's external audit because is it critical that the board gets its governance right.

09:15

Colin Beattie: Within NHS Tayside, two additional non-executive posts were added due to significant workload. What was the significant workload that triggered that? Is it just a case of the board not having enough non-executive directors per se, or has the transformation put an additional workload on the board? Is the board properly equipped to do this work? Are we getting the right non-executives in?

Caroline Gardner: I will ask Fiona Mitchell-Wright to come in in a moment. The initial increase in the size of the NHS Tayside board was, I think, a response to this committee's scrutiny and the audit findings about the level of challenge that the board was facing. You will recall the questions that were asked about the endowment fund, information technology funding NHS-wide and the other challenges the board was facing. Fiona, can you pick up the detail of the question?

Fiona Mitchell-Knight (Audit Scotland): It is right that size of the board was increased in response to the scale of the challenges, the extent of the transformation that was needed and the workload and expertise that were required from the non-executives. The two extra posts remain vacant; they have not been filled, although there is an on-going recruitment campaign.

The board's review of its governance arrangements under the blueprint process identified support for non-executive directors as an area for improvement, and the board has been taking some actions to improve support for and development of those board members.

Colin Beattie: How long has the board been trying to fill those two posts?

Fiona Mitchell-Knight: Since the additional posts were approved.

Colin Beattie: Which was when?

Bruce Crosbie (Audit Scotland): In excess of a year ago.

Fiona Mitchell-Knight: Yes, it is in excess of a year now.

Colin Beattie: So, for more than a year, the board has not been able to identify people for two non-executive posts. That is not very encouraging.

Caroline Gardner: They need to be of the calibre required. Membership of any health board is a significant governance responsibility. These two boards, by their nature, have significant challenges. You are right that it is matter for concern that it is hard to recruit and keep non-executives of the quality that is required to do those jobs.

Colin Beattie: I have a final question about both NHS Tayside and NHS Highland. Given where they are now with their senior management and their non-executives, are they in a position to move forward and implement the changes that are needed? Do they have the skills at this time to be able to do that?

Caroline Gardner: I hope the message that comes across in both section 22 reports is that both boards face significant challenges. In my view, NHS Tayside is starting to show signs of progress. We have seen some improvements in its financial management and governance, and its high-level plan looks to be in the right place.

NHS Highland has more challenges ahead, simply because of the scale of the challenge that it needs to address and the fact that most of its responses so far have been short term and reactive rather than longer term and strategic.

Alex Neil (Airdrie and Shotts) (SNP): A theme running through your reports on the NHS—including the section 22 reports on NHS Highland and NHS Tayside—is that of managerial weaknesses at every level in the national health

service in Scotland. Has the time not come for a fairly fundamental review, at a national level, of all aspects of the management of the national health service in Scotland? We have 22 NHS boards, 15 of which, including NHS Highland and NHS Tayside, cover territorial areas. In the age of the computer, do we need 15 directors of finance? Do we need 15 human resources departments, not to mention all the back-up at St Andrew's house and so on? If we could save on that huge administrative overhead, we would free up some resources for the provision of healthcare. Is it not time for a very fundamental look at the whole structure?

Caroline Gardner: I think that you have asked me that question regularly since you joined the committee, Mr Neil, and I am afraid that my response is going to be similar to my response in previous years. First, the structure for the NHS is a matter for Government rather than for me, as the Auditor General. I do think, though—I have said this to the committee before—that having the number of bodies that we have makes it harder to recruit, retain and develop the required number of high-calibre people to do the jobs. Running a health board is difficult in any circumstances, but, at a time when the financial pressures are acute and we need to see a transformation to meet the needs of an ageing population, we must make the best use of the people who have the skills, experience and capacity to do it.

Alex Neil: But if we do not modernise the model of delivery, we could be having the same conversations in 10 years' time—in fact, the situation might be even worse.

Caroline Gardner: I would not necessarily characterise management as being simply an overhead. Good management—good governance—is important to any organisation, and especially to health boards.

Alex Neil: Absolutely.

Caroline Gardner: Nevertheless, you are correct in saying that it is important that we use those people in the right places and that the jobs are big enough that they have the levers to make the necessary changes, although not so big that people are overwhelmed by the pressures. How we get that balance right is an entirely appropriate area for the committee to explore with the Government.

Alex Neil: Let us consider NHS Highland and NHS Tayside. Looking at performance against non-financial standards, a common theme in the appendices to both reports is that performance is not that bad compared with the Scottish average. Although NHS Highland has been very poor on the overall treatment time guarantee—it achieves 54 per cent against a national average of 68 per cent and a national target of 95 per cent—its performance on the 12-week first outpatient appointment, cancer treatments, the provision of child and adolescent mental health services and so on is exceeding both the targets and the average for Scotland as a whole. Similarly, when it comes to the delivery of healthcare, despite the challenges, NHS Tayside is still—as it has been for about 10 years—one of the best-performing boards on accident and emergency turnaround times, achieving 96 per cent.

It seems that, although there are areas of healthcare delivery that clearly need to be improved, a lot of the problems are not in the day-to-day delivery of healthcare. Despite all the challenges, those health boards are not doing all that badly—in many areas, they are doing very well. A lot of the problems seem to be on the non-front-line health side, as we have been discussing. However, surely, there must come a point when management problems start to adversely impact performance in the delivery of healthcare. Are we near that point in either of those boards?

Caroline Gardner: You are absolutely right that, if we look at the performance of those two boards against the national standards, we see that they are not doing badly at all. Last year, NHS Highland met six of the 18 national standards and NHS Tayside met five, whereas, across Scotland as a whole, only two of the standards were met. Both boards performed significantly above that level.

It comes back to what the convener asked about in the opening question this morning. We tend to see the triangle of standards, finances and the quality of care; if people are achieving well in one aspect, there is pressure on another—there is that movement through the triangle. The boards undoubtedly have had some challenges with their governance and management, which we have reported on in previous years. There has been a concern across the NHS that a focus on achieving financial performance and clinical standards can put pressure on staff, which makes it harder to continue doing that in the longer term.

As I said in my report "NHS in Scotland 2019", those standards tend to focus on what is happening in acute hospitals, and getting those right can mean that people are not investing enough time, effort and focus in developing the community-based and primary services that can not only relieve the pressure on acute hospitals and the staff who work there but provide better care to people with continuing health problems and people who simply need more support because they are older. That is why pulling the lens back from simply what is happening on national standards is important. We include national standards as one element of context, but

they are not the only thing that we focus on in our reports on the boards or on the NHS as a whole.

Alex Neil: NHS Highland operates a completely different model from that of any other territorial health board in Scotland in that health and social care are run by NHS Highland on behalf of NHS Highland and Highland Council. It does not have an integration joint board. Is there any evidence that that model is working better or worse than the integration joint board model?

Caroline Gardner: I will ask Joanne Brown to comment in a moment. There is certainly evidence that the lead agency model, whereby the health board is responsible for providing social care as well as healthcare to older people, is one of the factors that is increasing the financial pressures on the board. Can you pick that question up, Joanne?

Joanne Brown: NHS Highland and Highland Council are looking again at the lead agency model and the integration that sits under it, with a view to reviewing that model by the end of the financial year. The pressure that NHS Highland faces is partly a result of the increasing challenge of the demand on adult social care under the current lead agency model, which is based on a fixed sum of funding flowing from the council to the NHS board. Any increase in demand or pressure on the service has to be financially met by NHS Highland.

Both parties recognise the benefit of the model that they have in place. They also recognise that they need to look at the model financially and at the governance structures that sit alongside it in order to focus on improved outcomes.

There are examples of patients being treated more quickly and the right solutions happening faster because the service is run entirely by NHS Highland. Nevertheless, the board recognises that, within the current model, a lot more needs to be done to improve outcomes and to improve how closely the board and the council work together.

Alex Neil: From what you say, it seems that there is underfunding because of the fixed nature of the money that is coming in for social care.

Joanne Brown: NHS Highland would probably be better placed to answer that question.

Alex Neil: Let me rephrase the question in a way that allows you to answer it. If we look at the percentage increase in the demand for social care that NHS Highland is responsible for meeting in the context of any increase in the resources that are being made available overall for NHS Highland, is there a bigger gap than would be faced by the integration joint boards?

Joanne Brown: It is difficult to comment on the IJBs, but, from that cold financial perspective, you would say that it looks as though NHS Highland is underfunded—which would be NHS Highland's argument about how it works with the council.

That obviously has to be balanced against how well the service is run, whether there are efficiencies to be made and whether additional financial savings can be achieved, which link to NHS Highland's wider challenge of identifying savings and delivering them. However, looking at it in a cold way, NHS Highland would say that, under the current model, the board faces all the risks and challenges of the increasing financial spend and the demographics.

Alex Neil: It is not inherent in the model that the funding for social care should be frozen—that is not a requirement of the model. That decision must have been taken elsewhere.

Joanne Brown: Both organisations are comfortable with the model; they are just looking at the financial arrangement that underpins the model. When the model was set up, five years ago, it was set up in a certain way and, over time, things have changed. Pressure on the service has changed, and the set-up and healthcare needs are changing, which is why both parties are reviewing the model—particularly the financial aspect—for the end of this financial year.

Alex Neil: Obviously, Highland is a huge area that is covered by NHS Highland and Highland Council. Is there any evidence that there needs to be additional funding in respect of the additional cost of delivering services in such a sparsely populated area? You have a concentrated population in Inverness but the further you go from Inverness, the sparser the population is, and it clearly takes a lot more money per head to deliver in rural areas than it takes in Inverness or in any other city.

Joanne Brown: I do not have the information to hand to answer that question, but I can tell you that the chief executives of NHS Highland and Highland Council meet frequently—at least weekly—and their discussions reflect the remote, rural nature of the Highlands as well as the joining up of council and NHS services to support NHS Highland's plans for community development and community hospitals. They are working quite closely to look at some of the specific challenges of the Highland region, but I cannot answer your question on the financial side of that. NHS Highland would be better placed to answer that question.

09:30

Caroline Gardner: The funding formulae for NHS boards and local government are intended to take account of rurality and remoteness.

Alex Neil: Yes, but is it enough?

Caroline Gardner: You will know that there is a continuing debate about whether there is enough funding on that side as opposed to funding for the additional demands that come from areas of greater deprivation, for example in greater Glasgow. That is a continuing conversation.

The Deputy Convener: On that point, I have a blunt question: do you get any sense that, all things being equal, the lead agency model delivers the outcomes that we are all looking for better than the IJB model does?

Caroline Gardner: We have reported on integration and IJBs three times now since IJBs were set up in legislation, and we have never come to quite that conclusion. Some integration authorities are working very well and some are making much less progress but they are all under the sorts of pressures that we are talking about.

My personal view is that, if people get it right, the lead agency model has the virtue of simplicity; it builds on the bodies that are already in place. Where it works, it tends to be because of good working relationships, as Joanne Brown has described in Highland. We have not had enough evidence yet to conclude that one model works better based on how the policy has been implemented across the country, partly because of the slow progress that has been made.

The Deputy Convener: I understand. Willie Coffey has the next question.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): I would like to put on record that great work is being done by the staff in both these boards. We always focus on the problems and the issues but it is important to recognise the quality of the work that is going on in delivering healthcare in these two boards. Looking at their financial performance so far, the two boards have made some progress. Caroline Gardner mentioned that NHS Highland has managed to identify £26 million of recurring savings and NHS Tayside has managed to identify £21 million of recurring savings. We have to note that and give credit for that.

There is information on cost overspends on page 9 of the NHS Highland report and page 10 of the NHS Tayside report. I want to drill down a bit more into the reasons behind some of those cost overspends.

For a number of years, all the health boards have had overspends in relation to drug and prescription costs. We hear that all the time. What is going on there? Do we just get the forecasts wrong? Do the drug companies increase the prices without telling the boards? Do we not have an old Scotland-wide procurement policy for purchasing drugs? What is the reason behind that overspend in particular? Why do we always seem to get that wrong and why are NHS Highland and NHS Tayside suffering as a result of that?

Caroline Gardner: There is a lot going on there—I will kick off and my colleagues may want to add more, particularly in relation to the individual boards. First, drug costs tend to increase as a quantum because new drugs are discovered that can treat new conditions or treat existing conditions better. New drugs tend to attract premium prices because they are within patent. As members will know, we have seen very financially driven behaviour, with people buying up existing drug companies and hiking the prices where they think that they can do that. That is a live issue in discussions about future trade deals. Drug cost inflation tends to be higher than general inflation anyway.

Beyond that, the people who prescribe—particularly in primary care—are the individual doctors. They will follow their own practice; they have their preferences and their views on what is the most appropriate for a patient. The NHS as a whole and individual boards have done a lot recently to bring back that variation, to encourage people to prescribe generic drugs or bio-identical drugs, to give them information that shows how they compare with their peers with similar practice populations and bring outliers back down towards the average prescribing practice of general practitioners. We have seen some real improvements across the country, including in these boards.

We are also seeing more support through things such as board-employed pharmacists, who work with GPs to help them think about polypharmacy—when people are receiving five or six or more prescriptions, you need to think about how the prescriptions relate to one another and whether they are doing more good than harm and whether you can make savings by improving prescribing, so there is a lot going on.

I will ask Joanne Brown and Fiona Mitchell-Knight to talk you through what we have seen in the two individual boards and why the cost pressures are the way that they are.

Joanne Brown: From the perspective of NHS Highland, it has put looking at drug costs into its transformation programme and there is much more focus on drug costs in terms of having better control of the spend against the budget. It also looks at whether the budget that it set at the start of the year is a realistic budget. To build on the Auditor General's points, NHS Highland is looking to really focus on lessons learned from other boards and to look at alternative practices that are being applied and are working successfully in other boards, to see how they can be introduced into NHS Highland to start to take the spend—and

the overspend—on drug costs down as far as possible.

Fiona Mitchell-Knight: I will reiterate what has already been said. NHS Tayside has a similar focus on prescribing costs as part of its transformation activity. Although for 2018-19, we were reporting on the overspend, we are seeing some promising signs in the outturn for the 2019-20 spend position that prescribing costs are underspent, so there are some promising signs that some of that work is starting to have an impact.

Willie Coffey: That is good to put into the mix, but is the basic model that the costs come from the bottom up, where the GPs can decide which drugs to prescribe right across the two boards and that cost then reaches the top or is a budget set aside and they try to procure the same drugs across the board? What way does it work? Is it bottom up or top down?

Caroline Gardner: All doctors, including GPs, are entitled to prescribe the drugs that they think are most appropriate. I think that we would all want that to continue to be the case.

The NHS does a lot of work nationwide to put in place procurement contracts that give people access to the best prices that can be achieved and which use the buying power of the NHS across Scotland. The difference is more in the prescribing practice of individual doctors—GPs and doctors in hospitals—in terms of the cost and volume of the items that they prescribe. The bottom-up approach is really important and that is why there is pharmacy support. National information is provided and sitting down and talking to GPs about why their prescribing practice might differ from somebody else's is also important. It is also true to say that in NHS Tayside, prescribing has historically been more expensive than in most of the rest of Scotland, because of the number of items prescribed and the cost of those items.

Willie Coffey: Alex Neil covered some of the additional demands and social care costs, particularly in Highland, but there are a number of items in the NHS Tayside report that I would draw your attention to. There are some additional cost overruns in there, including an overspend of £4.4 million in corporate services

"due to overspends in the cost of patients referred outwith the Tayside area".

Can you explain the reason behind that, please?

Caroline Gardner: I am not sure that we can tell you very much more about it, but I ask Fiona Mitchell-Knight to give you what information we have.

Fiona Mitchell-Knight: We do not have much information on the detail of that. Within the transformation programme, the review of the clinical strategy and the approach to delivering care is obviously a priority and that is one of the areas that will be built into that activity.

Willie Coffey: We might want to follow up on that issue as a committee, just to drill down a bit more on that.

Finally, I have a similar question to one that I asked last week, when we were talking about the situation in NHS Ayrshire and Arran and the interventions by the Scottish Government and others to help turn that around. Is such intervention happening in these two boards and is it beginning to bear fruit and show some signs of success?

Caroline Gardner: Yes. Both boards are currently at level 4 in the intervention framework. I think that NHS Tayside has been at level 5 and has come back down to level 4. They both have support coming in from the Scottish Government. I ask Leigh Johnston to summarise that for Mr Coffey.

Leigh Johnston: Yes. Fiona Mitchell-Knight and Joanne Brown might be better placed to give the detail, but there has been external support in terms of not only secondments from the Scottish Government to offer day-to-day support in the financial turnaround but external consultancy, particularly in NHS Highland. For a time, NHS Tayside also had an assurance and advisory group and the transformation support programme there to help; 11 or 12 different areas were outlined. The last report looked at NHS Tayside's progress against the recommendations and it was all quite encouraging.

Joanne Brown: For NHS Highland, one of the key areas of support from the Scottish Government has been through turnaround directors, two for a period of time up to the end of July and one now on a full-time basis through to the end of the financial year to support the financial turnaround. On top of that, there has been some additional support from the Scottish Government to support the board in its own development in relation to values and good governance. The Scottish Government is also working with the board on that.

Willie Coffey: I see from paragraph 32 of the NHS Tayside report that five or six new directors have been appointed to the board. Is that within the mix of this intervention that we are talking about here or has that happened separately?

Caroline Gardner: There have been new appointments that are separate from the support that we have been talking about, partly because of the scrutiny that the board has been under and the turnover that resulted from that. If you would like

more detail, Fiona Mitchell-Knight can give you a sense of the changes.

Fiona Mitchell-Knight: Following the appointment of the current chief executive, in November 2018, there was a review of the senior officer structure. Some of those vacancies are new posts within that structure but there are also vacancies in existing roles. Since we wrote the report, there has been some progress and some key roles have been filled. A permanent chair has now been appointed and new medical and nursing directors have been identified. However, there are still vacancies in a couple of key posts, including the deputy chief executive and the permanent director of finance, so things have moved on but there is more to do.

The Deputy Convener: This committee reported on NHS Tayside in May and said that there was still a lot to be done. Of course, NHS Tayside has an assurance and advisory group that was set up, but you conclude in the report, Auditor General, that the plans for transformation remain very high level. Can we be reassured that this group is delivering, and are you reassured that the Scottish Government is providing the right type and level of support to get through this?

Caroline Gardner: The team will keep me straight but the assurance and advisory group completed its work earlier this year—in May, I think—and was stepped down at that stage. We make reference in the report to its final findings, which are very similar to ours; some of those first steps have been taken but the really challenging job of detailing the plans and then delivering them remains to be done. It was useful to identify where the problems and the opportunities are for NHS Tayside and to start the clinical conversation about how the necessary changes can be made, but that work still needs to be done to deliver it.

The Deputy Convener: To go back to the lead agency model, there is something that I want to understand: presumably, if there is a cut in funding to the council, that exposes the lead agency in a way that the IJB model would not—is that correct?

Caroline Gardner: I am not quite sure that it is. Joanne Brown will keep me straight on this, but I think that under the agreement that is in place in Highland, the amount of funding that comes from the council to the health board for adult social care was set at the beginning. Whatever happens to Highland Council's funding, it is committed to providing that much funding to the NHS and, whatever happens to demand, the NHS is committed to providing the services that are required.

That is why, in this case, the financial pressures are on the health board. In other IJBs, we have seen exactly what you describe: councils feeling that their funding is under pressure and feeling able to commit less to the IJB budget. The tensions also come through in other ways. It is important to remember that the system is under pressure for health and social care, particularly for older people across the country.

The Deputy Convener: I understand. Thank you.

Bill Bowman (North East Scotland) (Con): I will return to governance and touch on the audit committees, I will ask first about NHS Highland, then maybe the same questions will flow on to NHS Tayside.

We have, in the past, had issues with audit committees in the Scottish Police Authority and, more recently—and surprisingly to me—in the Scottish Government. Your report states that

"The audit committee, and its role in supporting effective scrutiny and challenge, was not as effective as it should be"

and that

"102 internal audit recommendations were overdue."

Can you give us a little background to that?

Caroline Gardner: Joanne Brown is well placed to do that.

09:45

Joanne Brown: One of the challenges that the audit committee has started to recognise is in respect of the quality and timing of information that it receives to do that effective challenge and scrutiny, and to get the balance right in terms of seeing the big picture without straying into operational detail. The audit committee often struggled with, for example, the sub-group on risk, which would give a verbal update rather than produce an actual risk management paper through which the audit committee could scrutinise and understand the risk management position. That was flagged up in the governance review for action.

There is a challenge in that, over time, the number of outstanding internal audit recommended actions has grown and grown. Some have gone past the due date and the audit committee has been slow to hold the executive team to account for delivery of actions. The executive team has not necessarily owned the actions or had oversight of their delivery. Although that has been acknowledged, progress has been slow. The chief executive has committed, with the senior management team, to reducing the number of outstanding actions as far as is practical by the end of the financial year. We will obviously look at that as part of our audit of this year.

Bill Bowman: The performance of the audit committee is not necessarily down to the

information that comes to it; I think that the audit committee should be in the driving seat. Are there any auditors on the audit committee? How independent is it? Is it independent of the public sector or does it include people who work for other public sector agencies?

Joanne Brown: The chair of the audit committee has a financial background, although I would have to check whether he is financially qualified. At the start of every meeting he declares the link between himself and Highland Council, on which he is a councillor.

The other individuals on the audit committee do not have governance, risk management or financial backgrounds. The audit committee, with the board, is looking to develop such skills. Until relatively recently the board's employee director was a member of the audit committee. That has changed with one of the new non-executive members who has come in to strengthen the skills in the committee. It is recognised that it would benefit from more experience in risk and financial management.

Bill Bowman: I had a quick look at some audit committee minutes to see the names, which seem to have been the same for some time. From the way that you describe it—I mean no disrespect to the members—I am not surprised that there are problems. It is also a little bit strange, in the lead agency model, to have a councillor from the local council being the chief person on an audit committee that is meant to challenge what goes on.

Joanne Brown: On the link between the chair of the audit committee and Highland Council, the chair was appointed through the public appointments process. It is not a dual role and he does not have the role because of his link with Highland Council. The other members of the audit committee have been members for a while.

The board recognised, when it had three non-executive vacancies, its need for different skills—not just on the audit committee, but at board level. Recruitment of the three new non-executives has allowed the board to move some audit committee members around in order to get different skills and perspectives on the committee, but there is still some need for training for audit committee members.

Bill Bowman: What is the Auditor General's view—perhaps from a wider perspective?

Caroline Gardner: We have talked before in this committee about the challenge of recruiting to public bodies' boards enough people with the right skills and experience. Mr Bowman will know that audit committee skills in particular can be in short supply. That is not the case only in the public sector; it is the case in the corporate world, as well. Obviously such skills are among the really important checks and balances within a good governance system. That is one of the reasons why our auditors look at the matter and why we report on it when there is a problem.

Bill Bowman: When you know that there is a problem with an audit committee's make-up how do you to try to make it more effective in the short term?

Caroline Gardner: The starting point is the work of the appointed auditor. All appointed auditors work with the health board, with the audit committee, and with the audit committee chair on such issues. Audit Scotland provides general training and support to board members and to audit committee members as part of our work across the piece. When things go wrong, my route is to bring the matter to this committee and to ask questions of the Government about what it is doing to appoint and support people who are responsible for governance.

Bill Bowman: In general, does a committee chair who is also a councillor—even although the role has come through the route that you mentioned—sit well with you?

Caroline Gardner: It is worth remembering first that, by statute, all health boards now include local authority representatives. That in itself throws up questions about the size of a board and what people think they are there to do—whether they are there as a board member or as a representative of another organisation.

I agree with Mr Bowman that there is a particular set of questions when the lead agency is represented, as it is in Highland. As Joanne Brown said, the chair of the audit committee declares that interest at each meeting. However, there are questions about whether more separation might be helpful, especially when times are challenging, as they are just now.

Bill Bowman: I will move on to NHS Tayside, and ask the same questions. Are there any auditors on the audit committee there and are its members independent of the public sector?

Fiona Mitchell-Knight: There is quite a different situation in NHS Tayside, whose audit committee has changed quite a lot over the past year or so. It has a new chair and its focus has changed: it is now an audit and risk committee. That is quite a change in how it operates. With that change, the board has recognised that it needs to provide members with support, so it has examined its induction arrangements and the support that it offers.

Perhaps Bruce Crosbie can say a little about the background of the chair of the audit committee.

Bruce Crosbie: I cannot say much about the chair of that committee. He does not come from a local government background, so I do not think we have concerns, in that respect.

Concerns have previously been voiced about there not being financial expertise within the audit committee. Some financial expertise has been brought in—a couple of members have such expertise—and it is being brought to bear in a good and informed fashion across NHS Tayside's audit committee.

Bill Bowman: Are there any auditors on that committee?

Bruce Crosbie: There is no member with an audit background.

Bill Bowman: What is the situation in terms of independence from the public sector?

Bruce Crosbie: I will have to come back to you on that.

Fiona Mitchell-Knight: We are not aware of any such conflicts. As is the case in NHS Highland's audit committee, conflicts of interests would have to be declared at the meetings: meetings are structured such that people declare interests.

Bill Bowman: We spoke earlier about appointing board members and you mentioned two extra places. Have those been filled?

Fiona Mitchell-Knight: They have not.

Bill Bowman: Are we again talking about what needs to be done, with the audit committee perhaps functioning without the resources that it needs?

Caroline Gardner: As Bruce Crosbie said, there has been some change in the audit committee's membership; there is now some financial expertise there. As we said in response to an earlier question, the Government has not yet been able to fill the two additional non-executive posts. It is fair to point out that it is difficult to recruit, to the range of public bodies, people who have the skills and experience that are needed—particularly, people who have an audit background. That is not only a public sector problem.

Bill Bowman: I will ask about one final aspect. If, in an audit, you come across a board and an audit committee that you believe do not have all the requisite skills, do you change your approach?

Fiona Mitchell-Knight: We would certainly include that in our annual audit report and, as the Auditor General said, we would discuss it with the chair of the audit committee and make the committee aware of our concerns. We provide support, in terms of understanding roles, for members.

Bill Bowman: Such an environment cannot be what you would want it to be. Therefore, I presume that you have to adjust, and do more work.

Joanne Brown: One of the things that we would consider is management override of controls and journals. In assessing risk, as auditors we think about the control environment in the organisation and whether it help management to override wider controls because of poor governance. We factor that into our approach. Our challenge is in how we plan.

I reiterate Fiona Mitchell-Knight's point about escalating such issues to—in this case—the chief executive and the interim chair of the board. We also look to give support, such as strengthening the audit committee, through our reporting.

Bruce Crosbie: In NHS Tayside, I do not think we would be required to change our audit approach because we would have reported any concerns we had about the audit committee. That audit committee is not performing badly; it is effective, it is well chaired, it responds well to reports that go to it and it asks the right questions. Overall, I think that the NHS Tayside audit committee is working effectively.

The Deputy Convener: Thank you. Mr Mountain—do you want to come in at this point?

Edward Mountain (Highlands and Islands) (Con): I was going to come in at the end, convener, when all your committee members have had a chance to speak. From my experience on another committee, I am conscious that committee members do not appreciate it when—

Anas Sarwar (Glasgow) (Lab): I was going to ask questions about culture next, but I realise that the issue of NHS Highland concerns the region that you represent, and is, therefore, a local issue for you. I am happy for you to go first.

Edward Mountain: My question is not about culture, convener; it is really about management of finances.

The Deputy Convener: I think that that would be relevant at this stage.

Edward Mountain: The report highlights leadership instability; a lack of effective action by the audit committee in NHS Highland; poor risk management; and the fact that external consultancy is going to contribute to 10 per cent of the overspend of NHS Highland this year, anyway. You have said this morning that you think that NHS Highland's predicted balance of budget in 2021-22 is unrealistic. What do you think that the position will be?

Caroline Gardner: We do not recalculate, as it were, the public bodies' forecasts of their financial positions. Our interest is in ensuring that they are doing that long-term planning and in testing how robust it is, with regard to whether they have thought about all the things that might happen and have considered various scenarios.

You are right that, in my report, I say that the prospect of achieving balance by 2021-22 is unrealistic, given the lack of detail in some of the plans and the past record with regard to achieving savings and making change. I am not in a position to tell you what I think the position will be at that stage. Does Joanne Brown want to add anything to that?

Joanne Brown: With regard to 2018-19, NHS Highland is slightly further on in its financial transformation journey. In 2018-19, we have seen some improvements in that long-term financial plan. NHS Highland has been able to submit the details to the Scottish Government and we can see that there is a series of programmes and actions underpinning the savings programme. One of the challenges will be the delivery of that programme—taking the programme from the paper into actual savings. Culturally, how does the board get the organisation behind the plan to deliver those savings? Obviously, that is something that you cannot determine. The plans are better but its biggest challenge now is delivering on that plan.

Edward Mountain: I know you are very careful in your comments, Auditor General, so, for you to say that it is unrealistic that NHS Highland will balance its budget in 2021-22, you must have an estimate in your mind of why it is unrealistic. One of the things that NHS Highland has been particularly bad at doing in all my many years' experience of it is finding recurring savings. It is good at finding non-recurring savings—cutting with a sharp knife one year and then not following it through. Would that be your view as well?

Caroline Gardner: Yes. We say in the report that, last year, NHS Highland planned to achieve just over £50 million-worth of savings. Of those planned savings, it achieved £26.6 million, which is just over half of the savings that it planned to make. That is a pattern that we have seen over a number of years. Obviously, that difficulty is increased if you do not have a full and effective leadership team in place and if you do not have detailed plans for how your savings are going to be achieved.

For example, most of the savings that are planned in 2019-20 are expected to be achieved towards the back end of the year. For auditors, that is always a warning sign, because you expect people to have a steady plan during the year for how they are going to be able to achieve savings rather than it always being that little bit further out. That is the reason for the finding in the report that the current forecast for financial balance in 2021-22 is unrealistic.

10:00

Edward Mountain: Having spoken to the people on the ground who met PricewaterhouseCoopers in relation to the project management office that is being set up, I know that they were less than enthusiastic about it. Are you enthusiastic about what has been achieved by PwC with regard to its setting up of the project management office? Is it worth the more than £1 million—including VAT—that it is going to cost?

Caroline Gardner: It is clearly a lot of money. I can certainly understand the concern in the Highlands about the amount that is being spent on the project management office and management of the changes rather than on healthcare services. I say in the report that it is too early to comment on whether that represents value for money, but it is definitely something that Joanne Brown will be looking at in this year's annual audit report, and I am sure that my successor will report back to the committee on that.

Edward Mountain: Are we going to get a third consecutive report on NHS Highland?

Caroline Gardner: I would be surprised if you did not.

Edward Mountain: Me too.

The Deputy Convener: I have a question that I would like to ask before I bring in Mr Sarwar. More brokerage has been needed and will be needed to 2021-22 on the basis of your reports—I think that the figures are £17.5 million for NHS Highland and £16.8 million for NHS Tayside. Will that be repaid and, if not, can we really say that there was a break-even point in 2022?

Caroline Gardner: Committee members are aware that the cabinet secretary announced last year that brokerage that is outstanding as at the end of March this year—2019—does not have to be repaid. Our current understanding is that brokerage that is received in future years will still have to be repaid once the board achieves a break-even position, so it is rolled forward until break-even is achieved. The future arrangements for repaying brokerage are not yet entirely clear, and it might be something that the committee wants to explore with the Government.

The Deputy Convener: I understand.

Anas Sarwar: Good morning, Auditor General. I want to pick up on the culture part of the NHS Highland report. When we spoke to you last week, we talked more widely about workforce and

cultural challenges. Is the issue of culture and the on-going staffing pressures, which have an impact on the relationship between managers and senior clinicians, a recurring theme that you are picking up across the NHS, rather than being something that is specific to NHS Highland?

Caroline Gardner: Yes. The committee will recall that, when you took evidence on my report on the NHS in Scotland, one of the themes in that was the pressure on staff and the need for management across the NHS, from Government through to local leaders, to make sure that there is a culture that encourages and supports people and gives them space to do the work that they are there to do. That is important in any organisation, but it is particularly so in an organisation such as the NHS, which is absolutely about care and about the most personal support that any of us will ever need.

There were particular issues in NHS Highland that led to the cabinet secretary asking John Sturrock QC to carry out his review. Since that was completed, she has asked all the boards to carry out a self-assessment of where they stand against the recommendations in the Sturrock report and to set out what actions they need to take to make sure that people are being supported to carry out their jobs properly.

Anas Sarwar: Has NHS Highland agreed to implement the findings of the Sturrock review in full?

Caroline Gardner: I think so. Joanne Brown, do you want to pick that up?

Joanne Brown: Yes. Following the Sturrock review, the board pulled together an initial action plan in May this year, which was submitted to the cabinet secretary. As a part of that commitment, the board is setting up an independent external culture steering group, but it has also done more staff engagement and board development and has been out seeking a lot more views, following the initial action plan. It is going to do another action plan, but it has committed to implementing the recommendations of that report in full.

Anas Sarwar: Auditor General, you mentioned that the cabinet secretary has asked all health boards to do their own internal audit review. How seriously are they taking that? Based on a case that I heard of this morning in NHS Greater Glasgow and Clyde, and what the aftermath of that is going to be, I would say that there are real tensions between those who are involved in leading governance and those who are involved in the clinical teams. I do not get the sense that some health boards are taking that seriously. What do we do?

Caroline Gardner: I would not say that boards are not taking it seriously. I would say that I think they are in a difficult position. As I have noted in reports on those two boards and on the NHS in general, there are real pressures on the system, partly because of financial issues and partly because of demographic change and the increasing demand that that brings. People are working incredibly hard—clinicians, as well as managers and support staff—to do the best that they can, but that does not make the task easy, and there are those tensions.

Anas Sarwar: I suppose that the question that I am asking is, should a review that is similar to the Sturrock review in Highland take place Scotland-wide? I am talking about a review that is taken out of the hands of the health boards, which have vested interests, and is led instead by someone who is independent of the health boards and clinicians, so that we can really tackle the issues around culture.

Caroline Gardner: I think that it is too soon to say that there should be such a review. Self-assessment is a good starting point. As part of their general work on governance, the auditors whom I appoint will be looking at how boards have gone about that. We hear from individuals on health boards where there are particular concerns, and we follow that up as far as we can. It seems to me that getting the culture right is one of those things that has to start within the board—it is very hard to impose it from outside. For me, it is important that there is good governance in place, including staff governance, that things are working well with regard to the culture, the staff engagement and communication and that the whistleblowing checks and balances are in place. All of that is more likely to be successful than trying to impose things from outside, unless that is the only course that is open.

Anas Sarwar: The report also refers to locum fees. You will recall that, last year, we had the example of almost £0.5 million being spent in one year on a single locum. I see that locum fees in NHS Highland have gone up again: paragraph 5 of the report's summary notes that the locum fees rose from £14.9 million to £15.6 million. Are we seeing anything similar to the circumstance in which an individual locum was paid almost £0.5 million in a single year?

Caroline Gardner: NHS Highland has faced particular challenges with locums, as you know. Joanne Brown, can you pick that up?

Joanne Brown: The board has investigated alternatives around those two locums in particular, but locum spend is a key part of the transformational programme. For 2019-20, the board has in place a number of controls that it did not necessarily have in previous years. It has a target and ceiling rate card for locums and there is a weekly approval panel for locum decisions. It

has considered doing an exercise of converting long-term agency locums to either fixed or NHS-contract locums. Obviously, that will help in terms of the spend. There are still some recruitment challenges, given the remote and rural areas that the board covers, but the board is putting controls in place and, at this point in time, it is optimistic that it can deliver a decline in those costs. That is something that we will be looking at as part of our audit, linked to the financial transformation plans.

Anas Sarwar: Do we know what the highest payment to a single locum was this year? Obviously, we know that last year it was close to the £0.5 million mark.

Joanne Brown: We do not know what it was this year, but I can get the information from the NHS board.

Anas Sarwar: Excellent. I would like to ask a question about NHS Tayside. You reference the mental health inquiry in the Tayside report. There was some public discussion about this a few weeks ago, with the families again highlighting the disconnect that they felt from the review process—that disconnect was felt not necessarily in relation to the individuals leading the review but in relation to the way the health board was operating the review. Do you have any sense of whether that is progressing now? Is the process seen as a genuine partnership between the families, clinicians and the health board, or are there are still some tensions and pressures there?

Caroline Gardner: I am sure that there are still some tensions. In such difficult circumstances, it takes a long time to rebuild confidence and trust in ways of working.

We say in the report that the NHS Tayside board is now very focused on wider engagement with the people it serves, and is doing that in a continuing and consistent way that we have not seen in the past. I hope that that is the sort of thing that will both build confidence and avoid those sorts of problems occurring in future.

Anas Sarwar: Do you have any sense of when the review might publish its final report?

Fiona Mitchell-Knight: No. As far as I am aware, the board does not know that, either.

The Deputy Convener: Do members have any further questions?

Colin Beattie: I have a question that leads on from what I was taking about previously. We discussed the lack of success that NHS Tayside had in getting the two additional non-executive board members. I understand that there have also been two unsuccessful recruitment exercises for the chair. Has that been resolved now, or is that still up in the air?

Fiona Mitchell-Knight: A permanent chair has recently been appointed: Professor Nic Beech, who is the vice principal of the University of Dundee and has a business background.

Colin Beattie: Good. Thank you.

The Deputy Convener: As there are no further questions from members, I would like to thank the Auditor General and her colleagues for their evidence this morning. I now close the public part of this meeting.

10:09

Meeting continued in private until 10:35.

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