OFFICIAL REPORT
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Public Audit Committee

Thursday 12 December 2024

Session 6

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PUBLIC AUDIT COMMITTEE
32nd Meeting 2024, Session 6

CONVENER

*Richard Leonard (Central Scotland) (Lab)

DEPUTY CONVENER

*Jamie Greene (West Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*James Dornan (Glasgow Cathcart) (SNP)
*Graham Simpson (Central Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Stephen Boyle (Auditor General for Scotland)
Carol Calder (Audit Scotland)
Leigh Johnston (Audit Scotland)
Bernie Milligan (Audit Scotland)

CLERK TO THE COMMITTEE

Katrina Venters

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit Committee

Thursday 12 December 2024

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Richard Leonard): Good morning, and welcome to the 32nd meeting in 2024 of the Public Audit Committee. The first agenda item is a decision on whether to take agenda items 3, 4 and 5 in private. Do members agree to do so?

Members *indicated agreement.*

"NHS in Scotland 2024: Finance and performance"

09:00

The Convener: The second agenda item is consideration of the Auditor General for Scotland's section 23 report "NHS in Scotland 2024", which is a finance and performance report. I am pleased to welcome Stephen Boyle, the Auditor General, to this morning's meeting. He is joined by the following colleagues from Audit Scotland: Carol Calder, audit director; Leigh Johnston, senior manager; and Bernie Milligan, audit manager.

We have a wide range of questions on your wide-ranging report, Auditor General. Before we get to those questions, I invite you to make a short opening statement.

Stephen Boyle (Auditor General for Scotland): Thank you, convener. Good morning, committee members. As the convener mentioned, this morning I am bringing a report to the committee on the national health service in Scotland. It covers the financial and operational performance of the NHS during 2023-24. The report outlines the pressing financial and performance issues that the NHS is facing and the urgent need for reform in order to safeguard health and social care services.

In recent years, I have reported on the unprecedented challenges that the NHS faces. My report "NHS in Scotland 2023", which was published in February of this year, stated:

> "Significant service transformation is required to ensure the financial sustainability of Scotland's health service."

Those issues remain pressing—and, indeed, they have become more so, based on the evidence in the latest report.

Health spending remains the single biggest area of Government spending in Scotland, accounting for around 40 per cent of the Scottish budget. The year 2023-24 saw a real-terms increase of 2.5 per cent in health spending, but the sector has faced cost pressures from new pay deals as well as other inflationary pressures, meaning that boards have still struggled to break even. Many have required additional funding, are forecasting recurring deficits over the medium term and are facing wider risks to their financial sustainability. Health spending is forecast to continue to grow at a faster rate than other areas of public spending, and last week's draft budget for 2025-26 set out plans to increase total health and social care spending to £21 billion.

The NHS in Scotland is still seeing fewer patients than before the Covid pandemic. Most national waiting time standards have not been

met; commitments to reduce waiting lists have also not been met; and pressure remains across the system, with the highest recorded levels of delayed discharges. Accident and emergency waiting times remain considerably longer than they had been previously and below performance standards. Initiatives that had been put in place to address those issues are not yet having an impact on headline indicators.

Clearer and more transparent reporting on progress and evaluation of impact is therefore needed to better understand what is working and where the opportunities for change are. Wider reform and a focus on improving the health of Scotland's people are essential and need to be part of a clear plan for delivering on the Scottish Government's vision for health and social care. The situation also means that difficult decisions need to be made about transforming services and, potentially, about what the NHS should stop doing. The Scottish Government has called for a national conversation on how health services can be transformed to meet today's challenges, but we have seen little evidence of progress on that front.

Lastly, in our view, greater leadership from both the Scottish Government and NHS leaders is needed for the radical decisions about the changes that are required for longer-term reform to take place.

As ever, my colleagues and I will do our utmost to answer the committee's questions.

The Convener: Thank you very much. I will begin with a minor technical question. You came before the committee to give evidence in March this year, and you have changed the publication date for your latest report, so it seems that the cycle of your reporting on the financial state and operational performance of the national health service in Scotland has changed. Does that mean that you will revert to publishing your reports every 12 months around this time of year?

Stephen Boyle: Exactly so, convener. That brings us back to what we were doing before Covid, which was reporting in late autumn or early winter of the same calendar year for the preceding financial year. For clarity, it is not our intention to produce a report on the NHS every 10 months. Our expectation is that we will finalise our work programme in early 2025 and report on the NHS towards the end of next year.

The Convener: Thank you for clarifying that.

Your report includes a summary of progress against some of your recommendations from previous years' reports. Some of the recommendations that you made in previous years are repeated this year. Do you think that sufficient progress is being made in the areas that you have highlighted as being important for improving the performance of the national health service in Scotland?

Stephen Boyle: I do not think that we can say definitively that we have seen the progress that is required. Throughout the new report, it is spelled out that many of the issues that we have reported on before—not only last year, but as recurring themes in reports from me and my predecessor—about the need for reform of the NHS and public service reform more generally have not progressed at the required pace.

We think carefully about the merit of repeating a recommendation, but, because the issues are so significant and require such focus, we have gone back to many of the themes of previous reports. A central recommendation of this report is the need for a clear delivery plan to support reform, transformation and the delivery of the cabinet secretary's vision for the NHS, which was restated in the summer. As you referred to, that is not a new recommendation from us—much still requires to be done to build on previous recommendations.

The Convener: Thank you very much. I invite Jamie Greene to come in.

Jamie Greene (West Scotland) (Con): I was not expecting to come in so early. Good morning to our guests.

I want to look at the bigger picture, so let us take a top-level approach to this. In your opening statement, Auditor General, you painted quite a stark picture of Scotland's NHS. Despite a 2.5 per cent real-terms increase in funding from central Government, outcomes and outputs seem to be poorer and, in many areas, getting worse. Fewer patients are being seen, waiting times are getting worse, there are further delayed discharges from hospitals and, of course, there are the A and E waiting times—all of which we will come to in this session.

I suppose the logical question is: how on earth can the Government be spending more and more money on a public service but things be getting worse? In your opinion, what are the main drivers of that?

Stephen Boyle: I will bring in colleagues on that point in a moment.

I think that you are asking about the productivity of the NHS in Scotland, so I will set out some of the factors that are influencing the headline in this report. Many of those indicators are set out in detail in appendix 3 of the report, which analyses the Government's nine headline indicators to measure the performance of the NHS. It does so by health board and across Scotland as a whole, and it shows that we are delivering on only two of those indicators, which suggests that the system is under real pressure.

I will talk about productivity in a minute. First, there is one thing that I want to emphasise. The committee is very well sighted on last week's draft budget, which will increase the funding available to the NHS in Scotland to £21 billion, up from just over £19 billion in the current financial year. Much of that increase will be spent on settling pay awards for people who are working in the NHS. In each year, there is almost always a record level of investment in health and social care services, but that is not yet translating to improvements in outcomes, productivity or efficiency. That is why the report makes a core recommendation to operationalise the vision with a clear plan, so that people who work in the NHS—those charged with its governance and oversight—along with the Parliament and the public have the ability to provide scrutiny and clearly track what comes next.

Jamie Greene: I want to pick you up on some of the terminology that you are using, because there is a lot of audit language in there. You are talking about efficiencies, productivity and operational management, but I want to get to the nub of the issue. What actually needs to be improved?

More money is being pumped in, which you suggest is getting sucked into pay awards. I do not dispute that pay awards are an important part of public expenditure—nobody around this table would argue against placing value on our public service workers, particularly those on the front line. However, the year-on-year increases in money simply going towards pay awards does nothing to improve outcomes for patients and the public.

What exactly do you mean when you talk about productivity in the health service? What is the Government not doing—or what should it be doing—to improve public health outcomes?

Stephen Boyle: The headline answer to your question is that it is complicated. People are working incredibly hard in really challenging circumstances, and I have no doubt that, if achieving such outcomes was straightforward and easy, the NHS would have done it. It would have found a way to get back to pre-pandemic levels of performance—if not to better them—given the real-terms increases in funding that are going into the NHS.

We have peppered points on productivity throughout the report, and there have been references in both the budget and in NHS strategies and plans to a renewed focus on productivity as being what is required. However, it is complicated, because much of what drives productivity is investment in infrastructure and new technology. As is referenced in the report, the planned investment in national treatment centres has been paused due to the restrictions caused by the reduction in the capital budget.

We also know that Scotland's NHS estate is ageing and that patient flow through hospitals continues to be interrupted compared to the pre-pandemic period. You referred to delayed discharge as being one of the problems. People are spending longer in hospital, thus interrupting the natural flow of patients arriving, getting planned treatment and then exiting.

All of those are factors, but whether they are surmountable and how they are going to be tackled is a question primarily for NHS leaders to address—not just to identify the problem but to tackle what comes next.

I will bring in Carol Calder, who can offer more insight on productivity.

Carol Calder (Audit Scotland): As the Auditor General said, it is difficult to measure productivity, but, in simple terms, you must look at inputs and outputs. The outputs include in-patient and out-patient appointments, the number of procedures and day cases. The inputs include staff, supplies, facilities, spend and equipment. To measure productivity, you look at how those things are balanced.

The Auditor General mentioned that the lack of investment in infrastructure is one of the factors. In February, the Institute for Fiscal Studies produced a report that found that hospital productivity has decreased since the pandemic. It identified workforce factors that impact on productivity, including sickness absence levels and vacancies.

Demand has increased as patients increasingly require more complex care. There are more patients, and the care that they require is more complex, particularly if they have been waiting a long time for treatment because of a backlog. Fundamentally, there has been a lack of a shift towards spending on prevention and early intervention, which would improve population health. Delayed discharge has an enormous impact on the flow of patients through hospitals, which impacts productivity as well. Those factors have all been identified as influencing productivity levels.

09:15

Jamie Greene: That is helpful. Thank you. We are digging below the headlines a bit more with some of our discussion.

I am getting a feeling of déjà vu in this session. I have not been on the Public Audit Committee for very long, but I have been in the Parliament for eight and a bit years—other members around the table have been here for much longer—and we

know that these are perennial issues in our health service.

Auditor General, you talked about the so-called "national conversation" that we need to have about our health service. What should that national conversation look and feel like?

The NHS is sacrosanct in politics. Few politicians or political parties would want to tinker with it—in relation to its structure, how it is funded, or where the money comes from and how it is spent. However, health and social care are fully devolved matters. Therefore, the Scottish Government has the ability to take the direction of travel that it sees fit, in order to make the service fit for purpose and good value for money. I think we all want to see that.

What would you like to see happen in Scotland? What is that national conversation? What are the difficult things that we need to be talking about—as politicians, as a society and as a health service?

Stephen Boyle: As I mentioned in my opening remarks, there has been much reference to a national conversation. We are very supportive of a conversation, and it needs to be part of the process. We are looking for more evidence about what that process will actually mean for NHS leaders and the Scottish Government and how they intend to structure it.

In and of itself, a national conversation is important, but we need to move beyond it. In many of our reports, we talk about the need to bring service users with us through the process of change and about involving them in the shaping and structuring of public services and how they will be delivered. That absolutely must be part of the process.

Beyond that conversation, we will reach a point where we have to translate the Government's stated vision into a detailed, measurable plan for how we will deliver on it. The cabinet secretary restated that vision to the Parliament in June, and it involved a preventative model for population health. You are right to reference that this subject can become quite jargon heavy, but, ultimately, it is about keeping people healthy and out of hospital for longer, so that they lead healthy lives and can manage their treatment and care either closer to home or in a homely setting that does not require them to be in hospital. Personal responsibility and lifestyle orientation will be factors in that, as will where we choose to site different hospital services and the level of investment that we make in primary care—general practitioners and their colleagues—relative to hospitals.

My last point is one that I suspect the committee will want to explore further. I mentioned in my opening remarks that, in the report, we make the point that part of the conversation will be led by medical experts and professionals and will be about considering and prioritising what the NHS does and does not do. For example, Scotland's national clinical strategy makes reference to the fact that—in the view of medical experts, not auditors—about 20 per cent of medical interventions in Scotland are of low clinical value and do not produce the intended outcomes. That strategy dates back to 2016, and we are looking for it to be wrapped up as part of the plan. That will be difficult to do, because it affects people's specialisms and their careers. We will have to think really carefully about where we are adding most benefit and value for the people who use health and social care services. No doubt, that will be part of the conversation, but going beyond that is crucial.

Jamie Greene: You talk about difficult conversations. Is there an appetite for them?

We can have a national conversation, which I hope will produce some sort of Government vision, which then will produce some form of plan or strategy, which then will be implemented. All of that will take a huge amount of time. With the health budget running at 40 per cent of the total Scottish budget and that level increasing every year, it sounds to me like we are running out of time.

At what point do things become unsustainable? Should anything be on or off the table in those difficult conversations? What sort of things are we talking about here? There are many difficult conversations already happening, but politics often gets in the way of them. Is it fair, for example, that we get free prescriptions? Those are the difficult conversations that we, as politicians, perhaps ought to have, but we are not having them.

Stephen Boyle: Ultimately, it is for the Parliament and the Government to make policy decisions on how the Scottish budget is spent. You rightly point out that health and social care are devolved matters, so the Scottish Parliament undoubtedly has licence to get itself into potentially difficult territory.

As we have mentioned, health and social care currently receive 40 per cent of the Scottish budget. The Scottish Fiscal Commission projects that, decades down the line, without change and reform, the figure will grow to more than 50 per cent. At the risk of stating the obvious, that means that there will be less money available for other vital public services.

For me, that is the driver. We want to see an improvement in how that 40 per cent of the Scottish budget is used, but if the NHS does not reform, the risk is that it will consume 45 or 50 per

cent in the years to come. There is not necessarily any strong evidence that that increased level of spend will produce better outcomes, so we must change—or reflect on—the current arrangements for how we spend that money.

Jamie Greene: There are a lot of questions to ask, and I will probably come back in later. I want to have a conversation about preventative health care and some of the reforms that you have talked about, which may improve outcomes down the line as opposed to just costing more money.

I draw attention to exhibit 5 of the report, which I found quite interesting. When digging below the surface to work out why health boards are running out of money and why so many of them face deficits and are borrowing money, I read about "prescribed drug costs" and "staff costs", which goes back to my first question about pay increases and what is driving them. Has Audit Scotland done a piece of analysis on the main drivers of the current situation? Is it simply due to pay awards and the increased cost of drugs from pharmaceutical companies, or is there something else that we are missing?

Stephen Boyle: Leigh Johnston compiled the exhibit and did some of the analysis behind it. You are right in principle, although pay awards are not all the same. In the report, we refer to the analysis of pay awards. The increase of 5.5 per cent is for those NHS colleagues who have agenda for change terms and conditions. The increase is greater for consultants, and there is a double-digit increase for resident doctors as well.

We have not done a detailed analysis of the drivers behind the drug costs that we reference in the report. The committee might want to explore those with the Scottish Government.

I ask Leigh Johnston whether there is anything she wants to add.

Leigh Johnston (Audit Scotland): Thank you, Auditor General. We did not look at the drivers behind the pay deals, but it is worth noting a recent Institute for Fiscal Studies report that looked at recent trends in public sector pay. To caveat that, the report used England-only data, but it also looked at data from across the United Kingdom as a whole, and it looked at the trend in public sector pay.

In the pre-pandemic period, nurses and teachers received smaller pay increases, which has resulted in the higher pay awards that we have been seeing since then. Scotland's NHS staff have secured some of the best pay packages in the UK, and Scotland has been one of the only nations to avoid strike action in the NHS.

As the Auditor General said, we did not look in any detail at the drivers of prescribed drugs cost increases. However, it is worth acknowledging Scotland's increasing burden of disease, the increasing number of long-term conditions and our ageing population, all of which are having an impact on the increasing cost of drugs.

Jamie Greene: Thank you. That was very insightful.

The Convener: I will now bring in Graham Simpson, who wants to continue on some of the themes introduced by the deputy convener.

Graham Simpson (Central Scotland) (Con): Yes, the deputy convener helpfully touched on some areas that I want to ask you about.

Let us return to the so-called "national conversation". You say repeatedly, in report after report, that we need reform. You have made that point very clear in this report, and you touch on this "national conversation".

I do not know whether such a national conversation has been going on. The health secretary announced that there was to be one—I know that he spent some time talking to football fans, but I am not aware that a national conversation around the health service is actually starting. Have you seen any evidence of that?

Stephen Boyle: I will bring in Carol Calder, in a second, to talk about the detail of what we have seen.

As I referenced in my opening remarks, we have seen limited evidence of the Government's intention to hold a national conversation to move on and deliver its vision in the budget. Mr Simpson also references the need to reform health and social care services. I think that, at the moment, we are waiting to see such detail. Carol can offer more insight on that point.

Carol Calder: We do not yet know what progress has been made with the national conversation. We would hope, though, that the framing of that conversation is about what needs to change in the NHS and how we, as consumers, all need to change in terms of using the NHS. It should be an honest and realistic conversation about how the NHS needs to reform, rather than a conversation that rehearses the problem or that is a wish list of what the NHS should look like. It should be about what the NHS can look like within the constraints of the long-term affordability and long-term sustainability of the service.

Graham Simpson: My problem is that the phrase "national conversation" is thrown about by the Government and has almost become a new buzz phrase that does not actually mean anything. I am not clear who the Government is meant to be talking to or what the conversation is meant to be about. Do you have any clarity on what that

phrase actually means in relation to the health service?

Stephen Boyle: No. I hope that we have been clear that we do not have any additional detail beyond the commitment to it and how important it is.

At the risk of restating one of my answers to the deputy convener, the national conversation can only be an early part of the process. In and of itself, it is not likely to change the NHS's performance nor people's outcomes and experiences. Therefore, it has to be accompanied by detailed plans and measurable action.

We talk to the committee very regularly about operationalising strategies so that they are reflected in plans and you can see what is actually happening and what the intention is 12 months, three years or five years down the line.

Graham Simpson: When we talk about reform, we are potentially talking about making choices. One of your recommendations is:

"The Scottish Government and NHS boards should: Ahead of 2025/26, jointly identify areas of limited clinical value and consider how services can be provided more efficiently, or withdrawn."

Did you have anything particular in mind? Can you give an example of something that, in your view, is of limited clinical value?

Stephen Boyle: I refer the committee to paragraph 104 of the report you are considering today. We want to be really clear in our evidence to support that point. The first thing that I would say is that it is not for us, as auditors, to identify which procedures are or are not of clinical value; we are referencing the Government's own strategy. The Government itself, in its clinical strategy from 2016, cited a source that said that 20 per cent of medical interventions were of limited value. In our view, there needs to be transparency around what interventions exactly, in the Government's view, are of limited clinical value. If they are not delivering outcomes for patients or value for money, why continue with them?

09:30

We absolutely recognise that this is difficult territory and that it will be very emotive and challenging for people working in the NHS. For individuals who are receiving those services and their family members, it is going to require lots of careful engagement and discussion well before the personal interaction between the medical professional and the patient takes place.

Leigh Johnston can say more about the positioning of that strategy and the Government's intentions behind it.

Leigh Johnston: To be clear, the national clinical strategy that the Auditor General talked about is from 2016, but the Government has been very clear that that strategy is still guiding its work as far as the NHS is concerned.

We also know that the Scottish Government is looking at medicines and procedures that are of low clinical value. Paragraph 44 of our report talks about a 15-box grid of saving opportunities that was circulated by the Scottish Government and that boards have been working with. Two of the items in that grid are about medicines and procedures of low clinical value. We would like to see further progress. We know that the Government is still working on that and has not yet identified what those medicines and procedures are for the boards. So, we would like to see greater progress, but we know that the Government is working to circulate information on which medicines and procedures should be of lower priority for funding or, as we have suggested, stopped altogether.

Graham Simpson: If the Scottish Government is saying that one in five of the things that happen in the NHS—let us express it that way—is of limited clinical value, whatever that means, is it up to the Government to tell us what it means by that—in other words, to spell it out?

Stephen Boyle: Guided by the experts—that is probably how I would frame it. My question back to you, if you will forgive me for saying so, would be: if not the Government, then who? An explanation by the Government at that level of detail would have to be preceded by full engagement with those who work in the NHS—the medical experts—as well as engagement with the public.

To segue ever so slightly, I do not think that that is the only way that NHS reform will be delivered. It has to be accompanied by the productivity analysis that the deputy convener touched on. How we are using the estate, how we are supporting patient flow and what the attendance and turnover levels are all have to be part of the detailed delivery plan that translates the vision and moves beyond the diagnosis of the challenges in the NHS to where we actually want to get to in the years to come.

Graham Simpson: Turning to the issue of boards being given brokerage loans, it could be said that boards have been bailed out—I have used that phrase before. In the report, you say that, in 2022-23, five boards needed that extra money from the Government to break even and that, in 2023-34, the number increased to eight boards. My initial question is: in your view, why have things got worse?

Stephen Boyle: I looked at that in a bit of detail—not just while compiling today's report, but

through our analysis to build on this report's evidence and through the work that auditors across the country have done, looking at different boards. You are right in saying that there is a picture—the details of which we set out in exhibit 6 of the report—of increasing financial pressure on individual health boards.

The committee will be familiar with the NHS Scotland support and intervention framework and its various escalation levels. At a glance, it suggests that almost all the boards at level 3 and a handful of those at level 2 required financial support by way of brokerage.

It is worth noting that, on the back of the draft budget, the Government is in the process of changing its brokerage arrangements. Over the past week or so, it has communicated with health boards to signal a change of plan for brokerage in future years. We will wait and see how that unfolds over the rest of this financial year, but the presence of brokerage in 2025-26 might not be as significant as it has been in previous years.

We can say more about that in a moment if you wish, but first I will bring in Leigh Johnston to talk about the detail behind those points.

Leigh Johnston: Obviously, more boards have sought brokerage this year, which I think is due both to the fact that many boards rely on non-recurring savings, which means they are carrying forward deficits from one year into another, and to a combination of cost pressures. Boards that required brokerage identified a range of cost pressures. Those included the prescribing costs that we have just talked about, pay costs, services delivered by integration joint boards, agency staff costs and overspending in specific service areas—for example, in the acute service. A combination of factors feed into the pressures that the boards are facing.

Graham Simpson: Looking through exhibit 6 in the report, I see that, in the column titled "Primary factor for escalation", the phrase "Mental Health Performance" comes up time and time again. That appears to be a factor with a lot of boards: big spending on mental health services is perhaps pushing them over budget.

Stephen Boyle: That is a factor, but I am not sure that there is a correlation and that spending on mental health services was specifically the direct trigger for brokerage requirements. The escalation factor can also be about the quality and breadth of a service. However, inevitably, the provision of that important service will be part of the reason for escalation.

Graham Simpson: Are you able to say more about the change of procedure that you mentioned a few minutes ago?

Stephen Boyle: I think that that refers to correspondence to the chief executives of NHS boards from NHS Scotland's director of finance indicating that, in the light of the increased funding to boards provided for by the draft budget for 2025-26—assuming that it is passed by the Parliament—brokerage will not be available during 2025-26.

The committee will be familiar with some of the historical brokerage arrangements—there have been a couple of iterations—whereby previously owed balances were written off at the end of the last decade and there were no brokerage arrangements during the pandemic. The Government's approach to brokerage has fluctuated from time to time, but the indications are that, in the light of the proposed uplift to NHS funding, it is the Government's intention that no brokerage will be required.

I will offer a view on that, if it is helpful. I do not think that that is necessarily unhelpful, as it signals to boards that they must manage their funding within the allocation that they have received. That probably ensures parity in funding between individual boards across Scotland.

Graham Simpson: Yes, but every single board would, presumably, try to stay within budget. The reason that they ask for more money is that they do not achieve that.

It is all very well for the Government to say, "Sorry, lads, there is no brokerage this year." Some boards will, inevitably, not hit their budget targets and will come to the Government to ask for more money. What happens then?

Stephen Boyle: I have two things to say on that. We are exploring what the incentives or disincentives are for boards to seek brokerage when it becomes available. In the report, we have set out how savings have been achieved—Leigh can say a bit more that.

Savings are not achieved on a consistent basis. Some boards manage to consistently meet their savings targets and break even. I do not want to understate the complexity of that, Mr Simpson. There are a range of factors, and there are varying views about the appropriateness of the baseline funding model—the national resource allocation formula—and whether that is a fair starting point.

Regardless of whether brokerage is available, boards still have a requirement to meet their performance and financial targets and break even. In the event that they do not, the auditors of the boards must consider what that means in terms of their opinion, and any statutory reporting is for me to then think about.

Graham Simpson: This might be superseded now, but the Government was telling boards that

there was a savings cap of 3 per cent. That has now been overtaken by the Government saying that brokerage is not going to be available, so they should not bother asking.

Stephen Boyle: Those are two different things. If I understand it correctly—Leigh can keep me right on this—there is a target of 3 per cent in savings that the territorial boards must deliver each year. I think that the national boards had a higher savings target of 5 per cent.

Brokerage remains in place for the current financial year, 2024-25, but the Government's indications are that it will not be available in the light of the higher funding allocations proposed in the draft budget.

I will bring Leigh in, if there is anything she wants to add.

Leigh Johnston: All boards were asked to achieve an NHS-wide target of 3 per cent in recurring savings in 2023-24. They achieved about 3.3 per cent in savings, but those were a mix of recurring and non-recurring savings. Latterly, national boards were asked to make a further 5 per cent saving on top of that.

Graham Simpson: Okay. Thank you for that. I have a feeling that we will come back to that, whatever the Government says.

The Convener: Thank you, Graham. I invite Colin Beattie to continue with some questions on the theme of financial performance.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I will start with integration joint boards, which have been a favourite source of conversation in the committee in the past.

Paragraph 22 of your report highlights:

"Financial transfers are made routinely, from the Scottish Government's health and social care portfolio budget to the local government portfolio budget. For 2023-24, these amounted to nearly £1 billion ... This increased from £878 million in 2022/23. NHS boards allocate a significant portion of their budgets to integration authorities",

and I believe that the figure is about £7.6 billion.

The report also says:

"During the Covid-19 pandemic, IJBs built up significant reserves of about £0.3 billion, which were used largely in 2022/23."

Therefore, the financial position of IJBs is having a significant

"impact on the financial position of NHS boards, with a number of boards required to fund IJB overspending."

I know that, in my own area, the provision of health and social care is running way over budget—by multiples.

09:45

To come to my question, the report states that financial transfers of around £1 billion were made from the Government's health and social care portfolio to local government and that an allocation of £7.6 billion was made to integration authorities by NHS boards. What is your assessment of the financial strain on NHS boards caused by the overspending of IJBs, and what needs to change to improve the financial management and accountability of IJBs?

Stephen Boyle: I will turn to Carol in a moment so that the committee can hear her insight from working on our audit of local government activity and supporting the Accounts Commission. As we reference in the report, it reported earlier this year on the financial pressure that Scotland's IJBs are facing.

Before turning to the financial consequences for NHS boards resulting from the overspending of IJBs, I will provide a little bit of detail on the number that you reference in paragraph 23, which was the £7.6 billion transfer to integration authorities. That is largely the funding that Scotland provides to primary care services in Scotland—independent contractors, general practitioners, pharmacists, opticians and others—to support the delivery of their services.

The paragraphs on financial transfers to IJBs talk about the pressures that affect the financial circumstances of NHS boards. One of the drivers behind such pressure is budget increases caused by the commitment to pay the real living wage to workers in the social care sector.

There is no doubt about what we are seeing—certainly, the Accounts Commission has reported widely on the financial pressures that IJBs are facing. I will bring Carol in to say more on the detail of that.

Carol Calder: In the past couple of years, we have done a financial overview of IJBs. However, as they are local authority bodies, that has been reported on by the Accounts Commission. Next year, we will work on a joint report looking at IJBs in the context of social care, covering health and local government. That will be a joint report with the Auditor General.

As the report mentions in paragraph 24, IJBs built up a significant amount of reserves during the Covid pandemic. A lot of that money was due to underspend on staffing caused by difficulties in IJB staffing levels. Those reserves have now been diminished and we are at a bit of a turning point where some IJBs are struggling financially. We are just now looking at the accounts, and we will put out a report covering the IJBs in the spring.

The financial position of IJBs has worsened, and that will have an impact on both local government and health boards, which have to fund the IJBs. We have an eye on that, and, as I say, we will report on those bodies as a system through a joint report by the Auditor General and the Accounts Commission next year.

Colin Beattie: So, what needs to change? The IJBs are putting financial strain on NHS boards. What needs to change to improve their financial management and accountability? Accountability is an important issue that we have been concerned about in the past.

Carol Calder: That goes back to the issues of reform and sustainable services. IJBs provide health and social care for adults, and some provide those services for children as well. There is enormous strain on that part of the system, as we all know, which contributes to the financial pressures within IJBs.

Audit Scotland audits IJBs through our mixed-model approach, and some of the private audit firms audit all the IJBs in Scotland to look at their financial management and sustainability. We report on those separately, and the issues will be different in different integration authorities.

Our report next year will be able to answer your question more fully, when we have looked at the system and the impact that it has on local government and the health system. We will raise the issues of what needs to change in the financial management of individual integration authorities.

Colin Beattie: Do you have an approximate time for publishing that report?

Carol Calder: From memory, I think it will be in April.

Colin Beattie: That is sooner than I thought.

Carol Calder: I will check, and if that date is wrong I will correct it.

Stephen Boyle: As ever, Mr Beattie, there is no straightforward answer to that question. There are huge demand pressures on health and social care services. Particularly in social care, demand is driving some of the system-wide implications that we are seeing. The report that you are looking at today mentions examples of those, such as delayed discharges, the need to find people safe routes out of hospital—with appropriate care packages and so on—and the staffing pressures that exist in the sector, notwithstanding the commitment to a real living wage. Those will be some of the consequences of the financial pressures and of the changing demographics that we are seeing in Scotland.

The existing system has been in place for 15 years, if not longer. I recognise the committee's interest in integration authorities and health and social care models. To echo Carol's point, both the Accounts Commission and I recognise that it is appropriate for us to work together to look at how the model operates. In particular, we will look at delayed discharges—that is something that we will flesh out in a bit more detail early next year when we settle on our work programme, and we will then consult the committee on it; but we will look at how that process operates and at the implications it has for both the NHS and the integration authorities.

Colin Beattie: I could say a great deal more about that, but if a report is coming in April that will give us much more detail on the issue, I am content to leave it at that for the moment.

Moving on, you touched briefly on non-recurrent savings, which are something that we have discussed in committee before. In the current situation, the reliance on non-recurring savings is very substantial: 63 per cent of the savings achieved recently were non-recurring. That has been a constant worry and we have not really seen a reduction in the proportion of savings that are non-recurring.

Of the £471.4 million of savings in 2023-24, 63 per cent were non-recurring—that is a lot of money. In your view, what are the long-term implications of the reliance on one-off savings, and how does the continued use of non-recurring savings impact on the boards' ability to adequately forecast deficits in their three-year financial plans?

Stephen Boyle: I agree with your assessment that non-recurring savings have been a recurring theme in the positioning of NHS boards' approach to breaking even. At the risk of stating the obvious, non-recurring savings help in the year in question, but then you are back to square 1 at the start of the following year. Typically, they are a result of an approach to vacancy management—about the timing of filling vacancies—so there is a small saving, but as soon as the vacancy is filled, the saving is no longer available. Those savings also come from the use of accounting approaches to annual leave balances, or from procurement. Those are one-off savings; unlike recurring savings, they are not a new, fixed or recurring approach to service models.

If the NHS remains reliant on non-recurring savings, and if we layer in the Government's changed approach to brokerage in 2025-26, there is a risk of increasing the financial pressure on individual boards and reducing their ability to break even. Health boards must find a way, supported by the work of the NHS finance delivery unit, to revise their responses to individual pressures. That is my assessment, but Leigh can develop on the issue.

Leigh Johnston: I do not have a great deal to add. When it comes to recurring savings, the low-hanging fruit—in other words, the easy wins—has already been achieved. It then gets more difficult, as time goes on, to find recurring savings.

I refer back to the 15-box grid of saving opportunities that was shared by the Scottish Government, which it had agreed with chief executives. That grid focuses on different areas where boards can start to increase their recurring savings. We have already talked about procedures and medicines of low clinical value, but the grid also features things such as reductions in the use of nursing agency staff—which we have seen progress towards this year—as well as increased productivity, which can also create savings through theatre optimisation and remote out-patient appointments, for example. The Government is working very hard to find ways to increase boards' ability to make recurring savings.

Colin Beattie: Would it be correct to say that, unless recurring savings are found in reasonably substantial percentages, the percentages of non-recurring savings will need to become larger and larger?

Stephen Boyle: I think so—the only caveat being that the additional funding that is set out in the draft budget might make a difference in the short term. However, that possibility must be balanced with the Scottish Fiscal Commission's projections of changing demographics and the increasing call on health and social care services, which are likely to quickly squeeze out the growth in the 2025-26 budget. Without reform and the clear delivery plan that we have been talking about operationalising the vision of moving to a preventative model of health care services, I would assume that there would be ever more reliance on non-recurring savings.

Colin Beattie: Worryingly, your report also says that boards are

"forecasting recurring deficits ... even if they achieve ambitious savings targets."

What more can be done about that? You have just touched on some aspects, but it seems that something drastic needs to be done.

Stephen Boyle: That is the point that we have reached, Mr Beattie. I will not repeat my previous answer about the change in the budget, but the message at the heart of today's report is that there needs to be a clear, detailed plan for reform so that health and social care services can be sustainable and affordable. The vision for health and social care services needs to be translated into a measurable plan that the public and the Parliament can track and scrutinise. Otherwise, it is not clear to users how the health and social care services can move beyond those detailed metrics, which are of a health system that is not yet back to where it was before the pandemic, with indicators suggesting that the system is under real strain.

Colin Beattie: Moving on to staffing costs, paragraph 35 of the report says that

"Staff costs account for almost 60 per cent of annual NHS costs."

In a way, that is not surprising, because it is a people industry, if you like, and you need people to provide the service—or rather, the people are the service. However, paragraph 38 of the report goes back to what we were discussing earlier, mentioning that £116 million of savings in health and social care are expected in order to meet some of the additional costs that will come with pay increases. That seems odd.

10:00

Stephen Boyle: There is a fair amount in that, and Bernie Milligan might want to say a bit more about it. Intuitively, you are right. We would all recognise that health and social care services are intensely people-driven. Notwithstanding the investment in new equipment and so forth, that is probably how we would expect health services to be delivered.

We can come back to the financial pressures, but the report explores one of the drivers of how that investment is being used. Staff numbers have increased in the NHS in the past 12 months. We go on to explore some of the factors that connect back to productivity, such as turnover rates and staff absence, and how they are performing.

I will pause and bring in Leigh Johnston. Bernie, if you want to add anything, please do so.

Leigh Johnston: I do not have much to add, other than to say that the money that needed to be found to fund the pay increases was higher than anticipated and budgeted for, and the £116 million of savings that was announced was part of that.

Colin Beattie: You have highlighted the substantial increases in staff costs and the reliance on efficiency savings to meet pay commitments, but how confident are you that NHS boards can achieve those efficiency savings without services being impacted?

Stephen Boyle: What we have set out in the report is the need for change. We can frame that in terms of services being impacted or, on the other side of the coin, services being reformed. Our report is looking for that level of change. We are talking about the need to explore the prioritisation of spending in the NHS so that it delivers the intended outcomes. Otherwise, it will likely remain the case that there will be record levels of investment in the NHS, but they will not

translate into improved outcomes, shorter waiting times and fewer people on waiting lists.

We are recommending that the Government and the NHS take stock of what will be, in 2025-26, £21 billion of investment, and how that will deliver the intended outcomes that it is not yet meeting in terms of the targets. How we deploy staff, what savings we want to make and what savings the boards are being asked to deliver are all part of that thinking and the recommendations in today's report.

Colin Beattie: However, we have previously touched on how we are at the bottom of the barrel for efficiency savings. I cannot remember when efficiency savings started, but it must have been 20 years ago. Every year, NHS boards and so on are expected to save another 3 per cent, 5 per cent or whatever the figure is for that particular year, but there must come a point where there is just nothing left. Without a complete overhaul of the NHS, there must be a limit to how far we can go within the present system.

Stephen Boyle: That is fair. Leigh Johnston mentioned earlier that much of the low-hanging fruit has been plucked. The evidence in exhibit 3 suggests that, with a ratio of 63 per cent to 37 per cent, recurring savings are not the dominant feature. It is about delivering an in-year financial target rather than service change, and translating service change into delivering better outcomes for people.

It feels as though there is a disconnect between how we are investing in the NHS and what we are actually achieving. Savings are part of that, but they have to be supported by a detailed plan—a translation of the vision—and a move out of the cycle of recurring and non-recurring savings to looking at how we move to a preventative model and where we spend money that delivers those outcomes.

Colin Beattie: I will stay on the theme of staff expenditure. The figure for utilising agency staff has dropped. In real terms, the spending fell by almost £50 million—12 per cent. Your report says that spending on agency staff decreased last year, but it is still much higher than it was five years ago, which takes us back to back pre-Covid times. It is still 45 per cent higher than then, which is a significant cost—it is still £358 million.

What more can the NHS do to decrease reliance on agency staff? They are much more expensive than full-time staff.

Stephen Boyle: All that you say is true. Paragraph 89 in the report builds on that a bit further. The use of agency staff is still 45 per cent higher than it was five years ago, in spite of a 12 per cent reduction from the previous years, which we recognise equally.

The report says that boards have made more use of their nursing bank. Bank staff come with two benefits. One is that they typically have a lower rate of pay than agency staff. Bank staff also tend to be known to the NHS board and familiar with the workings of individual hospitals, unlike agency workers, who might be at one hospital one day and another the next.

That is the type of approach that NHS boards have used. I will bring in colleagues to give a bit more detail on the specifics of approaches that boards have used.

Leigh Johnston: There is a range of factors that need to be thought about when reducing the reliance on agency staff. Further reductions in sickness absence, turnover rates and the number of unfilled vacancies could further reduce the number of agency staff that are required to provide temporary cover, as well as increased use of the board's own bank staff, which the Auditor General mentioned.

I keep going back to the point that one of the key areas of focus in savings for NHS boards is reducing the use of agency nurses. A group has been formed to address the reliance on nurse agency staff and drive forward a more sustainable workforce model. The group is chaired by the Scottish Government's interim chief nursing officer and NHS Grampian's interim chief executive. It is trying to implement a series of phased control measures. That work is about grip and control on staffing to further reduce the reliance on using agency staff.

Colin Beattie: I will ask quickly about vacancies, absences and staff turnover. Staff turnover rates have fallen substantially to 6.6 per cent, but the reliance on agency and bank staff suggests that there are capacity problems. How confident are you that the Scottish Government's action plan to improve wellbeing and the working culture across the health and social care workforce will get the desired result?

Stephen Boyle: Leigh Johnston might want to offer a view on the work that the Government is doing on culture.

The Government is taking an important step in recognising the connection between wellbeing, sickness absence and turnover levels. Let us not forget that the health service is an extremely pressured environment in which to work. Therefore, the level of support that is available to NHS staff will be a driver as to whether they feel safe and supported and continue to turn up at their work each day. Leigh Johnston has her position on that.

What impact the Scottish Government anticipates that the action plan will have with regard to the support that is available is an

important issue for individual NHS employees, but it has wider implications for productivity—that is probably as much a question for us as it might be for the Government. Days lost in sickness absence or turnover levels will also be a factor in the system's ability to tackle waiting times and backlogs.

Leigh Johnston: We have seen the vision that the Scottish Government has for staff wellbeing and culture. Over recent years, we have reported on a number of initiatives that the NHS has implemented to look after staff wellbeing, particularly following the pandemic. The Government has said that it will produce an action plan on how it will deliver that workforce vision, but we have yet to see it, so I cannot comment on how confident I am in it.

Colin Beattie: Sickness absence rates are quite high—they are at 6.2 per cent, when the national average is 4 per cent. Is that simply because people in the NHS work in an environment with sick people?

Stephen Boyle: I do not know whether there is a simple answer. That will be a factor, as will environmental pressures. Turnover and absence also affect people's ability to function in highly pressurised environments.

In today's report, we observe that the sickness absence rate has remained largely the same as it was in previous years, but higher than the Government's target of 4 per cent. As I mentioned a moment or two ago, sickness absence will be a factor in driving productivity. If a key member of staff—and there will be key people in every hospital; for example, in a theatre team—is not available, that can lead to disruption and interruption in the flow of services and patients throughout the hospital. We are looking for the Government to give NHS leaders details about the plans to drive down sickness absence to and below the Government's target.

Colin Beattie: I am conscious that, as with a lot of the statistics that we get, we are comparing ourselves against ourselves. How do we compare with other health services, for example, in the UK?

Stephen Boyle: It is complicated. There has been much commentary over the past few days. Carol Calder mentioned the IFS report from earlier this year, and the analysis appears to suggest that people in Scotland are waiting longer for treatment, particularly for the longer waits of more than two years. There are low five-figure numbers of people who are waiting for more than two years for treatment in Scotland, compared with what is reported as being a few hundred people across England.

There will be a range of factors behind those figures and how the money is spent. The allocation of capital services and the use of the private sector will be a feature of that, too. The evidence suggests that NHS England has made more progress in tackling waiting times and recovering to pre-pandemic levels than the NHS in Scotland has.

Colin Beattie: What about things such as absences?

Stephen Boyle: I do not know whether I have the detail on that. I will turn to colleagues to see whether we have it. We might need to refer the committee to NHS leaders, or, if we have more detail, we can come back to you with that in writing.

The Convener: Auditor General, I thank you for resisting the temptation, which members of the committee have put your way several times, to offer clinical judgments. I really do not think that it is fair to ask you to make those judgments.

One area that you are more comfortable and qualified to talk about is highlighted in paragraph 100 of today's report. That is a recent report by the chief medical officer that talks about the need to focus on

"equity, prevention and early intervention".

I recall that, in the report, "Fiscal sustainability and reform in Scotland", on which we considered evidence last week, you once again used, as a touchstone, the Christie report, which you said had "remarkable longevity" and "ongoing relevance". Those themes are captured in the chief medical officer's assessment, too.

We have spoken a lot this morning about reforms to the NHS, but there is a wider palette of reform—perhaps social and even economic—that we might need to look at if we are to see a shift in the provision of health services and how we best improve public health in Scotland.

10:15

Stephen Boyle: That is a fair summary. The chief medical officer's report echoes the ambitions and intentions of NHS leaders and the Government. Quite reasonably, there is a thread back to the Christie commission's report from more than 10 years ago, which set out that better outcomes and more affordable levels will be achieved through earlier intervention and preventative-based approaches, instead of there being a resource-heavy focus on secondary care and treating people when they become unwell.

I am perhaps echoing evidence that I have given to the committee previously, but there is a need to move beyond diagnosis to a clear plan. Last week's draft budget report makes reference to public service reform, with a focus on improving

population health, prevention and early intervention. That will be accompanied by a desire to improve quality and access and to tackle productivity issues. The intention is clear, but the recommendations in our report are about operationalising that. There needs to be a clear delivery plan to support that intention.

The Convener: Let me pick up that theme. In your evidence to us last week, you referred to your concern about the lack of a medium-term financial strategy, which was also expressed by the Institute for Fiscal Studies and other bodies. In your report this week, you refer to there being insufficient clarity about a medium-term financial plan for the NHS and say that we are still awaiting an NHS capital investment and asset management strategy—so some quite important parts of the framework do not exist. I go back to my earlier point: the calls that you have made in previous reports still do not appear to have been met.

Stephen Boyle: Those are vital components to allow those who are leading the NHS to make some challenging decisions over the medium term and to allow the Parliament and the public to understand how services will be delivered in the years to come. We understand that the Government's intention is that those components will be prepared and published in spring next year. That will be really important because, together with the intentions, our report recommends that, over the next year, the Government should settle on a delivery plan to translate its vision, and the capital and financial plans will underpin that progress.

The Convener: One area of capital spending that has previously come under scrutiny by the committee relates to the programme of investment in national treatment centres. When the chief executive of NHS Scotland was before us in June this year, we asked her about that. She sent us correspondence in which she confirmed that the plan for six national treatment centres had gone from originally costing £200 million to costing more than that. The running total at that time—summer this year—was £827 million, which represents a quadrupling of the cost. Are you in a position to give us an update on where we are with the national treatment centres investment programme?

Stephen Boyle: I do not have an update on the detail that the chief executive shared with the committee in the summer, but it has been well covered that the factors behind the situation relate to the significant pressure that Scotland's capital budget is under. That has led to prioritisation of the national treatment centres. We can clearly see the implications of that for delivering the Government's NHS recovery plan to tackle waiting times and backlogs.

Last week's draft budget includes capital commitments in relation to a replacement for Monklands hospital in Airdrie, the Belford hospital in Fort William and the NHS Lothian eye pavilion. We will not be clear on what those capital plans will mean from the point of view of timing and cost, and—most importantly—what they will mean for the patient experience and waiting times, until next spring or the summer of next year.

The Convener: I think that that is right. That was a significant part of last week's budget announcement.

I want to move on to another area. I am looking at exhibit 7 in the report that we are considering today, which is a bar chart that shows the annual unitary charges that are payable under public-private partnership contracts. I was quite surprised that that chart stretches all the way to 2045-46. In other words, I thought that we had moved away from the model of private finance initiatives and public-private partnerships into a new age, in which we were no longer liable for the big unitary costs that that model involves, but it looks as though those costs are on-going.

You can keep me right on this, but I think that the normal lifetime of a PFI or PPP contract is about 25 or 30 years. If the expiry date is 2045, I presume that we are talking about capital projects that were commissioned under that form of financing fairly recently.

Stephen Boyle: I will belatedly bring in Bernie Milligan to talk about some of the detail of that.

You are right. In exhibit 7, we set out the movement over time, from the late 1990s into the mid-2040s, in the forecast cost of the use of private finance to the NHS in Scotland. That cost remains significant. The headline from exhibit 7 is that it is anticipated that the NHS in Scotland will make a further £5.8 billion of payments in respect of PFI and PPP contracts.

You are also right to say that, typically, those contracts have a duration of 25 to 30 years. I will not say everything that Bernie is likely to cover, but I will draw the committee's attention to case study 1, which follows exhibit 7. It sets out the fact that, especially for some of the earlier contracts, there is a range of different arrangements for what happens at the end of those contracts. Notwithstanding the significant amounts that are still to be paid, there is no clear model to follow in relation to what happens at the end of the 25 or 30-year period. It is not necessarily the case that the asset will return to the NHS at no cost. Sometimes, there will be a cost. A process of management needs to be put in place around that. The NHS is working with National Services

Scotland and the Scottish Futures Trust to ensure that it has the necessary level of expertise to manage what happens at the end of a PFI contract.

I am sure that Bernie will want to say more.

Bernie Milligan (Audit Scotland): I do not have the detail on the more recent contracts that could explain the push through into the 2040s. The main point that we make in the report through exhibit 7 is that quite a number of PPP contracts are now coming to an end. A small number have already come to an end, but the case study shows that, between now and 2030, contracts coming to an end is an imminent issue for boards. Once those assets come back into public ownership, there could be a knock-on effect on on-going capital and revenue budgets.

Very complex negotiations have to take place between now and then. Some of those negotiations are already taking place, and boards are receiving support from National Services Scotland and the Scottish Futures Trust. It is really important that we learn from how those closure arrangements take place so that we can understand what that will mean for the future capital and revenue budgets associated with those assets being taken back in-house.

The Convener: I have a few more questions on that, but I am conscious of the time, so I invite James Dornan, who joins us via videolink, to put some questions to you.

James Dornan (Glasgow Cathcart) (SNP): Good morning, Auditor General and colleagues. In your "NHS in Scotland 2023" report, you recommended that the Scottish Government confirm which indicators will be used to measure year-on-year reductions in waiting times, but this year's report states that that has not been done. Will you explain why transparency is so important in assessing progress and planning future activity? Has the Scottish Government made any progress in implementing the recommendation? What are the barriers to progress?

Stephen Boyle: You are right. I highlight to the committee appendix 2 of today's report, in which we track the recommendations from last year's report. I will bring in colleagues to share with the committee some of the engagement that we had with Government and what we look to assess by way of progress, but I will first address your point about transparency.

Clearly, we think that transparency matters and that both the Parliament and the public should have a clear say on, and a clear idea of the progress of, public investment in health and social care services. We have spoken this morning about not just a national conversation about the provision of services but supporting public service reform and making real the vision for the NHS through to the next stages and what that means in terms of a preventative model. Where will people access services? How will we, as a country, help people to stay healthier for longer outside the hospital setting? We recommended that, over the course of 2025, the NHS and the Scottish Government make progress on that front.

I will bring in Bernie to say what we have seen so far on the indicators.

Bernie Milligan: There is no update on the indicators. We have not had any progress reported to us by the Scottish Government on developing the indicators that relate to the waiting lists. The targets that were originally set in July 2022 on eradicating the long waits of over a year, 18 months and two years were recommitted to in 2023. As of last week, in the budget, there was a commitment on eradicating waits of over a year by March 2026.

There has been no update on that. We know that the last update report on the recovery plan was published in December 2023. We have had it confirmed that there will be an update on the recovery plan before Christmas, so it is very imminent. We will wait and see whether that contains any update on those indicators.

James Dornan: It would be helpful if that update comes out.

We note from your report that, unless the NHS in Scotland increases hospital activity and transforms services to focus on prevention and care close to home, it is likely that waiting lists and waiting times will continue to grow. That has already been discussed to some extent, but in your view, what more could the Scottish Government do to try to address that, other than, for example, through the £200 million that it has committed to in the budget?

Stephen Boyle: I was going to mention the £200 million to reduce waiting lists and support reduction in delayed discharges. We are looking to see the detail of that. The risk, which we have talked about to a degree, and which is set out in the report, is this. We continue to have record levels of investment in the NHS—as we have seen, up to £21 billion is planned for 2025-26—but that is not yet translating to significant change in activity and, therefore, reduced waits.

Funding will inevitably be one part of that, but productivity absolutely has to be, too. We do not yet know whether the additional funding that is planned, together with the increase to the baseline, will make a difference. At risk of repeating the point that we have made a few times this morning, we are looking to see that in a detailed plan, with metrics to be reported on and progress measured against them.

James Dornan: Will you clarify what you mean by productivity in the NHS?

10:30

Stephen Boyle: Carol Calder touched earlier on the volume of activity in the NHS—the number of operations and interactions. If the committee can give me a minute, I will be able to refer to the exhibit that sets out activity levels.

Exhibit 9 in today's report sets out the activity levels and the waits for the year to June 2019, relative to the years to June 2023 and June 2024.

Staffing levels, staff absence levels, investment in technology and building maintenance all weave a complex web of factors that drive productivity.

It is ultimately for the NHS and the Scottish Government to determine how they plan to improve activity levels by looking at factors such as delayed discharge or patient flow. There are multiple drivers in relation to productivity levels, but, at base level, it is about doing more than we are seeing in the system at the moment.

James Dornan: Some changes are being made or have recently been made. Do you expect it to take some time before you see the impact of those? Is there anything in particular that you have suggested to the Government that it should take forward?

Stephen Boyle: Much of that involves policy decisions about where to prioritise and where to spend resources. As the convener said, capital investment in the national treatment centres was identified as one of the main drivers in delivering NHS recovery from Covid and increasing activity. The publication of the capital programme in the spring of next year will be vitally important and will give a real sense of where some of the additional capital that is referenced in the budget will go and what difference it will make.

James Dornan: If the infrastructure budget had not been cut so drastically, the national treatment centres could have been up and running and helping to lower waiting times, which should have had a positive impact, but we are where we are.

I have a question about the positive changes made by NHS Forth Valley and NHS Tayside to improve their performance against national waiting time targets for child and adolescent mental health services. Do you have any more information about how those changes came about? Does the Scottish Government have mechanisms in place to ensure that best practice can be shared across all boards to meet its aim of clearing backlogs by December 2025?

Stephen Boyle: Today's report includes a case study of performance in CAMHS waiting lists at NHS Forth Valley. Bernie Milligan will undoubtedly say more about some of the detail behind that and the importance of sharing best practice across NHS boards.

We have seen a 10.3 per cent change in performance on CAMHS waiting lists compared to last year. Forth Valley drew on evidence from elsewhere in the UK and internationally, and applying that would be a significant step forward.

I will bring Bernie in to speak to that.

Bernie Milligan: We have reported that only two of the nine waiting list standards have been achieved and that there has been very limited improvement across most of the standards. There have been small declines against four of the standards, with small increases against a further four.

We have seen a notable improvement of 10 percentage points in the CAMHS standard and, although the standard is still not being met, it is good to see that improvement in an area of work that we have taken an interest in for quite a long time. Eight of the 14 boards are meeting the CAMHS standard, although some are still lagging behind, which means that the Forth Valley case study provides an opportunity for learning.

As set out in our report, Forth Valley has implemented an international model, the choice and partnership approach—CAPA—which has been tried and tested internationally and is about building capacity in the service. Forth Valley's CAMHS service has self-assessed against a range of criteria and it has put in place different measures, including workforce development initiatives, such as building staff capacity and skills. Dedicated CAMHS professionals have been recruited, and the skillset of the wider team has been extended. Improvements have been made to monitoring and managing demand for the service and evaluating how capacity responds. We have seen a marked improvement, and Forth Valley is now achieving the CAMHS target.

As you say, we need to consider how those improvements and the board's approach can be shared more widely. There is a lot of liaison across health boards, and the Centre for Sustainable Delivery will help to share improvement and learning and put innovative practice in place.

James Dornan: If obvious good practice is having a positive impact, what pressure would be put on other boards to follow the example?

Stephen Boyle: I will draw on a couple of examples—Leigh Johnston may want to develop the point. I have mentioned a couple of times that, ultimately, the central NHS Scotland team in St Andrew's house has a very developed understanding of how the NHS in Scotland is

performing, its financial position and its operational performance, and it acts as a conduit. There is a range of governance structures, accountability mechanisms and support across the NHS. I do not think that there is any shortage of insight that is shared between different boards about things that are working well. You mentioned pressure. I suppose that, equally, it will be about grasping the opportunity if one board is performing well and applying that in other parts of Scotland.

We mentioned the financial delivery unit, and there is the Centre for Population Health. Public Health Scotland also plays an important role that spans the NHS and local government in its sponsorship of the application of good practice across health and social care settings. Therefore, there is no shortage of structures; it is about helping NHS boards to be able to manage the intense pressure that they are facing, as we set out in our report in relation to some of the indicators, and supporting them to transition to a preventative model so that they can deliver against some of the improved outcomes that we all want to see.

James Dornan: I have one more question about waiting list times. Earlier, you talked about England being ahead of Scotland in bringing down the number of people who are on waiting lists for more than two years. There are reports that Scotland is ahead of the rest of the UK for A and E waiting times. Is there a correlation between those two things? Is there a focus on one aspect, to the extent that it causes a delay in the other?

Stephen Boyle: I am not sure that I am able to give you an assurance on that one way or the other. Colleagues may want to come in on that. In paragraph 73 of our report, we note that the A and E waiting time standard is an indicator of pressure in the system. As you and the committee will know, the performance target is for 95 per cent of people to be seen and admitted, discharged or transferred, as appropriate, within four hours. The performance has remained at around 70 per cent in NHS Scotland.

Ultimately, the prioritisation of A and E performance or waiting list times in different parts of the UK will be at the discretion of different jurisdictions.

On whether there is a direct correlation, I suspect that that is a question that is more for health economists than me, but I will pause to see if any colleagues wish to offer a view.

Leigh Johnston: It is a question that we are asked most years. We rarely compare NHS Scotland's performance indicators with those of NHS England. NHS England and NHS Scotland are structured very differently from each other, and the way in which they measure targets can be different. There are too many differences and caveats involved for us to robustly compare different performance indicators.

The overall message that the Auditor General was giving was just about the numbers of people on waiting lists, but we do not know what lies underneath that in terms of the way in which elective services or A and E services are delivered, and those things differ between NHS England and NHS Scotland. That is why we tend not to compare NHS Scotland with NHS England in our annual reports.

James Dornan: I would not have attempted to either, if it had not been brought up earlier. I thought some work might have been done that showed that there was some sort of correlation with regard to the issues of people waiting more than two years and the A and E waiting times.

I have one more question, Auditor General. Your report notes that new out-patient attendances and in-patient admissions have increased steadily over three years, yet planned activity remains lower than pre-pandemic levels. In your assessment, what factors are contributing to that, particularly in relation to specialties such as orthopaedics, where waiting lists are the longest? What steps can be taken to ensure that progress in reducing long waits for treatment is accelerated?

Stephen Boyle: The relevant numbers are set out in exhibit 9 and the detail that underpins them is in the following paragraphs.

Forgive me for being glib, but the factors that drive that situation are complicated. The explanation will relate to prioritisation of service. The report sets out issues around the medical condition in which patients are presenting—they are presenting in a more sick state than was the case before the pandemic. Covid remains a factor in the ability to treat people and manage throughput in hospitals. Also relevant are some of the issues that we touched on earlier, about staff turnover and absence levels, and there are issues around the quality of infrastructure. We have not touched on that this morning, but the NHS estate in Scotland is ageing, and it is becoming more expensive to maintain it adequately. Those are all factors behind why, four years after the pandemic, we have still not quite recovered.

Bernie Milligan can cover those issues in a little more depth.

Bernie Milligan: What we are seeing is that, although there has been an increase in activity, particularly with regard to in-patient and day cases, where there has been a 10 per cent rise in the past year, demand is still exceeding that growth. We have already discussed some of the complex factors around productivity in that regard.

Obviously, the delays with the national treatment centres and the pause in the establishment of the further centres is having an impact in terms of the ability to provide additional capacity that helps to tackle the backlog that has built up.

A range of other activities is going on, particularly within the national elective co-ordination unit, which is working with boards at a central level to validate waiting lists. That is helping to make sure that waiting lists reflect who needs care and that anyone who does not need to be on the waiting list can be removed, which can free up appointments that can be reallocated elsewhere. There are some reports that that is starting to free up thousands of appointments.

Things are happening at the granular level in different areas, but it is not having that impact on the headline indicators, and we are still seeing that growth in waiting lists. It goes back to the point about transparency and knowing what is working, what is starting to have an impact, and what can be scaled up.

10:45

The Convener: We have just a few minutes left, but there is time for a couple of questions from the deputy convener to finish the session by looking at a couple of other aspects of operational performance.

Jamie Greene: James Dornan raised some important issues there. I want to carry on with that theme, and particularly A and E. As has just been mentioned by one of your colleagues, Auditor General, we are sitting at around 70 per cent of the target of being admitted, discharged or transferred for treatment within four hours. However, we know that there is a huge disparity across the country in how quickly someone will be seen, depending on where they live and the hospital that they are taken to. In NHS Forth Valley and NHS Lanarkshire, that figure is as low as 54 or 55 per cent of target, which is shockingly low. However, NHS Tayside and NHS Western Isles are at 90 per cent and 96 per cent respectively.

I can speak only from my own experiences. In my health board, my local hospital is Inverclyde royal hospital, and the figures there are quite stark. There has been an 8,000 per cent increase in people waiting in A and E for more than four hours and a huge increase in those waiting for more than 12 hours. Is there any understanding of why there are such huge health board disparities in NHS A and E waiting times?

Stephen Boyle: I will bring in my colleagues, but we recognise the regional variation. We set that out in the appendices to the report.

Ultimately, the variation refers to unscheduled care, or people who are presenting either in emergency or accident circumstances at a hospital rather than having taken a planned approach through primary care services or planned attendance at hospital. One of the other relevant factors is that there are also planned attendances at A and E through engagement with GPs. Bernie Milligan or Leigh Johnston might want to say a bit more about that.

We recognise that the Government knows that this is an issue and is looking at some of the detail around why there is regional variation and why people present at hospital in an unplanned way. We are looking at those pathways through what is referred to as the urgent and unscheduled care collaborative.

Work is under way to better understand that. Primarily, we need to get to the point at which the sharing of good practice among different A and E departments means that patients are not accessing A and E as a protocol once they become ill, but rather that they have much earlier engagement with primary care services. I will pause if colleagues wish to develop that.

Bernie Milligan: We have not looked in detail at regional variations. Obviously, performance remains poor pretty much across the board, with the odd exception of boards such as Western Isles meeting the target and so on.

Leigh Johnston: Jamie Greene's question was about why there is variation, and it is a complex mixture of factors. As we have already talked about, there are different pathways that people can take to A and E now. Some of those pathways will operate by diverting people away from A and E or into planned attendances, and some will be operating more effectively and efficiently in some areas compared to others.

However, as we have talked about previously in the committee, one of the big things that has an impact on A and E is the space in hospitals to transfer people out of A and E to enable more people to flow through. Delayed discharges also come in there, and we know that there is huge variation in the number of delayed discharges in hospitals across the country. The Scottish Government is working intensively with some boards to address delayed discharges. Again, that varies, and it will impact on A and E and the flow of people through the system.

Jamie Greene: You have segued nicely into my next question, which is on delayed discharge. The report sets out some quite stark figures in that respect. On average, around 1,800 hospital bed days are being used up by people who should not be in hospital—and that is every single day. That equates to around 666,000 hospital bed days per

year being used up by people who should not be in hospital. In fact, at its peak, the figure sat at over 2,000 hospital bed days.

That is creating problems—it is creating capacity issues and issues down the line. It is also creating issues for the patients themselves; at the end of the day, there are people—sick people—involved in all of this. Nobody wants to be in hospital when they do not have to be there, and there are people in hospital who do not have to be there—it is as simple as that. Is there any evidence that the Government is tackling delayed discharge, given the number of very high-profile promises that it made to reduce or, indeed, eliminate it? These figures seem to be going absolutely in the wrong direction.

Stephen Boyle: That question raises various things, and Carol Calder might want to say something about it in a moment.

I think that you are referring to exhibit 10. There is absolutely a recognition from the Government on the need to progress with a range of initiatives in order to address the totality of what is a really serious issue. The numbers are quite stark, in terms of the number of daily bed days as well as the totality of the extra 666,000 hospital days involving people who did not need to be there. There is also regional variation across Scotland.

The only thing that I would say before Carol, if she wishes, speaks to the issue is to highlight again to the committee that, together with the Accounts Commission, we intend to undertake some detailed audit work on delayed discharges during 2025 to track the progress of some of these initiatives, the system-wide factors that are driving such delays, and the Government's progress in addressing them, together with local authorities' intentions in that respect. We will come back to the committee next year on that point.

Carol Calder: You are right that we have not seen improvement yet. In our report last year, we set out a range of Scottish Government initiatives to try to tackle delayed discharges, and I have to say that it does not look like those targets will be met. We have already mentioned the Centre for Sustainable Delivery, and there is also a delayed discharge and hospital occupancy plan, which was brought out in March 2023, and which boards are currently self-assessing against.

The hospital at home initiative has been quite successful, with an estimated 14,000 individuals prevented from being admitted to hospital in a year. However, the Scottish Government funding for that was non-recurring and ended in March, and we know that some boards are stepping back from the approach, which is unfortunate, as it seemed to be supporting more people in their homes and helping avoid hospital admissions.

We can say that there has been some improvement from last year, not in the figures themselves but in the data that is available to boards. There are now two dashboards that boards can use to monitor and make decisions around delayed discharges, and the collaborative response and assurance group has been set up by the Scottish Government and the Convention of Scottish Local Authorities to look at the wider issue of how social care and acute health are interacting. There is also the rapid peer review and response team, which provides practical support to specific boards that are particularly struggling.

However, you are right to point out that there is more to be done to unpick and understand why there is such regional variation. One might think that it is related to population. However, as we say in the report, we find that, in Highland, where, with its population, you would expect the figure to be a bit lower, it is actually much higher, whereas in Tayside, where you would expect the figure to be high, it is actually quite low. We know that the Scottish Government is doing a lot to try to understand the drivers at the local level, and as the Auditor General has mentioned, we will start some work in 2025 to take that forward.

The issue has a huge impact not only on patient flow and hospital occupancy, but on people. There are people coming in through A and E who cannot be seen in time because they cannot be moved to a bed; there are people who are receiving care in inappropriate places; and there are people who cannot get home and are suffering in hospital, because requirements for packages of support, adaptations or whatever are holding up their discharge.

Being delayed in hospital is linked to poorer outcomes and certainly much lower levels of experience and satisfaction for people who are stuck in that unfortunate position. It is a significant issue, and we are recognising that through our plan to do a piece of specialist or focused work on the issue next year.

Jamie Greene: That is helpful and insightful, and I agree with much of what you have said. At the end of the day, the people who are involved are often sick or elderly. People just want the best treatment for their family members and loved ones—they want them to be looked after in the right place. It seems to me that the blockage at that end is causing massive issues in the process, right from A and E all the way through to care. That must be addressed.

The page in your report that struck me the most is page 48, which is in appendix 3. We often get graphs and tables in your helpful reports, and the table on page 48 really stood out as the most shocking one. It is not on A and E but on planned care. The three main targets by which we measure

the success of the NHS are on out-patients, in-patients and planned care treatment times—the targets on those are 95 per cent, 100 per cent and 90 per cent respectively. That is ambitious and the targets are high, but not one of them is being met.

In the way that you present data to the committee, we expect to see little green ticks next to any targets that are met. On page 48, not a single health board in Scotland has a green tick next to it. Not a single health board in Scotland is meeting any of the out-patient or in-patient targets. That is shocking.

Stephen Boyle: The table illustrates the scale of pressure and challenge and, in our view, the need for a clear plan. Although any new investment will no doubt be welcomed by the NHS, I do not think that there is enough evidence to suggest that continuing to deliver services in the current way will make the step change in measurable impact that is required. Statistics on a page matter, but it is also about the impact on people who are waiting for treatment, for today and for years down the line. We absolutely recognise the significance of those numbers.

Jamie Greene: How many people have died while on an NHS waiting list?

Stephen Boyle: I do not have that detail, unfortunately.

Jamie Greene: I mention that because your report highlights that, in June 2019, 250 Scots were waiting for more than two years for in-patient treatment, and the figure has jumped to 7,100. Even just a small percentage of those people who are waiting and waiting for treatment might not make it—that is a piece of statistical analysis that one can do. As a percentage of 250, the figure would, I hope, be relatively low but, as the number waiting nears 10,000, you are talking about hundreds if not thousands of people not making it.

I guess that the point that I am raising is whether we should look at that. Could a piece of work be done on needless mortality in Scotland as a result of horrendously long waiting lists?

Stephen Boyle: I am sure that that would be of interest to many people, especially those who are on waiting lists. As well as the deeply regrettable fact that people pass away while on waiting lists, the situation also impacts quality of life for those who are waiting. It is a very significant issue to be tackled. As I mentioned, investment will go some way towards tackling that but, ultimately, to deliver the cabinet secretary's vision for a prevention-based model, we recommend translating that to a clear delivery plan as one of the key next steps.

Jamie Greene: Do we have too many NHS boards in Scotland?

Stephen Boyle: That is a structural issue and one of policy. It is for the Government to determine how it wishes to discharge its responsibilities on that, so that is not for me to comment on.

Jamie Greene: Okay—thank you.

The Convener: I will draw the evidence session to a close at that point. In doing so, I thank the Auditor General very much for the evidence that he has given us. I also thank Carol Calder, Leigh Johnston and Bernie Milligan for their input. We have quite a lot to think about and we need to consider what our next steps might be. Thank you very much once again for your time and input.

I now move the committee into private session.

11:00

Meeting continued in private until 11:35.

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