OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit and Post-legislative Scrutiny Committee

Thursday 15 November 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 15 November 2018

CONTENTS

PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE
25th Meeting 2018, Session 5

CONVENER

*Jenny Marra (North East Scotland) (Lab)

DEPUTY CONVENER

*Liam Kerr (North East Scotland) (Con)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Caroline Gardner (Auditor General for Scotland)
Leigh Johnston (Audit Scotland)
Claire Sweeney (Audit Scotland)
Kirsty Whyte (Audit Scotland)

CLERK TO THE COMMITTEE

Lucy Scharbert

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit and Post-legislative Scrutiny Committee

Thursday 15 November 2018

[The Convener opened the meeting at 09:00]

Interests

The Convener (Jenny Marra): Good morning and welcome to the 25th meeting of the Public Audit and Post-legislative Scrutiny Committee in 2018. I ask everyone to switch their electronic devices to silent, please, so that they do not affect the committee's work.

Item 1 is a declaration of interests. I invite Anas Sarwar to declare any interests that are relevant to the committee's work.

Anas Sarwar (Glasgow) (Lab): It is a pleasure to be on the committee. I have no interests to declare.

The Convener: Thank you, and welcome to the committee.

Decision on Taking Business in Private

09:01

The Convener: Under item 2, I invite members to agree to take items 4 and 5 in private.

Members *indicated agreement.*

"NHS in Scotland 2018"

09:02

The Convener: Item 3 is on the section 23 report, "NHS in Scotland 2018". I welcome our witnesses from Audit Scotland: Caroline Gardner is the Auditor General for Scotland; Claire Sweeney is audit director of performance and best value; Leigh Johnston is a senior manager in performance and best value; and Kirsty Whyte is an audit manager. I invite the Auditor General to make a short opening statement.

Caroline Gardner (Auditor General for Scotland): Today's report looks at how the national health service in Scotland performed in 2017-18. I have for a number of years been highlighting the increasing pressures that are facing the NHS. They have now reached the point at which decisive action is needed in order to secure the future of that vital service.

NHS staff are committed to providing high-quality care, and patient satisfaction remains high, but the quality of care is under pressure. NHS boards met only one key national performance target in 2017-18, and performance against the targets declined. No NHS board met all eight targets and more people are waiting longer to be seen.

The NHS is not currently in a financially sustainable position. NHS boards struggle to break even and they rely on a mixture of brokerage and short-term measures to balance their books. Boards made unprecedented savings of £449 million last year, but they relied heavily on one-off savings and are finding it harder each year. Cost pressures continue to intensify, with rising spending on drugs, high levels of backlog maintenance and continuing difficulties in recruiting staff. The focus continues to be on the short term, rather than on planning for the longer term.

The Government's medium-term health and social care financial framework and the other measures that have been announced recently are a welcome step. The detail of those will be important, together with the full impact of the United Kingdom Government's announcement on NHS funding. However, it remains essential that the underlying challenges that face the NHS in Scotland be addressed.

Transforming how healthcare services are provided will bring real benefits to patients, but urgent focus on the things that are critical to success is needed. Those include effective leadership, longer-term planning and ensuring that governance arrangements are clear and robust. Most important, without much more engagement

with communities about new forms of care and the difference that they can make to people's lives, it will continue to be difficult to build support among the public and politicians for the changes that are required.

As always, my colleagues and I are happy to answer the committee's questions.

The Convener: Thank you very much. I will start the questioning. There seems to be a little discrepancy between what the report says and what the First Minister said about the health budgets in the chamber at First Minister's questions on 25 October. That day, when questioned she said that

"Health boards are not facing cuts ... the health budget has increased in real terms ... by 7.7 per cent."—[*Official Report*, 25 October 2018; c 15.]

However, your report clearly states that there was

"a 0.2 per cent decrease in real terms on the previous year."

Will you outline for us whether there have been cuts to the health boards?

Caroline Gardner: We try to address that in part 1 of the report—in particular, on pages 8 and 9. The answer is that it depends on the way that you define them. I direct your attention to paragraph 8 of the report, where we set out that

"Between 2016/17 and 2017/18, the overall health budget increased by 1.5 per cent in cash terms"

which is a decrease of 0.2 per cent in real terms, when inflation is taken into account. That is the overall budget.

When you break it down into revenue and capital, the picture is different. Revenue funding for day-to-day spending increased by 0.8 per cent in real terms, which is 2.5 per cent in cash terms, but the capital budget reduced quite significantly by 23.5 per cent in real terms. That reflects, to a large extent, the completion of the Dumfries and Galloway royal infirmary and the near completion in Edinburgh of the new Royal hospital for children and young people and the department of clinical neurosciences. Overall, there was a slight decrease in real terms, but the revenue budget went up slightly in real terms.

The Convener: So, the answer is dependent upon how you define things and on which year you look at, over the piece. Your report points quite clearly to increasing demand on our health service. Can you give the committee a flavour of that? Are the individual boards feeling financial pressure as a consequence? Does it feel to them as though they have to make cuts because they have less money?

Caroline Gardner: Kirsty Whyte can give you a bit more detail on that but, in summary, yes, we believe that it is harder and harder for boards to manage their budgets and break even at the year end, and more and more of them are relying on short-term measures to do that.

Kirsty Whyte (Audit Scotland): As the Auditor General said, boards have for a number of years been relying on short-term measures, and that has intensified in the past year. In the report, we give some examples of the ways in which boards have been trying to break even this year. For example, they have been moving capital to revenue funding and vice versa. There have also been late allocations from Government. A lot of what they have been doing involves non-recurring savings. We made that point in previous reports as well as in this report. That is all combined with intensifying cost pressures, which we set out in exhibit 5 of the report. I am happy to go into that in more detail as questions come up.

Alex Neil (Airdrie and Shotts) (SNP): The key message of the report is that, as things stood at the time of writing, the NHS in Scotland is not financially sustainable. Since the work was done, however, we have had the announcement that, by 2023, spending on health will go up by £20 billion a year south of the border, and that there will be consequentials for Scotland. That process will start next year. Have you had a chance to consider the impact on the report's conclusions of the additional funding that we might expect?

Caroline Gardner: I start by saying that the conclusion in the report is that the NHS is not financially sustainable in its current form—I stress those last words. There are ways of transforming it to make it financially sustainable. Alex Neil is right to say that there have been a number of relevant announcements, including the United Kingdom budget and the consequentials that will come to Scotland from it. There are also the Cabinet Secretary for Finance, Economy and Fair Work's medium-term financial framework for health and care and some other announcements around brokerage and removal of the requirement to break even on an annual basis.

We are still waiting for the detail of some of that, and we will continue to consider those issues. However, our clear conclusion is that, although those things will provide a bit of welcome breathing space, they will not address the underlying challenges, which are twofold. First, as Kirsty Whyte suggested, healthcare costs tend to increase more quickly than general inflation in any case and, secondly, we have an ageing population, which means that we will in the future require different forms of health and social care from the sorts of things that the NHS was set up to do 70 years ago, which were much more about treatments and cures.

We show in the report that the NHS budget currently accounts for about 42 per cent of the total Scottish Government budget. Clearly, there is a limit to the extent to which you would be able to continue increasing that proportion without crowding out other vital services such as education and early years provision. The announcements that we have seen at Scotland and UK levels will help, but they are not a substitute for making the sorts of changes that we say in the report are needed.

Alex Neil: What are the three most important changes that are required in order to get the NHS into a financially sustainable position?

Caroline Gardner: We set out three things in the report that we are discussing, and in the report that we published today on health and social care integration. The first is clear leadership at national and local levels to ensure that the pockets of good practice that we see are being developed and spread more widely. The second is much better longer-term planning for what the service will cost and what investment is needed to get us from where we are now to where we need to be. The third is much better engagement with individual people, communities and staff in order to build a sense of confidence that we can in the future deliver measures that are not just a response to cuts, but are a way of meeting people's needs better than we currently can.

Alex Neil: Would you include in that an examination of overheads? If we include the 31 integration joint boards, the 22 health boards and the three regional structures, we find that 56 organisations are involved in delivery of the national health service—not including the substantial resource in St Andrew's house and in bodies such as the Mental Welfare Commission for Scotland. Is there an urgent need to consider that structure? I think that we would all agree that a problem for the health service down the years has been that every time a new structure is created it just adds to the existing structure and does not replace anything.

Caroline Gardner: That did not make my top three, which is what you asked for. However, in the report we say that the governance arrangements for health and care are increasingly complex. There is clearly a cost associated with that, and beyond that it makes it more difficult in some ways to achieve the changes that are required. Claire Sweeney will talk about our concerns in that regard.

Claire Sweeney (Audit Scotland): There is no doubt that it has become far harder to recruit to senior positions, and part of the story must be that we are looking for a greater number of top teams than has been the case in the past. On page 26 of our report, we give a few examples of recent instances when it has been hard to fill senior posts. That is an increasing concern.

Alex Neil: The other key part of all this is the exponential increase in demand, which we can expect to continue in the years ahead. As well as the need to look at overheads, is there a need for a robust demand-management strategy? Integration is key, obviously, but when I was Cabinet Secretary for Health and Wellbeing it struck me that we do not manage demand well. For example, spending more on prevention should, over time, reduce demand on day-to-day services.

Caroline Gardner: I would take a step back from demand management. On pages 17 and 18 of the report we say that trends in demand and activity are not currently well understood. Exhibit 6, on page 17, shows that the numbers of elective admissions, new out-patient appointments and repeat out-patient appointments fell last year. No one is sure whether that is because people are being treated better in different settings or because boards do not have the capacity to provide the services that are demanded.

Without having a clear picture of that, it is difficult to manage the flow in hospital and to plan alternative primary care and community-based services, which could provide better services to people. Those are really important questions.

Anas Sarwar: Alex Neil touched on leadership; I will come back to that, if I get a chance. Your report makes it clear that health boards have made savings of almost £450 million. Has there been analysis of the split between reduced running costs and service cuts?

Caroline Gardner: Kirsty Whyte probably knows more than anyone else here about that £450 million, so I ask her to talk through the big messages.

Kirsty Whyte: Savings are split into two elements: recurring and non-recurring. Recurring savings are what we typically regard as efficiency savings, which are the savings that we see year on year as a result of service redesign, for example. The main issue in recent years has been the significant increase in non-recurring savings—the one-offs, such as sale of buildings. That is a sign of the cost pressures that boards are under and the difficulties that they face in finding savings.

The pressures are also reflected in the increase in unidentified savings at the start of years. We find that, at the start of the financial year, boards are unable to identify what savings they will try to make.

The key element is the increased level of non-recurring savings. We have said this year, as we

have said in previous years, that the level is not sustainable.

Anas Sarwar: You mentioned the challenges that come from making it clear to boards that they need not break even at the end of year and from writing off brokerage. Is there a risk of appearing to reward the bad behaviour of boards that did not manage their finances well? Is there a risk of further chaos in future years, given that boards no longer need to worry about breaking even at the end of the year?

09:15

Caroline Gardner: Since I took this job, I have recommended that the health service move away from a sharp focus on annual financial balance, because that makes it harder to achieve long-term financial sustainability. I welcome the move, in that respect.

We are still trying to understand fully how the new requirement to break even across a three-year period will work in practice. Although the write-off will be welcome for boards that have outstanding brokerage, boards that have significant brokerage, such as NHS Tayside and NHS Ayrshire and Arran, currently have no plans to repay the money anyway, so the write-off makes no immediate difference to their financial standing.

As I said in response to an earlier question, all those moves are welcome in that they give breathing space to boards that are facing real financial pressures, but they do not help to address the underlying challenges. It is important that that is done in order to get underlying sustainability back.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I have a few questions on governance and leadership, but first I have a more general question. On page 23 of the report, key message 3 says that

"The healthcare system needs to become more open. People need to be able to take part in an honest debate about the future of the NHS."

Who do you envisage those people to be?

Caroline Gardner: The debate needs to take place at a number of levels. Any doctor or nurse in Scotland would know that the health service needs to change in order to meet the needs of an ageing population. Fewer people need to go to hospital to be treated and cured, and many more people need support for long-term conditions such as diabetes, for pulmonary diseases or for diseases that are associated simply with getting older and more frail.

There is wide consensus that the Government's vision is right, but changing health services is difficult. People are very attached to their local hospitals and the services that they know, so it is hard for them to accept flexible community-based services that do not have a building attached to them, and do not have a history.

We are looking for people to be involved at national level, with Government and the national clinical organisations talking about the changes that need to happen and which will improve services. There needs to be debate at health board integration authority level and at the very local level, with individual general practices and communities. There will not be a quick fix; it will take time.

There also needs to be more openness about why change is needed and about the way in which change will be funded and managed over a period of time, in order to build confidence that it is not just about cuts.

Colin Beattie: It will probably be fairly challenging to achieve that debate with that scope of people.

Caroline Gardner: It will involve all of us. The transformation that is required will be challenging, but there is no substitute for it.

Colin Beattie: In relation to that, paragraph 77 says:

"there continue to be many examples of public and political opposition to attempts by NHS boards to change how services are delivered."

I would appreciate hearing your definition of "public". You talk about "political opposition". Does that mean that local councils and local councillors are intervening to prevent change?

Caroline Gardner: Politicians at local and national levels are doing that. We can all think of examples throughout Scotland of proposals from health boards to transform the way in which services are provided. Very often, there are grass-roots campaigns against such proposals because engagement has not been done well, so people do not understand why change is needed or what is being proposed. Such campaigns often attract support from local and national politicians. We all understand why, but it can be a significant block to making changes that not only would help with financial sustainability but which clinicians see as being better services for the longer term.

The issue goes back decades in Scotland and more widely. However, given the intensity of the pressures that the health service is facing, it is becoming more and more important to start opening up conversations and looking at ways in which services can be changed to make them sustainable for the future.

Colin Beattie: To me, governance is the lead board of the local organisations. You have been fairly harsh in your comments about the difficulties in filling the positions, and the committee has discussed with concern the quality of some members of the boards of the various organisations.

You have mentioned delays in appointments, how effective they are and so on, but how do we change that situation? There is a huge demand across Scotland for non-executive directors, but you seem to be saying that the supply is not sufficient to meet it. If that is the case, how do we change the model to compensate for that?

Caroline Gardner: I will ask Leigh Johnston to talk about executive recruitment, because that, too, is a challenge, but I think that we need to look at the demand and supply sides of this. Alex Neil has asked about the number of bodies involved, and it is obvious that the more bodies we have, the more difficult it becomes to recruit people of the right calibre and with the right experience to do the job that needs to be done. At the same time, the jobs themselves are getting more difficult because of the scale of the challenge, the political—with a small p—climate in which people are working and the extent to which the jobs themselves are seen as being very difficult. None of that is helped by the continuing pressure on public sector pay and the many changes to pension taxation that we have talked about in this committee before.

Can you add a bit of colour to that, Leigh?

Leigh Johnston (Audit Scotland): I think so. As we say in the report, there is work to be done to better understand why some positions—particularly that of chief executive—are difficult to fill. I would not like to speculate on that, but I know that the Government is undertaking work through project lift to develop leadership and talent for the future. It has a number of people on various courses—

Colin Beattie: But is that on the leadership side of things rather than the governance side?

Leigh Johnston: Yes. The project is for people looking to become executive directors in the health and care system.

Liam Kerr (North East Scotland) (Con): I will follow up on some earlier lines of questioning. First, with regard to Alex Neil's questions about the number of bodies, I will ask you a very blunt question, if I may, Auditor General. Do we have too many acute hospitals for the population, size and geography of Scotland?

Caroline Gardner: There are people who are better equipped to answer that question than I am, but I think that the strategy not just of the current Government but for a long time has been to recognise that the things that need to be done in acute hospitals form an increasingly small proportion of the overall demand on health and care as the population ages and that, as technology progresses, the need for specialisation increases. Indeed, that is one of the drivers of the regionalisation that we are seeing in the health service.

It is also important to understand what demand looks like in each area of Scotland and how that plays out in the balance between acute hospitals and much better community-based services that can avoid unnecessary admissions, treat people close to home or get those who need to be admitted home from hospital more quickly. I would not say that we can answer the question whether we need fewer acute hospitals; what we can say is that we need fewer people to be treated in such hospitals when they can be treated as well or better in their own homes.

Liam Kerr: Let us move on from Colin Beattie's questions about governance. The service clearly faces huge challenges, as you have laid out in your report, which means that very high-quality boards will be needed. However, it appears that that sort of thing is not consistent. Indeed, paragraph 71 of your report says that

"there is no consistent approach across the NHS to ensuring"

that a board will be of that quality. Moreover, in paragraph 72, you refer to work that was carried out by the Health and Sport Committee that suggested that not even the boards themselves think that they have the required skill sets. What more needs to be done here, and who will do it?

Claire Sweeney: In paragraph 71, we have set out some of the issues that arose in the course of this work with regard to boards' ability to tackle all the challenges that we have set out. Issues that need to be addressed include the need for a real understanding of the skills around the board table, the need to identify whether people have any additional needs that require additional support, the provision of training and development, and the need to assess board members to help them to do a good job. Some of that work needs to be done centrally, and there is absolutely a job for the Government to do in that respect.

We also indicate, in paragraph 73, some other factors that might get in the way of board members doing a good job. We have seen examples of incredibly lengthy board papers, with 600 pages of reports, and of non-executive board members having a limited time to go through all those reports and review them to inform decision making. That is very challenging, particularly given the context in which they are operating, so we see

real scope for additional support to ensure that boards have the skills, experience, time and information that they need to inform good decision making.

Liam Kerr: Additional support from whom?

Claire Sweeney: There is a role for the Government in that, and there could also be scope for support across the non-executive group, so that board members can support each other. We know that they come together to get training and support for new non-executive members on all public bodies in Scotland, and there may be scope for more joint work as a peer support group, but there is definitely scope for the Government to provide more support.

Liam Kerr: You have mentioned the collaborative approach across the non-executive field. The committee tends to see examples of boards having not performed quite so well—that is just a function of what we are here for—but I presume that there are a number of boards that you, having investigated them, would say are performing well, have quality members and are exemplars of good practice. Can you highlight any of those boards? Are they able to share their knowledge across the estate?

Claire Sweeney: There are examples of particular issues that certain boards deal with effectively. I would say that it differs from board to board. There is a place for the Government in thinking about sharing that good practice more effectively, demonstrating what a good board looks like, how it operates and what lessons are to be learned, and particularly in linking that to some of the issues that we have drawn out in the report, on which challenging decisions need to be made. For example, a degree of openness is required from boards in showing how they are performing and how they engage with their local communities to make difficult decisions about the future. That is variable across Scotland, so there is scope to do more to share good practice.

The Convener: Is the Government doing enough to facilitate that?

Claire Sweeney: There is more to be done.

Anas Sarwar: I will turn to workforce issues. It is easy to focus on the financial issues, but, in the day-to-day running of the NHS, workforce challenges are a massive issue. Every time workforce challenges are raised, we get the response from the Government that we have more staff than ever before. Is that the right measure?

Caroline Gardner: We have done a range of work on the NHS workforce—particularly on workforce planning, given how critical that is to the NHS's ability to provide the care and support that we all depend on. It is true that there are more staff working in the NHS than ever before, but that is not surprising given that we are spending more on the health service and that activity levels in general are rising. The real challenge is in thinking not just about how to fill the vacancies that are likely to arise but about the workforce that the NHS and care services will need in the future as the changes come. The work that we have published so far has found that such workforce planning tends to be focused much more on the supply side than on the demand side of the equation. It is not taking a step back and asking, "If we are reducing our reliance on acute hospitals and providing much more care near people's homes, what does that mean for the roles of doctors, nurses, allied healthcare professionals and care workers?"

Anas Sarwar: Do you accept that the current workforce planning has not allowed for a staff base to meet demand? Do you also accept that the workforce planning that has happened to date—with three separate publications on different parts of the workforce plan—has not yet led to a comprehensive workforce plan that looks at all parts of the national health service, that provides an integrated plan across all health boards and that creates a national strategy rather than individual health board strategies?

Caroline Gardner: A couple of years ago, we published a report on workforce planning in the acute sector, and a follow-up report that looks at the rest of the NHS is due next year. So far, we have found that workforce planning has focused on the processes by which vacancies will be filled instead of stepping back and asking what the overall demand is likely to be and how we can best meet that demand.

Anas Sarwar: So far, the number of consultant vacancies is up, as is the number of AHP vacancies, GP vacancies, nursing and midwifery vacancies and other long-term unfilled vacancies. In your report, you rightly mention the risk of Brexit. Would it be fair to say that we have severe workforce challenges before Brexit and that those challenges could be amplified by Brexit?

09:30

Caroline Gardner: That is very much what the report says. In exhibit 8, you will see that some of the workforce pressures in the NHS are increasing. On page 21, we set out the possible impact of European Union withdrawal, depending on the terms of the final deal. We are not alone in facing such pressures, because there are real pressures across the UK on the NHS and care workforces. That is partly a result of the ageing population and partly because fewer young people coming out of schools and universities are filling the available training places. That just adds to the

need to think much more creatively about future demand and how we can provide the services that are required.

Claire Sweeney or Leigh Johnston might want to add to that.

Claire Sweeney: The NHS is full of people who are doing a good job and are dedicated to ensuring that patients receive the good-quality care that they need in a timely fashion. Some of the future challenges are related to EU withdrawal and the difficulty in filling posts, but a slightly different issue is the extent to which it is recognised that services need to change. Those changes will inevitably lead to changes in the workforce that is needed, because the jobs and roles will be different. There have always been questions about flexibility and about generalists versus specialists. Some of that questioning is starting to gather pace now, and people are starting to think about what a different model of care for people in local communities will require in terms of staffing and support and what that will mean for social care services. The integration joint boards, NHS boards and local authorities are starting to think through those challenges. There is therefore more work to be done around workforce planning, but it has to be done in the context of all those bigger challenges.

Anas Sarwar: The report also outlines an increase in sickness absence and staff turnover in the NHS, while sickness absence and turnover rates in social care are significantly higher. What do you put that down to? Is there a connection between financial pressures, staffing pressures and the impact on individual staff? Claire Sweeney rightly said that the staff who work in the NHS go above and beyond. What do you put the increase in turnover and sickness absence rates down to?

Claire Sweeney: It is very difficult to answer that question, because different things will be going on in different areas of Scotland. Work is under way to understand how happy staff are in their roles and what support they need in doing what are often difficult jobs. Rural issues can have an impact. In areas with small populations, the model has to be different and there are different expectations of the workforce. We know that it can be hard to fill key posts in some more rural areas of Scotland. A range of factors is involved, and boards have different activities under way to support their staff. There are still things to do on sickness absence and staff turnover, but the answers are different in different parts of Scotland.

Anas Sarwar: Representative bodies have highlighted a concern about vacancies not being advertised when people leave posts. Have you come across that? How would that impact on vacancy rates?

Caroline Gardner: You were talking earlier with Kirsty Whyte about non-recurring savings. One of the common ways in which boards attempt to make savings is by delaying filling a post when it becomes vacant. That helps the financial position, but it obviously does not help to provide services to the people who need them or to manage the pressures on the remaining staff.

Anas Sarwar: Does that delay mask the vacancy rate? Does it have an impact?

Caroline Gardner: Those posts are included in the vacancy rate, but it impacts on vacancies that have been empty for longer periods. You will see in the report that there are some quite high levels of long-term vacancies for doctors, nurses and, indeed, GPs.

The Convener: Claire Sweeney talked about staffing in rural areas. When we took evidence on the section 22 report, we discovered that two locum doctors in Caithness were being paid £400,000 each. Is that a sustainable way in which to fund the NHS?

Claire Sweeney: Through our work on the report, we have seen some of the more innovative approaches that have been taken in some island and very rural communities. The message is that the model needs to be different there. There is a job to do in thinking about what services are needed to support the local community and how they can be built in a sustainable way. There is also the issue of the mix of staffing and how their work might be very different in rural areas. However, all of that needs to be planned on a sustainable basis.

The Convener: But £400,000 has been paid to one doctor—are there any Scottish Government guidelines on that? Clearly, there was a need to get a doctor in place and the board felt that it had to pay more. In Audit Scotland's view, is £400,000 a reasonable salary?

Claire Sweeney: There is an issue about ensuring that the needs of the local community are being met. Whatever the service might be, and whatever the context that people are working in, there is a decision to be made about whether services are to be provided in the local area or whether more specialist services need to be delivered in different board areas. We see quite a lot of movement across Scotland. People will go to a different centre—a tertiary, specialised centre—to get care.

Local organisations need to think carefully about how they work with neighbouring boards, which services they are able to provide sustainably in their local areas and which services need to be provided through regionalisation. That is starting to happen, but we know that there is more work to be done on that.

The Convener: Auditor General, it is the job of this committee to follow the public pound. Is it reasonable to pay one doctor £400,000 to fill a rural vacancy?

Caroline Gardner: There is no doubt that £400,000 is an awful lot of money for any board to pay and for any individual to receive. However, I have some sympathy for our remote and rural boards, which have to keep delivering services. If they cannot recruit staff in any other way, they must pay the going rate to fill vacancies in the short term. In the longer term, as Claire Sweeney said, it is imperative that boards look at how they provide services and make the best use of taxpayers' money while meeting the needs of the local population.

The Convener: Is £400,000 the going rate?

Caroline Gardner: In very remote areas, there is sometimes no alternative to paying an individual—sometimes through an agency—shift by shift across the year in ways that add up to a significant amount of money. Across the piece, the amount that was spent on agency staff and locums in 2017-18 was down compared to the previous year's spending. I have no doubt that health boards are trying to manage the figure down as far as they can. However, we still see circumstances in which, if boards are to continue to provide a service, they have no alternative but to pay the rate that the market demands. None of us wants to be in that position, but, at the moment, without longer-term planning, the alternative is not to provide the service.

The Convener: The overall message of your report is that the NHS is struggling to be financially sustainable. Is that £400,000 salary for one doctor not a very good example of that pressure?

Caroline Gardner: It is an extremely good example of that pressure, which is one of the pressures that we pull out in the report as a whole. The challenge for the board is that, if it is not willing to pay that amount of money, it has to pull back a service from a community in an already fragile part of Scotland. This approach to much longer-term workforce planning and to planning how the service can be provided is essential to preventing that isolated example from becoming more common across the country.

The Convener: Have you seen any Scottish Government guidelines on how high boards should go, in terms of salary, to get a doctor into post?

Caroline Gardner: I do not know whether there are guidelines on what a cap might be.

The Convener: Should there be?

Caroline Gardner: I do not know. There are initiatives to reduce the reliance on agency staff in general and agency medical locums in particular, and we see the impact of those initiatives in a reduction of 10 per cent in the use of medical locums last year. The solution is probably less about having a cap on the figure, because that runs the risk of not being able to provide the service, and more about making sure that workforce planning is much more sustainable in the future than it was in the year just finished.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): I want to look at the relationship between the money that goes into the health service and the sustainability of the health service in the long term. Paragraph 10 on page 10 of your report shows quite clearly that, in the past decade, there has been a real-terms increase of 7.7 per cent in spending on the NHS. Only last week, the Cabinet Secretary for Health and Sport announced that an additional £3 billion would go in by 2023, which exceeds even the Fraser of Allander institute's estimate of what would be required just for the budget to stand still.

What I think that you are saying in your report is that it is not really all about money. Do you think that that level of investment will help us to get financial sustainability or do we need to do much more?

Caroline Gardner: There is no doubt that recent announcements by the Cabinet Secretary for Health and Sport and in the UK budget are helpful. The announcements will build in a bit of breathing space to deal with the immediate financial pressures, which have tightened again in the past year. At the same time, though, we know that the population will continue to age, which brings its own pressures, and that healthcare costs rise faster than general inflation. We already spend 42 per cent of the Scottish budget on the NHS—we cannot keep on increasing that indefinitely.

It is critical that we use the breathing space that the extra investment has bought to boost the speed at which the Government's policy of providing much more care in people's homes or in community settings is delivered. That is the right way to go, not just in terms of financial sustainability but to meet the needs of a population that is ageing and that expects different things from what our parents and grandparents expected. However, the pace at which the change is happening is not fast enough to meet the pace of the pressures as they ramp up.

Willie Coffey: That was what I was going to ask about. When would it be reasonable to expect to reap the fruits of the transformation? Is now too soon? You keep saying that we need urgent action and leadership on all the topics that you have identified, but when would it be reasonable to

expect to see that transformation having a real effect?

Caroline Gardner: The Government's 2020 vision policy has been in place since 2011 and, as the name suggests, the aim was that it would be in effect by 2020. It is clear that that will not be the case—we are very close to 2019 and there is still a long way to go. That is why we are seeing those pressures on the NHS and social care.

Today, we published a report on health and social care integration, which is a key part of how the Government intends to deliver the changes. In that report, we say that there are indications of some welcome improvements, such as reductions in delayed discharges and more people at the end of their lives spending time at home, rather than in hospital. More importantly, it shows that the changes can work.

It is really important that the Government, the Convention of Scottish Local Authorities and the other bodies involved get behind the changes and begin to be more systematic about how they learn from and spread good practice. They must provide the leadership for making change happen across the country and engage people in understanding why the change is important, needed and not just about cuts.

Willie Coffey: At a previous meeting, we mentioned that the NHS cannot do it alone. There are various partnership arrangements, not least with the different councils—for example, in the NHS Ayrshire and Arran area, there are three councils that are key players in the transformation strategy. Is that approach working as effectively as it should be in achieving delivery? That might be referred to in the report that you mention. Let me put it another way: does the pace of the change need to accelerate to deliver the benefits that we seek?

Caroline Gardner: The short version of today's report would be to say that the picture varies—there are some good examples, but they are not nearly widespread or fast enough. Many of the things that we think are needed are the same as those that I described in response to Mr Neil's earlier question. It can be done, but it is not being done fast enough to relieve the pressures that we talk about in the report.

Willie Coffey: Finally, your report says that, at the moment, the NHS is not in a financially sustainable position. Will the transformation strategy—if we get close to achieving it—ultimately make the NHS in Scotland financially sustainable? If not, we need to think of something else.

Caroline Gardner: We think that it can do. We have said in the report that we are discussing and in the report that we published today that we need that longer-term planning, including financial planning. It may be that some pump-priming investment is needed in some areas of Scotland to get from the current model to where we need to be. However, all of the indications are that, for the health service in Scotland—and, much more widely, across developing countries—that is the way of squaring the circle of increasing demand and changing expectations. We need to make that happen more quickly than it is currently happening.

Bill Bowman (North East Scotland) (Con): In paragraph 67 of your report, you discuss the fact that the director general of health and social care is also the chief executive of NHS Scotland—that is a dual role. The report says:

> "The Chief Executive is responsible for the day-to-day performance of the NHS and for implementing Scottish Government health policies. The Director General is responsible for holding the NHS to account for its performance and how well it has implemented Scottish Government policies."

Whether or not a real conflict exists, there is a perceived conflict. How should that be handled?

09:45

Caroline Gardner: The detail of how the issue is resolved is for the Government and the cabinet secretary to think through. The job is very big, given the scale of the challenge, and there is a tension between running the health service as it stands and being accountable for its performance, and thinking about how it will change in the context of integration, which involves working with councils and a range of other partners. There are different ways of dealing with that, but combining the two roles in one person creates a very big and potentially conflicted job to carry out.

Bill Bowman: I take it from that that the roles should perhaps be separated.

Caroline Gardner: That is one option, but it is very much for the cabinet secretary to consider how she wants to deliver the roles.

Bill Bowman: What other options are there?

Caroline Gardner: In response to Mr Neil's questions, we talked about how governance of the NHS and care has changed in recent periods. We now have formal statutory roles for the integration authorities alongside health boards and councils. A question arises about where that accountability sits. In other places, policy and delivery are separated, which is an option. The options that could be considered all involve thinking more seriously about the health and care system as a whole, rather than thinking about the NHS as one part of that.

Bill Bowman: I go back to the roles. You spoke about the need for good leadership. Do we get that from those roles?

Caroline Gardner: Given the scale of the job and the scrutiny that the roles come under, they are difficult to carry out. The situation is made more difficult by the number of jobs that we need to fill, which are increasingly difficult to fill. Claire Sweeney will add a bit on the basis of the work that she has done.

Claire Sweeney: The roles are difficult to fill for exactly the reasons that we have talked about—

Bill Bowman: I am talking not about filling the roles but about how they are being executed.

Claire Sweeney: How the roles are fulfilled varies. It is difficult to build all those good senior teams, given the number that need to be—

Bill Bowman: It is one person who does both roles at the moment.

Claire Sweeney: I am sorry—what are you asking about?

The Convener: We need a bit of clarity. I think that Ms Sweeney is talking about chief executives of health boards, whereas Mr Bowman is talking about the chief executive of the NHS in Scotland. I ask Mr Bowman to rephrase his question so that Ms Sweeney is clear, please.

Bill Bowman: We have had comments about the need for good leadership. Does giving the two roles to one individual provide good leadership?

Claire Sweeney: The messages in this report and in the report on integration, which highlight challenges and things that are and are not working in the system more generally, apply equally to the Government. There are challenges for the senior leadership team in the Government, and there are messages in the NHS report on the need for clarity about what is being delivered and on the difficulty of recruiting to top leadership posts. I am not answering the question about the roles that you described in particular; I am talking about the top team in the Government, where some of the challenges apply as much as they do to the boards that we looked at in producing the report.

Bill Bowman: Is the leadership at the top working?

The Convener: I am not sure that it is entirely fair to ask Audit Scotland that question. We have had a good go at the subject, and I will move to Alex Neil.

Alex Neil: I will go back to questions that the convener asked. When the committee previously discussed the national health service, we touched on the two individuals in NHS Highland who got £400,000. Does that figure include the agency fee? I think that you were to send us details.

Leigh Johnston: We are drafting a letter, but we are still working with the board to understand the position. It sent us figures, but we did not feel that they were clear enough, so we are seeking further clarification. We will get a letter to the committee very soon.

Alex Neil: I do not blame Audit Scotland, but the question is fairly simple—how much did the doctors get and how much did the agency get? The private sector agencies, which I tried to do away with when I was the Cabinet Secretary for Health and Wellbeing, are a bunch of rip-off merchants of the first order. The fees that they get are ridiculous. It is bad enough that we are paying £400,000 for jobs that are worth nothing like that; we also need to understand better why NHS Highland felt the need to pay that amount for locums.

Having been the health secretary, I fully understand the challenges, and I do not suggest that the situation is easy. Will Audit Scotland supply us fairly soon with more details about the agency fee and any other associated costs? What were the circumstances and what did the health board try before it decided that it needed to employ two people at a cost of £400,000 each—plus, I presume, agency fees?

Leigh Johnston: We can seek that additional information and put it in the letter that we have agreed to send to the committee.

The Convener: What is the timescale for getting that information to us? Clearly, you have started that work.

Leigh Johnston: Yes, we have. We are waiting for a response from the board. It is clear that the agency fees were on top of the salary, but we are trying to clarify exactly how much the agency fee was.

The Convener: Your response will be helpful, although the committee can of course go straight to the board, which we will want to consider.

From the information that you have received so far, you must know which agency it is. Can you tell us that?

Leigh Johnston: I cannot recall off the top of my head what the agency is called.

The Convener: Can you give us a timeline for when we will get the information?

Leigh Johnston: As I said, we are waiting for a response from the board. I will try to hurry that along and I will get back to you within the next couple of weeks.

Alex Neil: It should not take two weeks. All it requires is someone to look it up—it is basic information. I would have thought that we should have that information by the start of next week. Two weeks is a ridiculous time to wait for basic information. The board must have the information ready to hand. Let us get the information and see how much money has been wasted on agency fees.

Caroline Gardner: We will convey the committee's urgency to NHS Highland. Obviously it is the board's information rather than ours, but we will come back to you as quickly as we can.

The Convener: I remind the committee that we are still undertaking scrutiny of the NHS Highland section 22 report, so we could raise that issue as part of that scrutiny.

Liam Kerr: I have a bit of a daft-laddie question on that point. Do doctors, nurses and other healthcare professionals ever come out of practice and set up locum agencies to supply themselves back into the NHS?

Caroline Gardner: I am aware that some of the agencies that provide healthcare workers were set up by former nurses—and, I suspect, former doctors—but agencies now tend to be larger organisations because of the extent to which they can generate revenue from the health service. We have reported on that as an issue in its own right. One risk of poor workforce planning is that there are incentives for people to work for agencies rather than for the health service and in ways that are not in the public interest. That is why good workforce planning is so important.

Anas Sarwar: I turn to the targets, or the patient treatment standards, as they are called. The report makes clear that only one of the eight key performance standards has been met across Scotland and that not a single health board has met all its standards. In response to the report, the cabinet secretary said in the chamber that the report does not take into account the new waiting times improvement plan. I presume that that is the case, because you were not assessing the future; you were assessing the past and the here and now. After previous reports, we have heard from the Government that there is a plan in place to get to grips with treatment waiting times but, year on year, that has not happened or has not worked. Is it fair to say that previous years' planning has failed?

Caroline Gardner: There is no doubt that it has become harder and harder for NHS boards to hit the eight key national standards in recent years, for all the reasons that we have been discussing. Achieving that will remain difficult while we see the combination of financial pressures, demographic pressures and the focus on the quality of care, which we all understand.

In our work, we have also reported a concern that the national standards look at only one part of the health and care system. They focus very much on acute care and do not look at what is happening in primary and community health services, let alone social care. One of the messages that I have been trying to convey through our work is about the need to look at the system as a whole to understand not just whether the national standards are achievable but the impact that those standards have on other parts of the system, which can often be the answer to the issue of prevention and reducing the pressure on the acute system.

Anas Sarwar: I agree on the point about holistic measures of care across all sections of the NHS, but I want to focus on the acute sector. The targets include those for cancer waiting times, for example, and we know that the earlier someone is diagnosed, the earlier they are treated and the higher their chance of survival, so they are crucial standards and targets. For how many years has performance got worse? Do you accept that the action that the Government has taken to improve the treatment standards has failed?

Caroline Gardner: The information on performance over a number of years is not captured directly in the report, but we have reported on it previously. Kirsty Whyte might be able to give you more detail on that. What we are seeing is another example of the pressures on the health service, and there is no quick answer to the problem that does not involve looking at the system as a whole.

The standards obviously matter to patients. You mentioned the cancer waiting time standards, which are very important to the people who are affected. Accident and emergency waiting times matter to people for all sorts of reasons. However, if we simply look at the acute system, we are not looking at the opportunities for treating people at home rather than admitting them to hospital, which might not be the best place for them and might break down their support systems, and we are also not looking at the investment that is needed to avoid unnecessary admissions and to treat people in more community-based ways that would meet their needs better. We cannot answer the question without looking at the whole system, which the national standards do not do.

Anas Sarwar: On the treatment improvement plan, there is a three-year plan to reach the current targets that have been set. Will future reports measure against the interim target that has been set by the cabinet secretary, or will they measure against the actual target or standard?

Caroline Gardner: In the past, we have tended to measure against both the targets and the standards, and we have provided that detailed information. That gives people a sense of the direction of travel as well as the performance in the year.

Liam Kerr: In response to Anas Sarwar's question, you mentioned the pressures on A and E departments. According to page 17 of your report, emergency admissions have increased by just less than 1 per cent since 2016-17. You will appreciate that I am very much working on my feet, but that is an increase of only about 5,000 cases a year. Given that we have 14 NHS boards, that is an increase in A and E of about one case per day per board. I appreciate that people might talk about damned lies and statistics, because I am going across the piece rather than targeting a particular area. Nevertheless, that is not an enormous increase in A and E, and it is fairly consistent, so it can be planned for and, presumably, the concerns about waiting times that Anas Sarwar mentioned can be addressed.

Caroline Gardner: To be clear, the figure in the exhibit on page 17 is on emergency admissions, not A and E attendances. A lot of people who attend A and E departments are treated and returned home or referred to somewhere else for treatment. There is a slight difference between the two things that your question touched on. I will ask Claire Sweeney to talk about the national picture on emergency admissions.

Claire Sweeney: In exploring the issue, the committee might be interested in looking at what the integration report said about the impact that integration is having more generally. Emergency admissions is one of the areas that integration was intended to improve.

When we examined the data this year, we looked at the pattern of rising demand and the seemingly slower rate of increase in throughput—people coming into the system, being treated and coming out the other end. It is not clear why that is the case. We have asked ourselves whether that means that demand is continuing to increase but the system has got as hot as it is able to get, so it is not able to get through the numbers that it was able to get through previously. There is a load of interesting questions.

We continue to find it quite difficult to get good data on some of the things that do not relate to acute hospitals. We know that, even with the data measures in acute hospital settings, there is a need to improve focus and to improve the definitions with regard to what is counted or not counted. For example, when people come to hospital with an emergency, there needs to be a better understanding of how they are categorised and how that compares with what happens in other hospitals.

When we have published reports about the activity in accident and emergency departments, we have found it very difficult to be specific about what that activity actually looks like in practice. We need to think about the data, too.

Liam Kerr: On that point, which relates to the convener's earlier question, who should lead that data capture? Claire Sweeney said that the Government has quite a big role to play. Should the Government step in and say that we need better data?

10:00

Claire Sweeney: There is absolutely a role for the Government, centrally, to think about how all the boards capture that information, what categories they use and what the priorities might be. However, again, that is not just for the boards to do. Increasingly, because the system is so interconnected, IJBs have an important role, and there is a need for a much greater understanding of social care-related issues. There is a job to be done centrally, but all the agencies must work together. The Information Services Division, which is responsible for a lot of the statistics, needs to be involved in that conversation as well.

There is a role for Government in ensuring consistency and agreeing centrally what the focus will be, but the process is now far more of a partnership endeavour than it has ever been. I do not think that it is possible for someone in the centre to say, "This is the answer: we'll count X, Y and Z to the exclusion of everything else." There needs to be more of a collaborative effort.

Willie Coffey: I have a question about public satisfaction with the NHS. I can remember a previous report that touched on that. It was quite high at the time, and I think that it still remains quite high. Can you confirm that? I think that, despite the challenges and the pressures that we all know about, public satisfaction with the overall delivery of NHS services in Scotland is pretty high.

Caroline Gardner: On page 20, we try to pull together what information is available about patient satisfaction, and paragraph 43 shows that, as you suggest, 98 per cent of patients in the 2018 patient survey rated their care and treatment as good or excellent, which is similar to the 2016 survey. Further, 91 per cent of people were positive about their experience of hospital staff, which, again, is slightly up on 2016.

However, there are some indicators that suggest that that is under pressure—as always, there is never a single straightforward picture. The percentage of patients who rate highly the quality

of care that is provided by their GP declined to 83 per cent in 2017-18, and people more generally found that they were not getting the opportunity to involve the people close to them—their families and friends—in treatment, where they wanted to do that.

It is a mixed picture. We also know from surveys of staff that the staff increasingly feel that their time to provide the sort of care that they want to is under increasing pressure. You can see that in exhibit 8. That gives you the sense that people are doing their absolute best, but that it is becoming more difficult to provide the quality of care that every healthcare professional would like to provide.

Willie Coffey: If the satisfaction rates are very high but we are not meeting particular targets in a range of areas, what message do we take from that?

Caroline Gardner: I think that it tells us that it is complicated. We know that people value the NHS and recognise the efforts that most staff are making to provide the best care that they possibly can. Patient satisfaction in the NHS tends to be high almost whatever the experience of people is on a particular occasion. However, things are becoming more difficult. It is a tribute to NHS staff that satisfaction rates are as high as they are, but we cannot expect the levels of intensifying pressure to be maintained indefinitely. Something has to be done to address the underlying causes.

The Convener: There are a few worrying aspects of the report, but I was particularly interested in the issue of the estate. On page 16, you say that there is a maintenance backlog of £900 million. However, the capital budget has reduced by a whopping 32 per cent over the past 10 years. Is that wise, given that level of necessary maintenance in our hospitals?

Caroline Gardner: One of the main messages of the report is that the Government needs to come up with a clearer capital investment strategy so that the changes that require to be made can be made. Kirsty Whyte can give you more details of the picture.

The Convener: First, I would like to clarify what you just said. You said that the Government needs a clearer investment strategy. However, paragraph 33 of your report says:

"The Scottish Government has not planned what investment will be needed."

Has it done any kind of planning of the capital maintenance investment that is needed in hospital and community health buildings?

Caroline Gardner: What is quite good in the health service is the survey of the condition of the estate and the investment that is required to maintain the estate as it stands. What we are not seeing is a strategy for what buildings, clinics and so on will be required for a new type of health and social care in future. Kirsty Whyte can tell you a bit more about that.

Kirsty Whyte: The first thing to say is that the capital budget has always ebbed and flowed, depending on key investments such as big acute hospitals.

The Convener: But the overall trend is a cut of 32 per cent over the past 10 years, even taking account of the new hospitals in Dumfries, Edinburgh and Glasgow. Is that correct?

Kirsty Whyte: Yes. What is interesting is that, every year, boards survey their estate. They provide a report about the performance of the estate and they must provide a property and asset management strategy, which sets out what they think they need their capital investment to be over the next five years. The most recent report on that stated that boards thought that they needed £3.3 billion of planned investment over the next five years. That figure comes from adding together all the boards' own assessments.

The Convener: Did you say £3.3 billion?

Kirsty Whyte: Yes. Two thirds of that is acute, and the rest involves varying assets.

Obviously, we do not know what the capital budget will look like going forward. That is why we have said that it is important that the Government has a national capital investment strategy. "Scotland's Fiscal Outlook", which was published in May, predicted that the capital budget might remain relatively static. The NHS is only one of a number of public sector services that will need capital, which means that it is important that the capital budget is used strategically in relation to new projects in order to drive that change.

The Convener: Auditor General, if I understood you correctly, you said that the Scottish Government is aware that investment is needed just to bring our buildings up to a standard that is acceptable now, but that there is no capital investment planning for what the future health service will have to look like in terms of health and social care integration. Is that not concerning? How will we be able to deliver that future service if we do not have the buildings and infrastructure to do so?

Caroline Gardner: That is a really good question, and it is a question for the Government. That has to be part of the more detailed strategic planning for what the health and care services of the future will look like in terms of what that will cost, what workforce will be required and what capital investment will be required. Some of the buildings that we have now might well be able to

be used for a different type of healthcare in the future, but others probably will not. We might need investment in GP surgeries, primary care health settings and other things, including technology, in order to provide healthcare differently. Having that investment strategy is one of the really important things that are required to make progress with the 2020 vision and to get from where we are now to where we need to be in future.

The Convener: Do members have any further questions?

Anas Sarwar: I have one final question.

Picking up on what the convener said, how can people plan for the long term if there is such a high maintenance backlog just now? There is a £900 million maintenance backlog, 45 per cent of which involves issues that are classed as high risk or significant. That is a staggering statistic. What is the Government's response to that?

Caroline Gardner: That is very much a question for Government. There is no doubt that choices always have to be made between different priorities for investment within the NHS, within health and care and across the Scottish Government more widely. We need to balance the investment that we make in today's hospitals and clinics with what we need for the future, and we need to think about the impact that prevention could have further upstream. We need to consider the issues in the round. What we have done is give you a sense of the challenge that the Government is facing.

The Convener: I thank the Auditor General and her team very much indeed for their evidence. We now move into private session.

10:08

Meeting continued in private until 10:56.

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