OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit Committee

Thursday 23 March 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 23 March 2023

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PUBLIC AUDIT COMMITTEE
10th Meeting 2023, Session 6

CONVENER

*Richard Leonard (Central Scotland) (Lab)

DEPUTY CONVENER

*Sharon Dowey (South Scotland) (Con)

COMMITTEE MEMBERS

Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Craig Hoy (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Stephen Boyle (Auditor General for Scotland)
Antony Clark (Audit Scotland)
Leigh Johnston (Audit Scotland)
Bill Kidd (Glasgow Anniesland) (SNP) (Committee Substitute)
Fiona Lees (Audit Scotland)

CLERK TO THE COMMITTEE

Lynn Russell

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit Committee

Thursday 23 March 2023

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Richard Leonard): Good morning. I welcome everyone to the 10th meeting of the Public Audit Committee in 2023.

The first item for committee members to consider is whether to take agenda items 3, 4 and 5 in private. Are we agreed to take those items in private?

Members *indicated agreement.*

"NHS in Scotland 2022"

09:00

The Convener: The main agenda item is consideration of the Auditor General for Scotland's report on the national health service in Scotland in 2022. It was released exactly one month ago today. We are pleased to welcome the Auditor General for Scotland, Stephen Boyle, to give evidence on that report. He is joined by executive director, Antony Clark; senior manager, Leigh Johnston; and senior auditor, Fiona Lees; all from Audit Scotland. You are all very welcome.

We have a large number of questions to put to you on what was an impactful report. Before we ask those questions, the Auditor General will make a short opening statement.

Stephen Boyle (Auditor General for Scotland): Many thanks, convener. Good morning, everybody. I am pleased to bring to the committee the "NHS in Scotland 2022" report. It focuses on the Scottish Government's NHS recovery plan, looks at the progress to date against the plan's ambitions and examines the challenging operating environment and its impact on delivery of the plan.

The NHS continues to be affected by the impact of Covid-19, and a growing range of financial and operational challenges are making progress with recovery extremely difficult. NHS finances remain under severe pressure in spite of growing health spending. Rising inflation, increasing recurring pay pressures and on-going Covid-19-related costs cast doubt on the financial sustainability of health services. Both the legacy of Covid-19 and a challenging winter period are affecting how the NHS operates. The flow of patients through hospitals continues to be impacted by issues in the social care sector, leading to pressures throughout the healthcare system. The backlog of care that built up during the pandemic continues to grow, and the health and wellbeing of people waiting for treatment is being negatively impacted by longer waiting times.

The Scottish Government's NHS recovery plan was intended to tackle the backlog of care and to drive forward innovation and reform to make services more sustainable, but it lacks detailed actions that would allow the overall progress to be accurately measured. It is already clear, though, that delays to the opening of some of the series of new national treatment centres will mean that targets for increasing planned care activity will be missed. Some key recruitment targets in the recovery plan are not currently on track—some are—and that risks the successful achievement of the recovery ambitions.

Reform is essential if NHS services are to be delivered sustainably in the long term. Urgent action is needed on tackling the long-term demand for NHS services by improving people's health and reducing health inequalities. There is some progress on innovation and reform, which is welcome, but it is at an early stage and its longer-term impact is not yet known. It is vital that the Scottish Government presses ahead in those areas and monitors progress carefully to ensure that innovation and reform are having a positive impact. It must also make sure that there is clear communication with the public on how services may change in the future.

Lastly, the report highlights the need for greater transparency on progress against the Scottish Government's recovery ambitions and on clearing the backlog of care. The Scottish Government must make better use of its annual progress updates, reporting against the recovery plan, to provide an accurate and comprehensive summary of progress.

Convener, as ever, my colleagues and I look forward to answering the committee's questions as best as we are able.

The Convener: Thank you very much indeed. Without further ado, I invite the deputy convener, Sharon Dowey, to open the questioning.

Sharon Dowey (South Scotland) (Con): Good morning. The report highlights significant challenges facing the NHS in Scotland, while noting that healthcare systems are under extreme pressure across the world. How is the NHS in Scotland performing compared with other countries' healthcare systems?

Stephen Boyle: I will say at the outset that this report does not look to draw that comparison between the Scottish NHS and healthcare systems across the world. I will bring in colleagues in a moment. In this report, we wanted to provide an update on the progress that has been made against the Scottish Government's recovery plan, which it produced in 2021. Our general message is that it is proving extremely challenging to deliver all the ambitions. The Government has been clear in its communication of the extent of the pressure that the NHS in Scotland is facing. Over the winter, we all saw the scale of winter pressures and heard from the Government that the system in Scotland was extremely pressurised and challenged. There are some international dynamics to our report. We reference the reach that the Government is looking to have in broadening its international recruitment to the NHS, but the report does not look to draw an evidence-based comparison between the Scottish NHS system and systems elsewhere. Leigh may wish to elaborate on that.

Leigh Johnston (Audit Scotland): I do not have much to add to what the Auditor General said. We are not trying to draw comparisons in the report, but I acknowledge that we know from audit agencies across the United Kingdom, for example, that the other healthcare systems are facing the same issues: growing backlogs of patients who need to be seen and the challenges of trying to address that backlog in care.

Sharon Dowey: The report also states that Covid-19 spend will no longer be monitored. Given your call for transparency, recovery and progress, is it premature for the Scottish Government to stop monitoring that spending?

Stephen Boyle: As we have discussed in some of our recent reporting and in updates to the committee, there is now no separate Covid-19 budget line in the Scottish budget. I should make the committee aware that we committed to rounding off our Covid-19 reporting, and we will do that shortly with a web-based publication that sets out the totality of Covid-19-identified spending relative to actual spend. That is due to be published relatively soon.

Transparency relates to Covid-19 spending, but there is a wider point. As I said in my introductory remarks, Covid-19 still has a significant operational and financial impact on the Scottish NHS. I draw the committee's attention to appendix 2 to the report, which sets out some of the in-year forecasts that NHS boards in Scotland are making. You can see from that table that there are still significant financial challenges. Transparency matters, whether it relates to Covid-19 expenditure or the wider performance and financial position of NHS boards, but, ultimately, it is within the gift of the NHS and the Scottish Government to decide whether they continue to identify Covid-related expenditure. The indications that we have had are that that will cease to be the case and that there will not be a separately identified budget for it, but that does not detract from the overall need for transparency.

Sharon Dowey: What is your assessment of the progress of the Scottish Government's Covid costs improvement programme?

Stephen Boyle: I will bring in colleagues in a moment. Leigh might want to update the committee on that. The overall position is that Covid has dominated the services of the NHS in Scotland for the past few years. We are now looking at the delivery of the recovery plan—a clear plan that relates to the lingering effects of Covid-19 while moving to a position of stability that captures transformation in the longer term and clear, transparent performance in the short term. Leigh might wish to say a bit more about Covid.

Leigh Johnston: Covid costs have been reduced. For example, although Covid costs for this year are predicted to be about £723 million, we know that that is a reduction on earlier estimates. Boards have been working hard to try to reduce costs related to Covid, such as costs for personal protective equipment, vaccinations, test and protect, and various infection prevention and control measures. Each board was given a funding envelope to cover its Covid costs and they have worked very hard to try to keep them within that envelope.

Sharon Dowey: Will all health boards follow the same guidelines? If we are not monitoring spending, do we run the risk of some health boards spending a lot more on Covid than others, or, indeed, some not spending enough on measures?

Leigh Johnston: Spend will vary across boards. They are monitoring it this year, because they have that funding envelope. What we are talking about is spend going forward into the following year. The hope is that Covid costs will become part of core funding and operation and there will not be separate Covid-related spend any more—requirements such as infection prevention and control measures and PPE will become on-going core costs. There is now no additional money from the UK Government to cover our Covid costs, so they have to become part of the on-going health and social care budget.

Stephen Boyle: Antony also wants to come in on that point.

Antony Clark (Audit Scotland): This is an area of interest to us because it is part of the efficiency drive across the NHS in Scotland. Through Leigh Johnston and others, we are looking to see how effective the efficiency programme is, because there may be lessons that the NHS can learn about other ways of identifying and sharing good practice.

The implication in your question is whether learning and good practice is being identified and shared across the boards. Our sense is that the governance around it is trying to do that.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): I have a brief question on that point, Auditor General. Exhibit 1 in the report shows £723 million of Covid spend for 2022-23. Beside that, it is stated that the spend for 2023-24 is not yet known. Do you mean by that that you anticipate that that level of funding will still be required to support Covid initiatives from the Scottish Government but that you just do not know the figure? It is not that that money will be lost. Do you anticipate that it will still be required?

Stephen Boyle: There are a number of factors on which to expand, Mr Coffey. The money will not be lost. Rather, it is the extent to which the NHS in Scotland and the Scottish Government wish to monitor and report separately on Covid-related activity. We can all assume that the size of Covid spend will ebb further from the peak of a couple of years ago. Today marks the third anniversary of the first lockdown, but we can safely assume that there will still be some Covid-related expenditure. Leigh rightly mentioned that infection control measures are required for Covid patients in hospitals, but they will not be of the scale that we have seen previously. We therefore do not have a figure. There would be no harm in NHS Scotland's continuing to monitor the scale of expenditure, but we can assume that it will be lower than it has been up until now.

The Convener: The NHS is a very high priority for all of us in the Parliament and I reflect that the terms of our debate about it often contrast inputs and outcomes. Your report notes that there has been a £4.4 billion increase in NHS spending since 2018-19 and that the budget for 2023-24 is estimated to be over £19 billion. You assessed that level of expenditure as being three years earlier than anticipated. There is no question that there is substantial public investment going into the NHS, yet we do not necessarily see outcomes improving. The rather fundamental question is, do we just need funding or is it necessary to apply other factors in order to rise to the challenges that we are facing in the national health service?

Stephen Boyle: That is the nub of the vital issue here. The committee may have seen that the Scottish Fiscal Commission's report was published in the past day or so. It casts an eye over the next five decades of what public spending in Scotland may look like. That report suggests that there will be a 10 per cent drift in income and expenditure, which is largely attributed to the increase in the rate of health spending in Scotland. That suggests an unsustainable model, if we continue at that rate.

09:15

Antony will come in and talk about the key to unlocking some of the change. I do not wish to talk glibly about reform, but unless we move to a preventative model that tackles health challenges and encourages people to live healthier lives, we will not have a sustainable health system in Scotland. There is a real onus on leaders to make that kind of change.

In today's report, there are some very good examples of where some of that innovation and reform is happening. Scaling that up to make significant changes to improve the health of the people of Scotland is so important to delivering better health for us all, which is what we want, and to having a fiscally sustainable approach.

Antony Clark: You are quite right, convener. In many ways, the long-standing issue, of which we are all aware, is the burden of ill health that Scotland faces and the inequality in health outcomes across Scotland. The Scottish Government has tried to organise its care and wellbeing portfolio in a way that recognises and acknowledges the importance of focusing on prevention and working with partners to make sure that we can, if you like, change people's behaviour and work on the determinants of ill health, including things such as employment, housing and wellbeing. The Scottish Government has recognised that that is a really big issue for it.

Exhibit 12 in the report sets out some of the things that the Scottish Government is trying to do to drive that reform. It is about coherence across Government and getting different bits of Government to work better together. It is also about being clear on what a sustainable model for the health service looks like. As the Auditor General said, that has to be about reforming and changing how health is delivered. However, it is also about what we do as individuals. That focus on public health interventions and on changing people's behaviours is really important.

The report indicates that it is still relatively early days for that. We reported on these issues in the last overview, and you can expect them to have much greater prominence in our future NHS reporting. We are very keen to explore and report on how effectively the health department and the care and wellbeing portfolio will work with others to make that shift. That is really important stuff if we are going to have a sustainable health service.

The Convener: Yes, thanks. The broader questions, which we have touched on before, are around inequality and poverty, which are often the drivers of the demands that are placed on the national health service. So, there is a broader public health question and a societal question. We probably do not have time to go into that this morning, but it is an important thread that runs through the issue.

I will apply the handbrake and jump on to something else, which is related but quite different. In the report, you talk about the capital maintenance backlog budget. I know that it has been the focus of attention in previous years. Again, there is a long-standing critique of why it should be backlog maintenance rather than proactive maintenance. If maintenance is carried out on an on-going basis, it becomes less reactive and probably more cost effective. Again, that might be another debate for us to have.

In the report, you indicate that it is proposed to double investment in the capital maintenance backlog budget over the next five years. Given all the other pressures on spending in the national health service, how confident are you that that is an achievable goal?

Stephen Boyle: You are right: the report sets out that it is the Scottish Government's intention to double its investment in backlog maintenance and other maintenance over the course of the next five years. I draw the committee's attention to paragraph 21, where we also refer to the "NHS in Scotland 2020" report, which pointed out that the NHS capital maintenance backlog then stood at more than £1 billion.

We should step back for a second and acknowledge that this spending is about health and safety and appropriate conditions for the people who work in the NHS and for those who are receiving treatment. Of course, we have to invest in our estate in order to maintain standards, not just in new builds. I am sure that the committee will be interested in the national treatment centres that are part of the key strand to deliver additional capacity in the NHS in order to address the recovery ambitions. At the same time, it is just as important to maintain the quality of the existing estate.

You asked me directly, convener, how confident I am. We have to continue to track and monitor that spending and it is vital that that is done consistently. There is the temptation, particularly when times are fiscally challenging, to defer maintenance arrangements, not just within the NHS but across organisations. That has to be avoided, because, ultimately, all that that does is defer health and safety and lead to larger investment requirements at a later date. We will keep an eye on that through our programme of work over the next few years.

The Convener: Presumably, you will also keep an eye on how that fits in with net zero targets and that whole agenda of how the public sector estate needs to be changed quite substantially to meet our ambitious goals for reducing carbon emissions.

Stephen Boyle: Very much so. With the committee's agreement, we will update you in more detail next week on our future work programme, which covers our intentions on net zero and also on the public sector estate. I will give some additional context around that. The use of assets by the Scottish Government, its bodies and the wider public sector in Scotland was a key plank of last year's resource spending review, which set out that how we use assets is a key driver for fiscal sustainability, the experience that people have of public services and of public sector reform. We want to be part of that through our auditing work. I can say more next week, as you wish and if it is convenient.

The Convener: Yes, we will return to that next week and beyond. Craig Hoy has questions on one of the other topics that is important to the Parliament.

Craig Hoy (South Scotland) (Con): Good morning to you, Mr Boyle, and to your colleagues. In the past, you have said to this committee that you will not wait until the huge piece of public policy work that is the national care service is created before you start to audit it and to analyse the numbers around it. In your report, you warn that the national care service will place a huge strain on the health and social care budget. Obviously, concerns have been raised within the Parliament, particularly by the Finance and Public Administration Committee, in relation to the financial memorandum that accompanies the bill, which is on pause. What is your understanding as to why the legislation has been paused? Is it to look further at the numbers?

Stephen Boyle: You are right. I will bring Antony Clark in in a moment, as he has been closely monitoring that and will be able to say a bit more.

Audit Scotland, like many organisations, responded to the Finance and Public Administration Committee's call for evidence. We commented on the financial memorandum and the extent to which there were potentially some significant risks of additional costs that were not specifically identified in the financial memorandum but that might come to fruition and ought to be considered in coming to a more rounded assessment of the likely future costs.

We also have a history of undertaking audit work alongside the implementation of significant changes in delivery models or policy. Social Security Scotland is perhaps the most recent example of Audit Scotland undertaking a programme of public audit reporting while an initiative was being developed. A rationale for that has evolved over the course of the past 10 years. Historically, an audit organisation's work would have been entirely retrospective, but we reached the point where, given that so much public investment was at stake and there were such key outcomes for the people of Scotland, we felt that there was a role for us at a slightly earlier stage.

We think that that is an appropriate parallel with the national care service. Antony can come in on that, as he wishes, to say where we think that that programme of work goes next.

Antony Clark: Thank you for your question, Mr Hoy. Our understanding is that the pause is so that the Scottish Government can reflect on the various views that have been expressed on the merits or demerits of the proposals that have been put forward hitherto. The sense is that there is broad acceptance that the issues highlighted by the Feeley review around the need for greater consistency, better support for the workforce and better user involvement are all desirable, but that there may be different ways of achieving those outcomes. That is my understanding of the rationale for the pause at the moment.

In respect of our work in this area, we were very clear in our submission to the Parliament on the NCS consultation that the issues that face the social care system around sustainability, quality, consistency and workforce support need to be addressed now; we cannot wait for a national care service to achieve them. We are planning to do a suite of work focusing on particular themes and topics and looking at the issues that we highlighted in our briefing paper.

Alongside that, the Auditor General's colleagues in the Accounts Commission will report annually on the financial health of integration joint boards. That reporting will likely be expanded to cover performance and outcomes over time in the period running up to the implementation of the national care service. As the Auditor General said, if the decision is made to proceed with the national care service, we will want to audit the planning for that implementation, the effectiveness of the implementation and, in the longer term, whether the changes put in place deliver the policy objectives of better outcomes, better value for money and a more sustainable, high-quality service. This is a really important area of interest to us.

Craig Hoy: Thanks. The report highlights that the national care service, if it were to proceed, would require

"a significant unknown financial commitment to be met from the Scottish Government's health and social care budget."

To what extent are you concerned about the Scottish Government's ability to meet its spending commitments in relation to the NCS and the impact that that may have throughout the healthcare system in Scotland?

Stephen Boyle: There are two things to say in response to your question, Mr Hoy. The Scottish Government has to set a balanced budget every year. When the Parliament considers the budget bill, it will prioritise. Spending commitments will be met, but it will come down to the prioritisation of health and social care services relative to other parts of Scottish Government delivery.

Reform of health and social care is so important—that is relevant to the convener's earlier point and the Fiscal Commission's report. Our comment is not a detraction of, or about the merits or demerits of the national care service. The Government and its partners are absolutely clear on the intended outcomes from the national

care service, that there is transparency and that that is known and understood relative to other priorities. That is really where we, from an audit perspective, are coming at it.

Craig Hoy: Exhibit 2 of the report highlights the quite considerable increase in delayed discharges. Mr Clark, you identified that action needs to be taken now to remedy some of the issues. The problem of flow through the health service is down, in large part, to delayed discharges, which come down to capacity in the social care system. The Government has announced plans to purchase 600 interim care beds, with a 25 per cent uplift in the national care home contract rate. Have you calculated how sustainable and effective that relatively short-term intervention might be? Will it deliver value for money?

Stephen Boyle: It is premature to make a detailed assessment. I will bring in Fiona in a moment, as she has looked at that as part of our reporting. Delayed discharges are a key part of the challenge. We have seen through our work and have reported that having an effective, whole-system approach, from the delivery of hospital-based services through to community-based services and the interconnection between those, is vital. We know—we saw this during the pandemic and are currently experiencing it—that that is not all working as it was before the pandemic and that is causing delays in hospital-based settings and some of the challenges in delivering health and social care.

The interim arrangements are exactly that: they were designed to relieve some of the short-term pressures that were experienced as a result of winter pressures. What we call for in today's report is a comprehensive plan to deal with delayed discharges that involves the NHS and its social care partners moving to a sustainable care-based model. I will let Fiona say a bit more, if she so wishes.

Fiona Lees (Audit Scotland): I do not have much more to add to what the Auditor General said. It is too early to say what impact that intervention has had. We have seen a slight decline in the number of delayed discharges since the peak in November. It is going in the right direction, but we need a bit more time to see what is going to happen. As the Auditor General said, the important thing is to have a long-term strategy that will solve the problem.

Craig Hoy: The national care service envisages a significant role for the private sector; potentially, some have argued, a greater role for the private sector if local authorities step back from that. The true cost of care seems to be the fundamental issue. I looked at some numbers. The national care home contract rate is £832 a week and a 25 per cent increase takes it up to about £1,040 a week. Private sector care home providers, whom the scheme is meant to incentivise to free up capacity in order to address delayed discharge, argue that that still falls short of what they perceive to be the true cost of care, given that they are contending with the cost of living crisis, higher energy bills and staffing cost pressures. Is it part of the problem that, until we identify the true cost of care and therefore properly fund care—particularly for those who are not self-funding—and remove the element of cross-subsidy, we will never get the capacity that allows us to aggressively bring down those delayed discharge figures?

09:30

Stephen Boyle: That is the essence of the challenge. Antony can come in and talk to some of this. With the parliamentary consultation and now the pausing of arrangements, it is for all partners taking forward the national care service to be clear on a sustainable approach to delivery.

As Antony rightly mentioned, from our reporting and the committee's interest in this over the past 18 months or so, we know that there is an extremely challenging situation right now that cannot wait for a national care service down the line. There has to be a short-term plan, a medium-term plan and then a longer-term vision of the delivery of health and social care services in Scotland. Getting it right and moving to a sustainable approach relies so much on the partnerships with and between the Scottish Government, local authorities and private sector providers, Mr Hoy. Antony can say a bit more as he wishes.

Antony Clark: You are right, Mr Hoy. There is a very interesting question here around the cross-subsidisation of costs and the transparency of costs. Part of the work that needs to take place in the development of the national care service concerns the nature of the market that we are operating in and what market mechanisms will be effective and appropriate to deliver high-quality care that delivers the right outcomes but also protects the public purse and delivers efficiency. At the moment, it feels as if those questions are a bit unresolved.

Craig Hoy: Obviously, we understand that social care and the NHS are inextricably linked. Your report states that the Scottish Government's NHS recovery plan was not informed by detailed and robust modelling, nor were NHS boards involved in setting the ambitions of the plan. It further states that the Scottish Government is undertaking an exercise to model capacity across the whole health system. To what extent are NHS boards involved in that modelling process? Should it also include all elements of the social care

sector to ensure that we have the capacity for that displacement?

Stephen Boyle: In a moment I will turn to Leigh, who has done quite a lot of work looking at the construction and delivery of the NHS recovery plan.

We say in our report that the recovery plan was quite a high-level document when it was conceived. There is some element of mitigation, Mr Hoy. It was done in 2021, at the height of the pandemic, and we can recall what conditions were like at that stage. However, it was not done on the basis of robust modelling nor did the Government widely consult NHS boards.

As part of our approach to the NHS in 2022 report, we engaged with a number of NHS boards as case studies, just to test the experiences that they have had. We say not necessarily that the NHS needs a new plan, but that it needs to report, clearly and annually, on the progress that it is making, informed by more detailed modelling, as you suggest.

Leigh Johnston: How involved boards have been in the modelling is a question for the Scottish Government. We are aware that it is working on it and, as we clearly state in our report, we think that that should be progressed as quickly as possible. It has been on-going for a number of months, and we have still seen no evidence of what is to come or the result of that modelling. It is important that that is progressed quickly. However, how involved the boards have been in that modelling is a question for the Scottish Government.

Craig Hoy: The first annual progress report was in October 2022, and the first milestones of increased activity fall into 2023. Is it fair to say that, if you were creating a dashboard of those milestones of increased activity, they would still be flashing red? Do we need greater transparency around those, given that that progress and recovery was meant to come to fruition this year?

Leigh Johnston: There are lots of flashing red lights. Activity is still below pre-pandemic levels, yet the recovery plan promised to increase the number of procedures and the amount of activity. The national treatment centres are key to that but there have been delays to those for various reasons. Hopefully, once the national treatment centres come online, we will start to see progress in that area. However, there has not been the increase in activity that we would like to have seen by this point.

Craig Hoy: When we get the 2023 progress report, would it be prudent for us to press for greater transparency and more detail on what is actually being achieved?

Stephen Boyle: I think that the answer to that is yes—there should be a clear report on progress against all the intended milestones that were set out in the recovery plan. Governments can change tack. If the Government intends to produce a new recovery plan, that is entirely within its gift. Based on the current extant report, we suggest that clear progress against all the milestones should be included within a progress report and the one that was produced last year did not cover all the targets that were set out in the recovery plan.

In our appendix 3, we tried to give a fairly detailed analysis of the progress report. You can see from the analysis that there is progress against some of the measures. However—the committee may wish to explore this further—we have drawn attention particularly to the reporting on progress against the waiting times backlog, which felt a bit general. People care most deeply about the specialism or treatment that they are waiting for, and if that is not set out in the report, the report can be less helpful and less relevant to them. We suggest that that should be clear and comprehensive for all parts of the way that people use the NHS.

Willie Coffey: Auditor General, my question is on the process of discharge. Recently, I was speaking with the chief executive of the Ayrshire and Arran NHS board, who identified the issue that only consultants can discharge a person from hospital. To be honest, I did not realise that. She told me that there is wider expertise in the profession that could discharge people from hospital. Are you aware of that? If we could address that issue, could that help the discharge process? We understand that people could be in hospital capable of being discharged but are not being discharged because consultants are not getting to them on time to discharge them. Are you familiar with that issue?

Stephen Boyle: I will bring Fiona Lees in because she has looked at discharge arrangements more closely than I have, Mr Coffey, and has more familiarity with that.

While respecting the professional judgment of clinicians, we have seen evolving models in health and social care settings that are less reliant on medical staff and bring in the expertise of different specialisms. Fiona might be able to say a bit more on how that is applied across delayed discharge settings. If not, we can come back to you in writing.

Fiona Lees: That specific issue did not come up when we talked to each of our case study boards, but it is certainly an interesting question. I know that work had been done to improve the process of discharging patients, but the question that you asked did not come up. It is worth us asking that question in the future.

Antony Clark: As colleagues have said, we have not explored that in great detail, but it seems to me that there are some quite important issues around recognising the importance of the medical duty of care to make sure that people can be safely discharged and that it is appropriate for them to leave the hospital setting. My understanding is that it is not just medics and consultants who are involved in those discussions; often, occupational therapists, clinical nursing staff and others are involved. The evidence in the report and our analysis of the broader systems problems indicates that the problem here is probably less to do with the ability of consultants to make those decisions and more to do with the availability of support in the community to allow people to be discharged quickly.

Willie Coffey: It is an interesting point that was made by that chief executive, and she also said that more junior doctors, many of whom have 20-plus years' experience, are just as capable of making the discharge decision for the patient as consultants are. We could perhaps follow that up at a future date, convener.

The Convener: Yes, absolutely. I am sure that we will return to that point.

I will move things on and turn to something that has been of interest to the committee, not only in this but in the previous session, and that is the financial position of individual territorial health boards. In the report, you suggest that, in your assessment of the 14 territorial health boards, only three are expected to break even, which means that 11 are not. I presume that that does not mean that they will make a surplus, but that they face a financial deficit. We know that, in the past, that led you to have to produce section 22 reports about health board conduct, because concerns were raised about the routes that people chose to go down to get additional resources.

How fit for purpose are the brokerage arrangements? The term "brokerage" is about an intervention by the Scottish Government to help out individual health boards. At one point, I think, it was based on a one-year time horizon; it then went to three years. Will you bring us up to date on the current position and say whether, in your estimation, those arrangements will be robust enough to get the health boards through the challenges that they face?

Stephen Boyle: Yes, I alluded to that, but I will bring the committee's attention back to the heart of your question. Appendix 2 to today's report sets out the year-end forecasts made by the territorial and national NHS boards in Scotland. For the end of 2022-23, as you rightly say, only three territorial boards forecast that they will achieve at least a break-even position. It is probably reasonable to assume that the position will not be as bad as that at year end. There is an interesting example elsewhere in the report: one of our case study boards received additional funding when it identified to the Scottish Government that it had a cost pressure. Circumstances can be quite volatile. New money can be found from funding arrangements from Government or from savings identified by the board. That has tended to be the way of things, so it is worth considering that, rather than looking only at what the appendix states will be the case by the end of the year.

That does not detract, convener, from the fact that there is a real financial pressure within the system. Our report refers to inflationary pressures on goods and services and on pay arrangements, all of which are driving up costs in the NHS. We have already touched on the legacy of Covid, which has not yet been resolved and is still reducing efficiency. All those factors are relevant.

We recommend in our report that, whether it is brokerage or otherwise, the Scottish Government needs to review its medium-term financial framework for the health system in Scotland—what it looks like and its forecasts—to allow it to financially plan into the medium term with more detail, so that it has a clearer understanding of the resources at its disposal. Whether that means that it should plan to revise the brokerage arrangements or change any part of the funding environment is a matter for the Government. We are saying that the current model needs revision.

The Convener: May I clarify something that probably stems from my ignorance? On the one hand, you talked, and I asked a question, about the increase in resources—an additional £4 billion over the past five or six years—but, on the other hand, the narrative in paragraph 24 of the report is about how health boards have to make savings. Can you reconcile the two for me? A record level of public money, £19 billion, is going into the national health service—not into the broader category of public health but into the national health service—yet, at the same time, there is a call on national and territorial NHS boards to make savings.

Stephen Boyle: Yes. Those two things feel contradictory but, at the same time, they are both true. Funding is at record levels, but funding is always at record levels, convener. The nature of public spending growth is such that, in the context of the NHS, it will continue to grow. That is based on the projections that we have seen in the resource spending review, which gives the Government's forecasts. How far that spending goes, however, is constrained by cost of living and inflationary pressures—purchasing food for hospitals, the cost of medicines, dressings and so forth—and pay pressures. All those pressures are eating into the extended capacity that the over £19

billion offers, and that leads to the requirement—the well-trodden path that this and previous committees have heard about—for boards to make savings.

I fear that we will always be in that position. There will be a growth in public spending and a requirement for boards to make savings, unless that is underpinned by a wider examination of the sustainability of the health model that captures, exactly as Antony Clark said, how we as a population can lead healthier lives. We need a preventative model that is less focused on interventions at a later and more expensive stage.

09:45

The Convener: That is very helpful. I will develop that theme a little bit. There is the question of innovation. It comes back to the fact that it is not just about the money but about how we do things. You cite in the report a couple of examples of innovation. One of those—the NHS 24 system—is a bit more long-standing and structural. It has been reviewed and reformed.

There is a case study in the report about the Scottish Ambulance Service intervention. I think that you said that it has established an integrated clinical hub to introduce a level of clinical judgment to determine whether, where there are calls for ambulances to attend, a reasonable demand is being placed on the service. The finding that the Scottish Ambulance Service supplied to you was that, when interventions were made, it was discovered that up to 50 per cent of the calls did not require a 999 ambulance. That result is based on intervention in 15 per cent of calls. Will you reflect on that? If there were a greater level of intervention so that more calls were screened or had that clinical judgment applied to them, would that lead to the same kinds of results right across the entire service?

Stephen Boyle: In a second, I will bring in colleagues who have looked at that closely, starting with Fiona Lees. At a strategic level, that type of testing of change and innovation is crucial to changing the model of health services. Patients behave rationally, as we know. If they think that they are unwell, they will phone 999. The steps that the Scottish Ambulance Service is taking are really important. Early signs are that they are very successful, too. The expansion of that approach across Scotland, with a thorough evaluation, really matters. It is also about building on approaches across other aspects of healthcare. Fiona can start and others can jump in as they wish.

Fiona Lees: We had a good conversation with the SAS about that project. As you said, advanced practice clinicians consulted with patients in 15 per cent of cases. In half of those cases, they were able to stop a 999 ambulance having to go out, so that was a really positive development. The SAS has done a lot of work over the past year on managing demand and capacity. A lot of that is about trying to prevent patients who do not need to go to hospital from going. It is therefore about finding the most appropriate care pathway for them, and sometimes that is within the community. That work is on-going, but the early signs are that there has been a really positive step in that direction.

The SAS also said that it is doing a lot of work with boards and local authorities on talking about that approach and how it can be best applied in local areas so that it is not happening just through the service. Flow navigation centres are part of the redesign of urgent care. They are designed to help to prevent patients from going to hospital when that is not necessary and to find the most appropriate care pathway for them in the community.

The Convener: Is the clinical hub a pilot in one particular geographical area? How is that working?

Fiona Lees: It is not in one particular area for the SAS. There is now a flow navigation centre in every board area, but the arrangements are slightly different. As I said, it is part of the on-going redesign of the urgent care programme. The evaluation of that is on-going as well, and I think that it is due to report later this year.

The Convener: I am quite sure that we will be interested in keeping a close eye on that.

Antony Clark: On a more general point, the health department has been very focused on unscheduled care and unplanned care. This is a very important strategic programme of work and the SAS programme is one element of that work. It also ties in with some of the primary care reform activity that has been going on across the health service for some time. It is a question that we will be exploring in our future NHS audit work, and it may be an issue that the committee might want to explore with the Government, if you invite it in for evidence.

The Convener: Thanks. Another area mentioned in your report is NHS 24 interventions. By the same token, how effective have they been? Is NHS 24 revising the way that it works? Is more investment going into it, particularly given the Covid-experienced environment that we are now in? The delivery of public services is viewed slightly differently, is it not, in light of what had to happen over the course of the pandemic? Can you enlighten us on the NHS 24 changes or interventions and how effective they have been?

Stephen Boyle: Again, that might be one for Fiona. I absolutely agree, and we have all seen how central NHS 24 has become over the past

few years. Often in the NHS, we use terms such as triage and pathways, but it is really about getting patients the right care that they need in the right place and supporting their understanding of where best to go and when. Fiona is best placed to talk the committee through that.

Fiona Lees: The work that is happening with NHS 24 is at the heart of the programme that I talked about for the redesign of urgent care. The stated aim of that is to help to reduce the number of people who self-present to hospital as a first port of call by 15 to 20 per cent. The most up-to-date figures that I have seen from NHS 24 papers show that, compared with 2019, there has been an 11 per cent reduction in that figure. As I said, that programme of work is on-going and is yet to report, so I urge a bit of caution around those figures until they are officially published.

When the winter pressures were at their greatest towards the end of last year, an announcement was made about additional funding to recruit 200 people to work in NHS 24 to help meet the increased demand on it. It looks like progress on that is on target. From looking at the most up-to-date board papers from NHS 24, it looks like the target figure will be surpassed.

The Convener: Thanks. We are short of time. The committee will want to return to these areas because they are worthy of further examination. Time is tight, so I will ask Willie Coffey to come in. He has questions on the use of agency nurses and so on.

Willie Coffey: My question is about staffing capacity and wellbeing issues. Auditor General, your report clearly tells us that staff numbers are at a record high—as you said, everything is at a record high in the NHS. However, we still face a problem with workforce and recruitment and the excessive cost, let us say, of employing bank and agency nursing staff. How do we resolve those two issues? What are your views on what the solution to that particular problem may be?

Stephen Boyle: You are right, Mr Coffey. Our report, as it has done for many years, identifies how pivotal NHS workers are to the delivery of health services. We reference the fact that there is a new NHS workforce plan but that the system remains under significant pressure in terms of wellbeing. There is still emphasis from health professionals on that sense of burn-out that NHS workers have experienced.

The cost of hiring bank and agency staff is not a new issue. The issue of NHS boards having the right access to the skills that they need at the right time has been around for decades. Bank and agency costs have increased. There are not enough people to fill the nursing posts. There have been some innovations, such as through training places in universities, and we know that the chief nursing officer for Scotland is actively engaging with the boards to try to come up with a longer-term solution.

In nursing, in particular, our report also says that the reach of the NHS in Scotland has expanded internationally to try to access some of the additional skills to support services. They have considerable interest in value-for-money arrangements around this and have taken the view that, while there was an initial premium, the fact that the Scottish NHS has not paid for training arrangements offsets some of that cost.

A sustainable model is what is needed, Mr Coffey, and the totality of a workforce plan should deliver for health and social care in Scotland. Bank and agency costs are one component of that plan and I suspect that they always will be, but the extent of reliance upon those staff matters and should be tackled.

Willie Coffey: Sharon Dowey may come in on the internationalisation of recruitment in a wee minute. Your report also talks about wellbeing, Auditor General. The report notes the Government's view that

"there is not a culture of seeking help in the health and social care sector."

Could you say a wee bit more about that, and about what role the national wellbeing hub is playing? It is an important area because, as we know, absence rates are particularly high. Give us a flavour of the issue.

Stephen Boyle: I am happy to start and I will bring in Fiona, who has also looked at this.

Like you, I was struck by the sense of resilience and robustness and by the need for NHS workers to seek help and support. The challenge and trauma that they have experienced in dealing with Covid over the past few years cannot be overstated. It is important not just for them as individuals but for their employer to have appropriate arrangements to support health and wellbeing. The Government is approaching this through the leading to change initiative—I think that is the phraseology—to build stronger, more effective arrangements to support colleagues in accessing health and wellbeing support.

It is also about building the right sustainable conditions so that NHS workers do not have to operate under extreme pressure for prolonged periods. Fiona can say a bit more about the planning and the evaluation that the Government will complete.

Fiona Lees: I do not have an awful lot more to add, except to say that, when we had our case study interviews with the boards, it came through loud and clear that staff wellbeing is critical to

them. Retention is crucial: you can recruit as many people as you like but, if you do not retain them, you are on a hiding to nothing. In paragraph 51, we talk about some of the steps that are being taken, including putting in place wellbeing coaches for staff and having people in those teams to try and encourage a culture of speaking up when things are not going well and to promote that culture from within. I have no extra information on the evaluation of that programme.

Willie Coffey: Is it too early to guess whether those measures are effective in dealing with wellbeing, absence rates and a high turnover of staff? Is it too early to say that we are making an impact?

Fiona Lees: I do not have enough evidence at the moment to say how well it is working. Up-to-date data about staff absence and turnover will not be available until later this year. It will certainly be worth looking at that when it comes out.

Willie Coffey: Absolutely.

Stephen Boyle: Fiona is right. There needs to be evidence and data to form that evaluation. There are also the surveys that trade union and representative bodies undertake, and those are pretty consistent, Mr Coffey, about how their members feel the pressure, the extent of burn-out and the need for support. We need to ease that pressure. We have some examples in the report. Only 37 per cent of nurses report that they are able to take the breaks that they are expected to take. That points to the on-going challenge that they have been experiencing. Nobody wants to experience that in the workplace. Inevitably, that will have a flow-through impact on absence rates and people will decide to make different career choices. Wellbeing matters, but there is almost an element of reactive response. How do you ease pressure in the system? The other examples that we have heard about—NHS 24 and the Scottish Ambulance Service—are all components of that.

Sometimes, when Audit Scotland talks about a sustainable model, the inference is that it is only about the financial position, but it is about sustainability across the piece, not only for patients but, just as importantly, for those who work in the NHS.

10:00

Willie Coffey: Thank you. That sounds like a clear area of focus that the committee might want to concentrate on in the future.

The Convener: One of the most startling figures in the report is in paragraph 46, where you talk about the extent to which bank or agency nursing staff are being called upon. Those figures are for the three health board areas that you have looked at in most depth and they are striking. You say that the expenditure on bank nursing is up by 57.2 per cent in NHS Lothian, by 90.5 per cent in NHS Highland and, in NHS Ayrshire and Arran, by even more at 90.8 per cent. Why on earth is that happening?

Stephen Boyle: Colleagues can come in and give a bit more detail behind that, but the numbers are startling, in terms of the scale of change of the call upon bank and agency staff. Those numbers are not sustainable from a financial perspective, but one must bear in mind the need for consistency of care. Health workers talk about having a relationship of familiarity with patients in their care, and if that is chopping and changing through different workers, all of that will inevitably impact on outcomes. Some of this situation will be driven by inflationary pressures, such as the cost of living and the availability of staff. In some of the more rural areas, in particular, there will be a premium. Access to external factors that are beyond the control of the NHS, such as affordable housing, plays a key part in the ability to recruit and retain permanent staff. If they are not available, it will, inevitably, lead to a call on bank and agency nurses to backfill those vacancies. Colleagues can elaborate on the specifics behind the numbers.

Leigh Johnston: If you look at the figures, you will see that they are from 2021-22, so the other issue impacting on the situation was obviously the effect of the pandemic, when high levels of staff absence, as well as the vacancy rates that we have talked about, led to the need for bank and agency staff.

The Convener: Okay. Obviously, we are talking about people, but, from an audit point of view, the unit cost to the health service of agency staff is considerably more than the cost of a direct employee, is it not?

Stephen Boyle: Yes, it is. There is no value judgement for us about agency workers relative to permanent staff, but there is a cost perspective. Yes, employers will pay more, however, they will, periodically, require that flexibility, whether that is due to staff absence or a planned increase in capacity. It is the planned nature that matters most. Continuous, long-term reliance on bank or agency staff suggests increased costs and not the provision of care that you would want through having permanent employees.

The Convener: As a committee, we will retain a strong interest in that to see where it goes in the next financial year.

We are short of time, so I will bring in Bill Kidd, who has a number of questions.

Bill Kidd (Glasgow Anniesland) (SNP): Thank you for everything so far; it has been extremely interesting.

Linked in with a number of the elements that you have talked about are, obviously, waiting times and waiting lists. Exhibits 4 and 5 on pages 21 and 22 of the report show that waiting times and waiting lists for planned care have increased and continue to grow, as has been said. They show that 5,458 people—3.4 per cent—have been waiting for more than a year for a diagnostic test or investigation. The report refers to limited progress in tackling that backlog of care and the increase in waiting times and waiting lists. Have we any evidence of people starting to look beyond the NHS for their healthcare? I ask that because we have all seen, on television, people saying that they are going to eastern Europe, or even further away, to get treatment more quickly.

Stephen Boyle: I will take your questions in reverse order. I do not think that we have seen anything other than anecdotal evidence. We have not gone looking to see whether people are exercising other options for where they receive treatment.

The wider point about waiting lists and tackling backlogs is one of the central planks of the report. As a result of many factors, people are still waiting longer for treatment than they did before the pandemic. We are calling for real clarity—we touched on that earlier—so that, across specialisms, people can have a clear expectation of how long they will have to wait for treatment.

There have been some aspects of progress, especially for those who have been waiting the longest for treatment. Patients who have been waiting for two years and longer have become a priority for the NHS, so that aspect of wait times is reducing. Unfortunately for the NHS, because of the way the performance indicators are constructed, that looks like a deterioration in performance. Because the indicator is based on a certain number of weeks to treatment, if the NHS is focusing on those who have been waiting the longest, it does not tackle how that interacts with the performance indicator. There have been aspects of progress for the longest waits, but, fundamentally, the report calls for real transparency for patients across all specialisms about how long they will have to wait and, if needs be, an update to that part of the recovery plan.

Bill Kidd: Waiting times for planned care vary significantly by specialty across and within boards. Is that being investigated? Is there any scope for more collaborative working across and within health boards to reduce those waiting times? Is it possible that the health boards could co-operate if there is a longer waiting list for certain treatments in one area than in another?

Stephen Boyle: I will start, but I will bring in Fiona to talk about how that is working at individual board level.

One of the key planks of the Government's plan to tackle waiting lists is the creation and expansion of national treatment centres to boost capacity. In the report, we touch on the fact that there are cost growth and timing challenges in the delivery of some national treatment centres and that has since been reported. We suggest that there should be clear on-going communication around the delivery of the treatment centres. Our report also touches on how the national treatment centres should look to be geography-blind, if I can use that expression. They are a national resource. It is helpful that the Government has clarified that, regardless of where they are positioned in the country, patients from across Scotland should have uniform access to those services.

Fiona can say a bit more about how boards are working together.

Fiona Lees: In our case study interviews, we found good examples of boards working together locally, regionally and nationally to try to offer mutual aid and share good practice. As the Auditor General said, one of the ideas behind the national treatment centres is that we should not get hotspots, and that some of the capacity can be shared across the country so that, hopefully, problems in areas where there is a particularly long waiting list can be resolved more quickly. For example, if there is a very long waiting list in Glasgow and it is much shorter elsewhere, you may be able to move people around a bit, if they are willing to travel. The centre for sustainable delivery is a new unit that was set up in 2021. All the boards mentioned to us that the work that it is doing is greatly helping them to work together and share best practice to reduce waiting lists.

Additional waiting list data has come out since we published the report. It shows that, for out-patients and in-patients, there is still an increase in the waiting list, although the rate of growth has begun to slow, whereas, for diagnostics, for the first time in a long time, we have started to see the size of the waiting list decrease slightly, particularly for radiology. The only thing that I will say that will temper that slightly is that, with winter pressures, some boards have had to pause some of their elective and planned care, and we are not sure what impact that might have on the figures for the next quarter.

Bill Kidd: Thank you for that. There are some interesting points there.

I will go off on a minor tangent, but it is still linked. Patients are removed from the waiting list when they have attended their appointment or have been admitted for treatment; they are not on

the list any more. If the treatment is no longer required for a patient for whatever reason, you would imagine, hopefully, that they are not on the list any more. Is there any data for the number of patients who have been removed from waiting lists due to no longer requiring treatment? Are there any trends that can be identified there?

Fiona Lees: Yes, data exists about patients no longer requiring treatment. I do not have a further breakdown within that to say what the particular reasons are. There could be a number of reasons; they could decide not to go ahead with the treatment or decide to go down the private healthcare route. To be honest, I have not looked at those trends in any great detail. There was nothing that jumped out at me hugely when I looked at that data, but it does exist.

Bill Kidd: It does; right, okay. Thank you very much for that.

The impacts of increased waiting times on people's physical and mental wellbeing are highlighted in evidence that patients are presenting for care in a worse condition than prior to the pandemic. The report states that longer waiting times are impacting on people's health and wellbeing, with patients presenting for care in a frailer and more acute condition and with more complex needs. Are assessments being made of the impact of current waiting times on the health and wellbeing of patients prior to their attendance in hospital or wherever?

Fiona Lees: We have not talked about that assessment specifically. I can say, however, that all our case study interviewees said, without a doubt, that they were seeing cases of people presenting in a much frailer condition than before the pandemic. We also had a good conversation with Versus Arthritis, particularly about some of the patients that it supports. It definitely said that it was seeing the impact of wait length on people's independence, pain levels, and physical and mental health.

Bill Kidd: Right. Are figures being produced on that?

Fiona Lees: There is information from a survey that Versus Arthritis did in 2020. I do not have those particular figures with me, but the survey showed that most respondents said that they had increased levels of pain, reduced mobility and independence, and a deterioration in physical and mental health while waiting for treatment. There are some figures around that.

Bill Kidd: That is really helpful; thank you very much for that.

Stephen Boyle: Our report also touches on some of the analysis of excess deaths as a result of the pandemic. At this stage, the national data is inconclusive on whether wait times are a key contributor to excess deaths. We have also seen the Government being clear with people about some of the things to look out for. The NHS is open, in spite of the circumstances that arose over the course of the winter pressures, when some urgent situations resulted in delays to planned treatment. The totality of the message is that the NHS is open and, if people have conditions or symptoms they should seek treatment, rather than referencing back to where we were two-plus years ago about easing off access to services.

Bill Kidd: Thank you very much for that.

The Convener: That was a public information announcement by the Auditor General. Excellent. Craig Hoy wanted to come in on this area.

Craig Hoy: Mr Kidd referred to the private sector and you mentioned that the evidence was anecdotal. There was the BBC "Disclosure" programme. Again, it was a survey, so we cannot necessarily put a lot of store by it. Nevertheless, it found that one in five people on NHS waiting lists had had some contact with the private sector over the past 12 months—it was something broadly of that order. Is it worth interrogating, perhaps, the size and the use of the private sector at the moment? Would that read through to some of the pressures that we see in the NHS?

10:15

I am thinking particularly—again, anecdotally—about my postbag, and this is probably true of colleagues' postbags. Many people, when they have their first clinical appointment in relation to the treatment of orthopaedic issues or early-stage cataracts, are told, despite your saying that the NHS is open, that it will take three to five years for that treatment. They automatically pivot to the private sector if they can afford it and that obviously undermines the fundamental principles of the NHS.

I am concerned that, if there is a growth in people electing to do that for those specialisms, you might see staff drifting towards the private sector. While that may bring down waiting lists in some senses, it also means that those with the means or the borrowing capacity to do that will access healthcare far more quickly and will therefore not reach the same level of acuity as those who are not necessarily able to do that. Is it worth taking stock of whether there has been some shift to the private sector, because we will, at some point, undoubtedly have an issue in relation to the capacity of the NHS workforce and its waiting lists?

Stephen Boyle: I will think carefully about what that means for our work and, I guess, about the

boundaries of our responsibilities as they relate to public spending. Yes, we are interested in the use of health services, whether that is the growth of national treatment centres or the extent to which alternative arrangements from the NHS lead back to the NHS through its accessing private providers, as it has done in the past, to tackle waiting times.

Like you, Mr Hoy, I have only anecdotal evidence that people are exercising that choice. We will keep an eye on it—that is probably as much as I can say—through surveys and the analysis of data. Perhaps most pertinently, as Fiona suggested, if that is leading to any tangible, noticeable change in the patterns relating to the size of waiting lists and we can reach a discernible judgement from that, we will build that into our thinking for next year's overview report. That is probably as much as I can say at the moment.

The Convener: Thank you. We have mentioned the national treatment centres a few times this morning. They are, in part, a national health service response, in place of the private sector, to some of the pressures. Three national treatment centres that were scheduled to open last year did not open. The last I saw, they were scheduled to open in the first half of this year. Rumour has it that the First Minister, in one of her final acts, may open one before the end of the week, but whether that is true remains to be seen.

My serious point is that there have been delays. Can you elaborate on your understanding of the reason why the opening of those treatment centres was delayed? That delay has also contributed to the pressures that we have been talking about for the past hour and 20 minutes, has it not? Can you update us on whether those NTCs are on schedule to open this year?

Stephen Boyle: I will bring in Leigh to share what we have on that. Some of the announcement of delays was made after the publication of our report, so there is, perhaps, a bit of an overlap.

Before I pass to Leigh, the most important thing to say is just how important the national treatment centres are to building capacity. Across Scotland, 10 are planned, with 40,000 procedures to take place by 2028. We know that the delays in opening will likely push some of that required capacity towards the end of this decade. I am not sure whether I have the detail to be more specific about that, but I will turn to colleagues to update the committee as best we can.

Leigh Johnston: As far as we are aware, the three NTCs that are due to open will do so over the next couple of months. That is the latest information that we have. A number of factors have been at play in causing the delays. Some of those were already in train when the pandemic hit. There have also been issues of other sectors being impacted, which has affected the availability of construction materials and the cost of construction. Another obvious challenge is making sure that the necessary staff are in place. Some of the key staff needed for those centres are notoriously difficult to recruit: for example, theatre nurses and anaesthetists. Again, a combination of factors led to the delays but, as far as we are aware, three NTCs will open in the next couple of months.

The Convener: Thank you. We will add that to the list of watching briefs on which the committee will need to keep an eye. I have one more question before we draw to a close. I will also bring in Sharon Dowey, Bill Kidd and Willie Coffey for one last go each.

I am interested in teasing this out. I know that, in July 2022, new national planned care targets were announced. As I understand it, the deadline for some of those targets has already passed without their being met. Are you aware of whether those targets are being reviewed and do you know what the new targets and timescales will be?

Stephen Boyle: Fiona has that detail, convener. I will bring her in.

Fiona Lees: I am not aware that any of those targets is being reviewed or revised. You are right in saying that some of the deadlines have passed. Although substantial progress has been made on reducing some long waits, it looks as though the targets—depending on how you define "target"—have not been hit. I am interested to know whether there are plans to revise those targets, particularly in the light of some of the elective care policies that we saw at the start of the year.

The Convener: That is fine. We will, I am sure, return to those issues in subsequent sessions on the NHS.

Sharon Dowey: The report highlights the point that workforce capacity is the biggest risk to recovery and shows that one key recruitment target, that of increasing the general practitioner workforce by 800, is not on track to be achieved by the 2027 deadline. What is the Scottish Government doing to address that? Is the target still achievable?

Stephen Boyle: At a high level, you are absolutely right. We have seen that a sustainable workforce is fundamental to delivering the recovery of the NHS and a sustainable service going forward. I will bring in Leigh to update you on the GP delivery target. Our report raises a red flag about the fact that progress towards the delivery of the target of 800 GPs is at risk and that the planned steps that the Government needs to take are fundamental. It relates back to shifting the

balance of care from an acute setting to primary care and a preventative context.

Before passing over to Leigh, I wish to say that—I am happy to say more to the committee next week—we are giving a bit of thought to future audit work in that area. We are looking at potentially doing some audit work on primary care services that can track and report further on the progress that has been made towards increasing GP numbers. Leigh can say a bit more about what that looks like at the moment.

Leigh Johnston: The Scottish Government is trying to increase training places to encourage people to pursue a career in general practice. It is a challenging target, though, and there is no getting away from that. The Scottish Government is also focused on a range of other things, such as GP retention. Our GPs are very stressed and burned out following the pandemic, and there is huge demand on them. It is therefore also about how we retain the GPs that we currently have. A number of reforms are in progress. One of the main ones is to have multidisciplinary teams to try to reduce the workload for some of our general practitioners. As I say, it is a challenging target, and, as our report states, it is not currently on track.

Sharon Dowey: Thanks. Are enough conversations happening among Government departments before they make announcements such as, "There are going to be 800 extra GPs"? Are they then speaking to the universities and giving them the funding? We hear that Scottish universities are limiting the number of Scottish students because they need fee-paying students to pay the costs. Is enough funding being given for those places?

You spoke about primary care workers as well. The Government is trying to put in place more pharmacists to help GPs and reduce the workload. I have, however, heard that, after pharmacists have gone in, GPs have reduced their hours because they are burned out, so that measure is not helping. There is also an issue with workforce planning for pharmacists. Is enough funding being given to the universities to make sure that we can give places to Scottish students?

Leigh Johnston: Although we did not look at the funding in any detail, we did not find any evidence that universities do not have the capacity to offer the additional training places being planned for by the Scottish Government.

As we outline in our report, there are pressures on supervision. When the trainees come through and go into general practice, they need to be supervised for a time, and we are aware that there is some pressure on the number of GPs who are allowed to supervise trainees. NHS Education for Scotland is looking into how it can improve that situation and address that pressure, but we did not look at the funding in any detail.

Stephen Boyle: It is part of the plan: the target of 800 is not a notional one. Clearly, people have to be brought into those roles, and that is absolutely part of the funding through universities. That is not just for GPs. Our report also talks about funding for nursing vacancies and the work that the Government is doing with universities and colleges to support that.

NHS Education for Scotland has a key part to play as it has a role in supporting trainee doctors through to qualification and practise. That brings us back to the fact that there needs to be a co-ordinated and detailed plan to deliver on those targets. That will be the route to tackling some of the challenges that are set out in our report.

Bill Kidd: Paragraph 111 on page 37 of the report highlights the Scottish Government's short to medium-term strategy to mitigate the domestic supply of staff through international recruitment, and that £1 million is being provided to each board to help to identify international staff who can complete the training. You mention three boards that have recruited internationally. However, the report also notes that

"NHS Highland found the process time-consuming and expensive".

Does that strategy represent a suitable option for future NHS workforce growth?

Stephen Boyle: I do not think that we have reached a view on whether it is the best option or a suitable one. That is likely to be a question that the NHS can best explore when it is looking at its longer-term strategy. It feels like it is part of a number of steps and a number of tools that it has at its disposal to tackle a short-term issue. You can see that there have been some aspects of progress and some successes from it. The cost benefit of going down that road relative to recruiting and training a domestic workforce needs to be evaluated. It is one of many aspects, but it should not be seen as being a very clear, direct alternative to longer-term training as part of a co-ordinated workforce plan.

Bill Kidd: Does that essentially mean that you cannot do just one or the other? You have to build them into a longer-term programme.

Stephen Boyle: Yes. My sense is that international recruitment would be only a small component of recruitment into the NHS. It was a necessary reactive step to bring in capacity when it was most needed during the pandemic and in the aftermath that we are now in. It does not feel like it is a long-term, key element of workforce planning for the NHS. I should say, Mr Kidd, that

we have not done any detailed work on that yet, but it feels like our interest would be in a much wider evaluation of how NHS workforces operate.

Willie Coffey: Auditor General, one of the huge issues that we have seen over the years, dating back to Bob Black's time, is how the Government and the NHS engage with the wider public in the journey of reform and get their support.

I visited a GP practice in Kilmarnock recently and 20 or so GPs spared some time to talk to me about that issue. They are concerned and disappointed that the public perception of GPs is that they are not working for the public and are not willing to see the public. That is a big issue. All members throughout the Parliament have heard that, but it is not true. GPs are delivering services and are engaging with the public face to face, but public perception is a big issue.

Can you offer any advice to the committee about how the Government could revisit that problem and have closer engagement with the public to enable them to make the journey of reform along with us?

10:30

Stephen Boyle: That is a very interesting example, Mr Coffey. Like my predecessors Bob Black and Caroline Gardner, I have said that the sustainability of the NHS in Scotland needs detailed evaluation and engagement with decision makers, parliamentarians such as yourselves, people who work in the NHS and, most fundamentally, people who use the service: patients. That has not yet happened in a really detailed national conversation about the sustainability of health and social care services. It is not just us; many people have said that we are not in a place where we have a sustainable model that can work for all of us in what it costs, recruiting people to work in health and social care and delivering better long-term preventative outcomes for the people of Scotland. We have to do that. We have to engage with the public about their expectations and what is achievable.

A key part of our report and one of our recommendations is that that step now needs to happen. That might be challenging and might involve some changes to deeply held convictions about how health and social care operates in Scotland, but we need only look at what we have been experiencing over the past few years to see that we have a system that feels fragile. The view of experts in the Scottish Fiscal Commission is that, if we continue on this path without making reforms, it will require very unpalatable choices about prioritisation and affordability. If we continue to invest in health and social care services in the way that we are doing, it will mean that we will not be able to afford other key parts of public services. All of that requires a detailed, structured conversation, fundamentally with the public, so that they can have their voice heard on what matters to them.

Willie Coffey: Have you views on how we should deliver that? What kind of participation processes should we try to create and promote to truly engage with the public on the reform process that we all know is needed? Saying that it is needed is great, but how do we deliver it? Do you have any suggestions to offer us?

Stephen Boyle: You are right: it is easy to say it. I will probably reserve my chance to comment on that, because it is primarily a question for the Government and the NHS. Do they agree that that is necessary? If so, it is about moving on to how best to do that. There is also a role for the Parliament in thinking about how we are measuring the performance of the NHS in Scotland. Are the performance indicators that we currently use and report on so regularly giving a good enough story about how healthy Scotland is as a country? That is equally part of it, Mr Coffey, but there are people better placed than I am to suggest how we best go about that and the most effective way to do public engagement. It is clear from our report that that needs to happen next.

Willie Coffey: Okay. Thank you very much for that. It is a really important point.

The Convener: My take from that is that we cannot rely on a top-down solution; there needs to be proper participatory engagement of people if there is going to be any faith placed in any reforms that happen.

Thank you so much for your evidence. As I said at the start, the report was impactful when it was published and I think that it will continue to resonate. It has certainly given us, as a committee, quite a number of areas that we will want to pursue to get to where we think public interest needs to get to on where these reforms are; what is happening with the money that is going into the NHS; whether the outcomes are being delivered; and, if they are not, why not and what can be done to fix that. Thank you very much for your contributions this morning, and I thank committee members for their questions.

10:34

Meeting continued in private until 11:10.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

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