OFFICIAL REPORT
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Public Audit Committee

Wednesday 29 January 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 29 January 2025

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PUBLIC AUDIT COMMITTEE
4th Meeting 2025, Session 6

CONVENER

*Richard Leonard (Central Scotland) (Lab)

DEPUTY CONVENER

*Jamie Greene (West Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Stuart McMillan (Greenock and Inverclyde) (SNP)
*Graham Simpson (Central Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

John Burns (NHS Scotland)
Alan Gray (Scottish Government)
Caroline Lamb (Scottish Government)

CLERK TO THE COMMITTEE

Katrina Venters

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Public Audit Committee

Wednesday 29 January 2025

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Richard Leonard): Good morning. I welcome everyone to the fourth meeting in 2025 of the Public Audit Committee. Agenda item 1 is to decide whether to take items 3, 4 and 5 in private. Do members agree to do so?

Members *indicated agreement.*

"NHS in Scotland 2024: Finance and performance"

09:30

The Convener: Our main item is consideration of the Auditor General for Scotland's section 23 report, "NHS in Scotland 2024: Finance and performance", which covers the national health service's financial position and performance measures.

I welcome our witnesses to the committee. We are joined by Caroline Lamb, who is the chief executive of NHS Scotland and director general of health and social care in the Scottish Government. Alongside her is Alan Gray, who is the director of health and social care finance in the Scottish Government. We are also joined by John Burns, who is the chief operating officer of NHS Scotland.

We have questions to put to the witnesses over the next hour and a bit, but before we get to those, I ask Caroline Lamb to provide us with a short opening statement.

Caroline Lamb (Scottish Government): Thank you, convener. I welcome the report by Audit Scotland and—as I have stated previously—I see the close engagement between my team and Audit Scotland as incredibly important. The First Minister, in his speech on Monday, set out clear priorities for NHS Scotland, together with a commitment to deliver further detailed plans over the next few months.

The Scottish Government's draft budget, if it is passed by Parliament, will provide a record £21 billion of funding for health and social care, including, importantly, £200 million to reduce waiting lists and increase capacity, all of which will help to improve the flow of patients through hospitals and reduce pressures on both urgent and planned care.

We are determined to continue to improve the performance of our NHS and, as we work to deliver on the priorities of the Cabinet Secretary for Health and Social Care and the First Minister, we will pay careful attention to the Audit Scotland recommendations.

I am happy to take questions.

The Convener: Thank you very much indeed. I begin by asking you that perennial question: do you accept the findings and recommendations of the Auditor General's report?

Caroline Lamb: Yes, convener, we accept the findings and recommendations and, as I said, we are already working to consider carefully how we use those recommendations in the work that we are taking forward.

The Convener: Thank you very much for putting that on the record.

I turn to the review of actions since the previous report—"NHS in Scotland 2023"—was issued. Appendix 2 of the most recent report charts the progress that is being made since then. In broad terms, the Auditor General finds that some of the recommendations that were made last year are "In progress". That includes the medium-term financial strategy, which the committee has been concerned about because of its delayed announcement; I think that we are now expecting to see it in spring this year. The Auditor General also notes that an update to the national workforce strategy is "In progress", although he says that "no timeline is confirmed." He then talks about "Limited progress" on a long-term vision, and says:

"The restated vision from the Scottish Government does not clearly set out national priorities or provide a framework for reform."

I wonder whether you could comment on those areas.

Caroline Lamb: Yes, absolutely. I will start with the restated vision. As the First Minister set out in his speech on Monday, with more detail being provided in response to a Government-initiated question, the plans are being worked up with our NHS boards—again, that was a recommendation of NHS Scotland—into a detailed operational delivery plan that will be published by the end of March.

We are committed to producing the population health improvement framework. Again, substantial work has been undertaken on that with partners, including, importantly, the Convention of Scottish Local Authorities, and it will be published in the spring. We have also committed to publishing a framework for the medium-term reform of health and social care by the Parliament's summer recess.

It is important to set those areas out. That is not to say that there has not already been a lot of work under way on the components of those—I am sure that we can go into more detail with the committee about that. However, that very much links back to the workforce strategy and the commitment to provide an update to that strategy. That will need to take into account the detailed operational measures to make the best use of the resources that we have in the short term, while looking at what we need to do to deliver on the ambition to shift more work and activity into primary and community care and to deliver the longer-term reshaping of NHS services.

Work is under way to look at and understand all that, and, importantly, to understand the impact of the increased use of digital and innovation with regard to the workforce. We need to incorporate all that into a refresh of the national workforce strategy.

The Convener: In the speech that the First Minister made on Monday, he said:

"we"

need to

"put in place clear milestones and targets",

which is music to the ears of the Public Audit Committee and, I am sure, the Auditor General.

The problem is, however, that we have heard that so many times before. Let us look at the areas where the Auditor General identifies that there has been no progress. The annual recovery plan update, and the whole recovery plan, was first instituted in August 2021, and there is a real lack of transparency around that. The Auditor General also notes that the annual updates that we expect on service reform are not there either.

Why, only now—that is, two days ago—is it once again necessary to say that we need a new clear direction and we are going to set out milestones, when the evidence before us appears to show that, even when ambitions are set, progress reports are not made, milestones are not clear and there is no real sense that progress is being made? Why is it going to be any different this time?

Caroline Lamb: First, I note that we published an update to the original 2021 NHS recovery plan; that was published after the Auditor General produced his report. However, we accept that we need to be much clearer about the metrics that we are using to measure improvement, and we need to be able to demonstrate the impact that our reforms make. A lot of that is linked to the ways in which we have been changing, improving and evolving the way in which the system runs.

The Auditor General himself, in his report, reflected on the fact that our traditional ways of capturing activity in our accident and emergency departments did not include some of the developments that have been made through the establishment of flow navigation centres and the ability to book people in for appointments at emergency departments. Work has been under way, and from the beginning of this year, our reporting will include and capture that activity. We have been in a bit of a process of needing to catch up our reporting and our metrics with the changes and improvements that we have been making to the way in which services have operated.

The Auditor General was also clear that he expected the Scottish Government to work with NHS boards in developing those plans. We have absolutely been working with NHS boards on that. The detailed operational plan that we publish in

March will have been worked through in collaboration with NHS boards so that we are clear about what boards will be delivering in terms of their core capacity, and what the additional funding—which is critical to that—will provide.

We will be looking to provide very clear milestones for short-term improvement. That might well be an iterative process, because we will need to work with Public Health Scotland on creating and putting into the public domain new data sets, which will, increasingly, enable us to capture new areas of activity. That will include, for example, capturing the activity that goes through active clinical triage—which is, again, a new way of thinking about how we provide services—and a patient-initiated review. At present, the activity levels that we are capturing slightly undersell what we are doing, and we are very keen to be able to address that.

The Convener: Let us have a look at a couple of those points. In his speech on Monday, the First Minister reminded us that, last year, he referred to delayed discharge as

"the canary in the coal mine of our National Health Service."

Paragraph 80 of Audit Scotland's report says that delayed discharge rates are at the highest levels on record, so what is the state of the canary at the moment?

Caroline Lamb: None of us would argue that delayed discharges are not at an unacceptably high level. They have an impact on our health service's ability to function efficiently and effectively. Such delays mean that our hospitals are far fuller than they should be for efficient operation, which impacts on the way in which we run our services and on our ability to see people quickly, whether they present in an emergency, for unscheduled care or for planned care. Much more important, though, that also impacts on the people concerned. We know that it is really bad for people to be in hospital when they do not need to be there.

This is a complex and multifaceted issue. To address delayed discharges, we need to work together; it is not an issue on which the NHS can pull all the levers. The health service can absolutely take steps to increase the number of short hospital stays when patients do not need care at home and therefore will not need support after discharge. It can also work on reducing the number of long stays for patients in the same category. However, we need to work with our partners on people who need support to enable them to get home or at least into a homely environment.

Since the summer, the Cabinet Secretary for Health and Social Care and the Minister for Social Care, Mental Wellbeing and Sport have been convening various partners through our collaborative response and action group, or CRAG. COSLA co-chairs that group, and Councillor Paul Kelly has been co-chairing its meetings. The group has focused on the work that is happening in better-performing areas. There is variation across Scotland: some areas perform extremely well and others not so well.

Our interventions at national level have aimed to expose that data to enable us to clearly understand where areas are performing well or not, and what helps to drive improved performance, and then to seek to challenge that performance. The First Minister's announcement on Monday described that work. The proposed Scottish budget includes £200 million to address elective waiting times. That will allow us to take steps that we know will help to prevent people from being admitted to hospital in the first place and to enable those who are to be as discharged as quickly as possible.

The Convener: On the subject of delayed discharge, you are the accountable officer for health and social care, the latter being the other key component in resolving the delayed discharge crisis. Do you not accept any responsibility for that?

Caroline Lamb: I absolutely accept that the position on delayed discharge is not where we would want it to be.

Yes—my title is director general for health and social care. The health part of the portfolio makes significant contributions into the social care budget, and has done so for a number of years. However, the operationalisation aspect—the allocation of funds into our integrated joint boards and our health and social care partnerships—is driven by health boards, over which we have strong levels of influence, and by local government. We need all those partners to come together and to play their parts. We have been convening CRAG to ensure that local systems know where they stand on whether their performance is good or poor and what they can do to improve it.

The Convener: You mentioned regional variations. Appendix 3 of the Audit Scotland report shows quite marked variations in some of those measures. For example, on referrals for suspected cancer within the 62-day treatment guarantee, the figures for the two health boards in the area that I represent are 83 per cent for NHS Forth Valley and 89 per cent for NHS Lanarkshire against a target of 95 per cent. For NHS Shetland, the figure is 50 per cent against that target, and both NHS Tayside and NHS Grampian are at just 60 per cent. What analysis have you done to understand

why there is such a variance between different health boards and health board areas?

09:45

Caroline Lamb: Our approach to that, first of all, is to set out, for health board areas, what good performance looks like in relation to rapid assessment and treatment of cancer. Where NHS boards have taken steps to really look at that framework and challenge themselves against it, they have achieved substantial improvements. You point to the performance of NHS Lanarkshire. It has improved substantially and continues to improve, which is really good news.

We are now working with all NHS boards so that they look at each of the steps that are set out in that framework, assess where they are individually and learn from what NHS Lanarkshire has done in improving performance in that area. What Lanarkshire and, indeed, Forth Valley have done proves that it is possible. Some of that is about cutting out unnecessary steps and making the pathway much smoother. We need to make sure that that is happening in every area and ensure that there are no particular barriers, particularly in some of our island boards.

The Convener: To give a fuller picture, if I look at the A and E stats, NHS Forth Valley and NHS Lanarkshire perform very poorly, do they not? The statutory target is for 95 per cent of people to receive treatment within four hours, but Lanarkshire's performance is 55 per cent and Forth Valley's is 54 per cent.

I will ask you a question that was posed to the Auditor General when he was here. Is there any correlation between poor performance in A and E and better performance in some of those other indicators?

Caroline Lamb: As you identified, every health system has its own challenges and successes, and NHS Tayside performs extremely well against the A and E standard, but it has some challenges and needs to do better against the 62-day cancer treatment target.

Our work is about identifying the things that improve performance across all areas and ensuring that boards are absolutely focused on the measures that they can take—whether they be around unscheduled care, treatment pathways or productivity in relation to planned care—and on their metrics and how they are doing against them.

I do not think that we can say that there is a clear correlation between doing well in one area and not doing so well in the other. I do think that there will be underlying issues in every NHS board in relation to its estate, its footprint, its workforce and its capacity. Part of that is understanding what good looks like, what things make a difference, and whether they are all being done in the board areas.

We work with the national centre for sustainable delivery to ensure that all our boards have support to make the necessary improvements against those areas. If good performance is possible in one area, we need to understand the absolute barriers—if there are any—that prevent that from being possible in another area.

John, do you want to say anything in addition to that?

John Burns (NHS Scotland): The only additional point that I will make is that we are clear in our engagement with boards around the framework for effective cancer management. On a regular basis, we meet boards and their cancer teams to work through their pathways, give them support and share learning. We have a cancer treatment delivery group that is very focused on the 62-day target, which is where we need to make improvement.

In response to your question, convener, I do not think that we can make a direct correlation in relation to good performance in one area and poorer performance in another. As Caroline Lamb said, many different factors are at play in relation to population demographics and referral patterns into boards.

We are working on that, and the national centre for sustainable delivery has a key role in helping to bring that understanding and share that learning across Scotland.

The Convener: We are going to touch on some of those performance measures as the morning progresses. Before I take us to another area, I place on record my membership of two trade unions that organise in the national health service.

I turn to staff sickness absence rates, which is recorded in this annual performance report on the NHS in Scotland as being at a 10-year high. What is your assessment of that issue, what are you doing to address it, and how are you going to turn it around?

Caroline Lamb: Sickness absence levels are certainly higher than we want them to be, and there is variation in them across all our NHS boards. Some NHS boards perform pretty well and are effective in managing sickness absence, which is really down to what happens at a local level. It involves the line manager regularly engaging with the staff member who is off sick, and following up and identifying the issues that would help them to return to work, particularly if it has been a long-term absence.

Our expectation is that, with their human resources directors every board is working through

line management structures and training and development, so that there is an understanding that line managers feel confident and skilled in being able to support staff to get back to work. We expect all that work to go on locally, and we regularly meet with HR directors to support them in that work. We also intervene through our national workforce support services, but on the ground, it is very much a matter for boards to manage, and we look at the variances between different boards.

The Convener: As the director general for health and social care, do you have data that shows you the reasons why people are off? Some jobs in the NHS are physical jobs—manual handling and so on—and, as a result, some people might be off through work-related injury. There is also the possibility of an increase in workplace-related stress. Do you have data that lets you know what is going on out there, so that it can be tackled and support can be put in where it is needed?

Caroline Lamb: I need to come back to you on the detail of the data. At the board level, we absolutely expect boards to be looking at, for example, the balance between musculoskeletal factors, which, as you said, potentially relate to lifting and perhaps to people needing more support regarding how to do that, and stress-related illness. I need to come back to you about the extent to which we collect that data at a national level, because the interest in that happens at a board-by-board level.

The other thing that we use is iMatter, which is the annual staff survey and is very much for boards and teams. The questions are asked at a team level, then the teams develop their individual action plans, which enables us to take the temperature of how people are feeling and enables teams to work together to identify the issues that might have emerged through that process.

The Convener: Sickness absence among NHS staff is at a 10-year high, and the First Minister announced on Monday that he wants there to be 150,000 extra appointments and procedures. How are you going to do that unless you tackle that level of staff absence?

Caroline Lamb: Tackling staff absence is an area that we expect boards to focus on in terms of their ability to be more efficient and productive. It also sits alongside other measures, such as reducing the use of agency staff. The Auditor General recognised in his report that some boards have been successful in doing that and in reducing the number of vacancies across the system.

We accept that having the right workforce in the right place is fundamental to achieving our ambitions, and we will continue to work with boards and stress the importance of them comprehensively managing and supporting their workforce at the local level.

The Convener: I now turn to Colin Beattie, who has some questions to put to you.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I would like to cover various aspects of financial sustainability. NHS funding in 2023-24 grew by 2.5 per cent in real terms, but that increase mainly went on pay rises and inflation. Health is the biggest single area of Government spending. In 2023-24, it was 40 per cent of the Scottish budget. The affordability of healthcare spending was always a big issue, but it is now even more urgent and needs to be addressed. The scale and pace of reform need to increase. That was emphasised in the First Minister's speech on Monday.

I would like to look at some different aspects of financial sustainability. One is the cost of drugs and prescriptions. The Auditor General has told us that some analysis of pay awards has been done, but nothing seems to have been done on drug costs and what drives them. As a society, we are getting older and we have longer-term illnesses and so on, but we do not know what proportion of spend drugs, for example, takes up. What is the cost and what are the projections? Do you have any information on that?

Caroline Lamb: You are absolutely right that prescribing costs are a significant pressure on the budgets of all our NHS boards, and we seek to support boards to manage that in a number of different ways. First, comparisons across different NHS board areas are helpful. We have focused on the replacement of some of the more expensive drugs with cheaper, generic drugs, and we have focused on polypharmacy and making sure that people are not being prescribed more drugs than they need to be prescribed. That is better for them and better for the public purse.

At the other end of the spectrum is the growth in new and very expensive medicines. We have a process of horizon scanning to support boards to understand what might be coming and what might be being approved through the approval mechanisms, and we are working with boards to understand how we can best accommodate that.

We need to continue to focus on our data in this area. It is one of the areas that we ask boards to focus on, particularly in their efficiency and productivity measures.

Alan Gray, do you want to say anything more about that?

Alan Gray (Scottish Government): You have covered the main aspects of what we are trying to

do. We have quite a lot of information, particularly about primary care prescribing. We have focused on moving from branded to generic medicines, and we are looking at polypharmacy and reducing the number of medicines that we prescribe to people. Within secondary care, each board has a formulary, and there is a controlled process through which drugs are added to or taken off that and made available for patient treatment.

As Caroline has said, the growth in new medicines, particularly drugs for rare and orphan diseases, is increasing year on year. The numbers show that the growth in the past year was 2.4 per cent, which is broadly in line with our increase in expenditure in the past five years, which is 5.2 per cent, so it is probably not the biggest single thing driving our expenditure. You made the point about staff costs, and those are probably driving our expenditure much more than drugs and prescribing.

Colin Beattie: What is the current percentage for expenditure on staff costs?

Alan Gray: We spend just over £11 billion on directly employed staff against a budget, or net expenditure, of about £18.4 billion, so about 60 per cent goes directly on staff costs. In addition, we pay for primary care contractors who are, in effect, staff who are employed through a contractual arrangement with the NHS. Including primary care contractors probably moves the figure for our total direct people costs closer to 65 to 70 per cent.

Colin Beattie: That is a very high percentage, but the NHS is a people organisation.

Alan Gray: Indeed.

Colin Beattie: You need the bodies there to deal with the patients. Unfortunately, robots are not yet available for that. How do we compare with other health boards south of the border and on the continent?

10:00

Alan Gray: The UK generally employs fewer doctors and nurses than other countries in the Organisation for Economic Co-operation and Development, but we employ more staff than are employed in England. Proportionately, we employ broadly the same number of doctors, but we employ more nurses and more staff in other roles to support the health service, which means that we have a bigger staff base than our equivalent in England. I do not have a comparison figure for Ireland, but I know that our staff numbers are probably comparable with those in Wales. We definitely have significantly more staff than NHS England does.

Colin Beattie: I said that the organisation is inevitably people driven. When we think about how well we are doing, we often compare ourselves to south of the border. We have additional staff and have a higher headcount than south of the border, so why are we not exponentially better?

Caroline Lamb: There are a number of factors to look at. Because of the way that we count things, it is hard to make direct comparisons between the performance figures that are published in England and those that we publish. We must also take particular Scottish demographics—the nature of our population and its rurality—into account.

We have more staff, and we also pay them slightly more than staff in England are paid. Having more staff and rewarding them better in itself means that we have sometimes had less money available to spend on other innovations, such as digital. We are expanding that area at the moment.

Colin Beattie: What happens if we look at quantifiable areas, such as drug costs? How do those compare with the percentages that are being spent elsewhere?

Caroline Lamb: I do not know whether we have those figures. Perhaps Alan Gray can help.

Alan Gray: I do not have the direct numbers, but could find them out. I think we are broadly in line and not too far out of sync. Things are a bit different in Scotland. We have a slightly different process for bringing in new drugs via the Scottish Medicines Consortium, and we introduce new drugs at a slightly lower affordability threshold than in England. I think that we are broadly not too far out of line. We can provide the committee with further information.

Colin Beattie: I will move on to another aspect. Different health boards have been under different pressures over the years, and the committee has been very much involved in looking at those situations. Eight territorial boards required brokerage in 2023-24 and some boards are forecasting recurring deficits over the next three years, which must create a risk to their financial sustainability.

Why do those recurring brokerage issues come up? Why are those boards under the pressure that they are under? It seems that Scottish Government policy is to try to do away with brokerage over a fairly short period, but that is not evidenced by what we are being told in the Auditor General's report.

Caroline Lamb: You are absolutely correct that a number of boards have been in receipt of brokerage over more than one year. Our approach is to be really clear that we cannot shift into a

culture where brokerage is always seen as being an option. We must work with our boards to get them back to a balanced position. That might take two, three or more financial years, but we need our boards to plan on that basis. In his report, the Auditor General absolutely recognises the amount of support that we at the Scottish Government are providing to boards to get them back into a balanced position.

Alan Gray may want to say a little more about the support that we provide.

Alan Gray: We provide a range of supports. We have an escalation scale that allows us to provide different types of support, depending on where the board is in relation to financial deficits. Five boards are currently at level 3, which requires us to monitor them more closely. We have a monthly conversation with each of the chief execs and directors of finance, but we also put in place external support. A range of external support has been offered to each of the boards, depending on the circumstances. Some might want support to help with operational issues that are linked to financial performance, and some are looking to help develop their savings plans in more detail. We have provided access to a range of different organisations to help support the boards to develop plans.

We gave a clear signal that, from the start of next year, we want boards to start turning back to financial balance and to take the steps and actions to do that over a reasonable period.

I reassure the committee that we are not aiming to do things without due care and attention, but we need to start to move away from brokerage being an increasing part of what we fund and towards boards returning to a sustainable position of financial balance.

Caroline Lamb: That also links to the objectives that the First Minister set out on Monday. In the short term, trying to improve performance is about making the absolute best use of the resources that we already have, while recognising, as you have recognised, Mr Beattie, that the proportion of the Scottish budget that goes to health cannot carry on increasing exponentially. To address that, we need to tackle the underlying causes of ill health in Scotland. That is not just for the health service to do—it is a cross-Government and society endeavour. That is why in the spring we will produce a population health improvement framework.

As you have heard, lots of developments have already happened around how we can deliver health services in a different way—more efficiently and effectively. We need boards to look at that locally with their partners, and we need them to work regionally and collaboratively.

From a national Scottish Government perspective, we also need to ensure that we are able to provide the innovation and infrastructure that enable the health service to shift to doing things in a more sustainable manner.

Colin Beattie: What is the main driver of the need for brokerage? Are staff costs driving it, or is it the cost of drugs?

Alan Gray: There are a range of factors. Part of it is due to the ability to recruit staff, so we maybe have to recruit additional locum staff. Further north or south of the central belt, there are more challenges around recruiting staff, so that increases the costs.

Another factor is delivery of services across large geographical areas. For example, Highland, Ayrshire and, to a certain extent, Grampian have large geographical areas to cover, so that incurs additional costs.

There are also variations in operational performance. Earlier, Caroline Lamb and John Burns highlighted some of the operational performance issues that impact on the financial position. A longer length of stay can impact on the number of beds that boards are carrying—funded or unfunded. A number of factors contribute to that.

Colin Beattie: NHS Highland covers greater areas at greater cost. That should not incur brokerage—it should be part of the cost of running the health board in that area, because that is never going to go away. It is part and parcel of the delivery of services. To say that geography makes a contribution to the need for brokerage does not seem valid.

Alan Gray: The NHS Scotland resource allocation committee formula, through which we allocate funding, takes account of rurality. Boards that have a greater population and are more rural receive a higher proportion of funding through the NRAC formula. The NRAC formula recognises rurality in the funding that we allocate.

Colin Beattie: So if boards need brokerage, that will not be caused by the fact that they have to bear the additional costs of their geographical areas.

Alan Gray: That is where we can separate where the additional costs are justified, as opposed to where we think that there are opportunities to make financial savings. There are still opportunities for us to reduce the variation, even in those boards that are in financial deficit, and for us to reduce the level of deficit that those boards are incurring.

You are right that there will be a point at which we have to balance off the additional costs of providing services, whether those are additional

staffing costs or additional costs that are connected to geography and location. However, there are still opportunities for us to reduce the deficits in those boards in order to get them closer to a position of balance.

Colin Beattie: I move on to an issue that affects every single board, which is non-recurring costs. They seem to be embedded as an area where boards achieve a high percentage—sometimes the majority—of savings every year. That is not necessarily anything to do with brokerage; it is across the board. How far is it possible to move boards away from that? In the long term, that is not sustainable.

Alan Gray: I agree, and this year we have tried to do two things. First, we have tried to increase the amount of savings that we are delivering. We will deliver about £600 million of savings this year, which is higher than the figure for last year, which was £470 million, and we will deliver £300 million on a recurring basis, in comparison with £173 million. Secondly, we have set a 3 per cent recurring savings target—we are not there yet, but we are working closely with boards, through the financial delivery unit, to support them to move closer to achieving that.

You are right that if we do not make savings on a recurring basis, we start the following year having to make the same non-recurring savings again. We are moving, therefore, to delivering a greater proportion of savings on a recurring basis, and a greater level of savings in total, to try to get back to a more sustainable financial position.

Colin Beattie: The problem is that, for years now, this committee has been seeing the reports coming in about non-recurring expenses—it is almost a core part of every board's annual activity. How are you going to get away from that? You talk about reform and changing the health service, and the way that delivery is made and all the rest of it, but with such a significant proportion of non-recurring expenses, how are you going to balance the books? You are just playing about with numbers, really.

Alan Gray: As I said, you are right that that is an issue, but we are delivering more on a recurring basis, so we are moving to a position where more savings are being delivered on a recurring basis.

We will never get to 100 per cent, because there will always be opportunities to make non-recurring savings, which we will take, of course, as part of our financial planning. There will always be non-recurring savings—for example, vacancies in staff posts would create a non-recurring saving for a board. That creates an operational pressure, but it also creates a non-recurring saving.

We will always have non-recurring savings that we have to take account of. What I am saying is that we are moving—the numbers show this—to a greater proportion of savings being delivered on a recurring basis, which is absolutely the right direction. We have focused effort on that, working with boards; that is now starting to deliver, and we hope that it will be reflected—

Colin Beattie: In previous reports that have come to the committee, there has been no indication of any significant improvement in non-recurring expenses. What is happening now that is going to make a difference?

Alan Gray: Within my directorate, we established the financial delivery unit, which is providing direct support to boards. We are providing direct support to boards, and—

Colin Beattie: I am sorry to interrupt, but when was that unit established?

Alan Gray: About 18 months ago.

Colin Beattie: Eighteen months ago.

Alan Gray: Yes, and the results of that investment are now starting to flow through. I hope that, when you see the report next year, you will see that we have delivered more on a recurring basis. That strategy and approach are now starting to deliver, and starting to show in not only the total number of savings—as I said, a higher level of savings in total were delivered—but in a greater proportion than is currently the case. It is still at 3 per cent, so there is more that we can do, and I accept the committee's challenge to drive that up, but we are moving in the right direction.

Colin Beattie: Are there any indications that the drive for efficiency savings is impacting on service delivery or performance?

Alan Gray: It is very much linked to that. We are trying to identify where there are opportunities. We are looking at comparisons and benchmarking where there are opportunities to reduce variation. As Caroline Lamb indicated, there is variation in how efficient or effective boards are at sharing our best practice in innovation and performance, which is highlighted in the report. We are trying to look at where best practice is working, and to share and implement that more consistently across Scotland, and that is starting to bear fruit.

There is the agency work that was referred to earlier. We have a concentrated effort nationally, led by the chief nursing officer and the interim chief executive, and that is resulting in change. We have worked on that together and we are making some clear decisions and choices about how we deploy staff. That is starting to deliver savings.

The more we do together—the more we share the information and data that we have, and our best practice—the more we manage the risk of doing things that might be counterproductive to performance.

Colin Beattie: I have one final question, which is on brokerage. The Scottish Government wants to put a cap on the additional financial support that might be available to boards in 2024-25. What happens if they exceed that cap?

Alan Gray: Quite a number of the boards will exceed their cap, hence the reason that we need to change our approach to try to get boards back into financial balance. We are looking at a three to five-year financial strategy to try to help them to do that. A number of the boards that are highlighted in the Audit Scotland report will reach their cap. That is one of the reasons why we have changed the approach to managing financial deficits by working with boards in a different way to reduce their financial gaps.

10:15

I agree that that is not the way to go forward. Brokerage was always intended to provide short-term funding where a board went into a small amount of deficit that it could repay by the following year. We now have a situation where such brokerage is unlikely to be repaid anytime soon. That is why I am proposing that we change our approach.

We see that in the work that focused on recurring savings. We have more to do on that, and the reform aspect will clearly play a part. We need to move to a position where we are living within our means and delivering savings, productivity and the types of services that the people of Scotland would like to see.

The Convener: Thank you very much indeed. I will move on and invite Graham Simpson to put questions to you.

Graham Simpson (Central Scotland) (Con): Good morning. I want to follow up on the question about brokerage. People watching this meeting might not know what brokerage is. If I might put it in layman's terms, it is about bailing out boards because they are overspending and need extra money. To follow up on Colin Beattie's question, which I do not think was fully answered, what happens if a board says, "We just can't do it—we need extra money"? Mr Gray, I know that you want to move away from that model—and rightly so—but there will be circumstances where boards just cannot meet their budgets. What will you do then?

Caroline Lamb: Perhaps I could make a start on that answer and then hand over to Alan Gray. Our approach is all about engagement with boards. As Alan said, we—Alan, his team and the financial support unit—meet boards very frequently to enable us to understand their positions and take assurances that they are doing everything that they can. It is about having conversations. The brokerage caps were set at the beginning of the year, and our approach is to review them as we go through the year. However, as Alan said, we also need to get away from the concept of brokerage being a short-term measure and move towards the more sustainable approach of delivering recurrent savings. Is that a fair summary, Alan?

Alan Gray: Yes. I have nothing more to add. Does that answer the question?

Graham Simpson: I am just trying to think realistically. I cannot see the Government putting itself in a position where, if a board comes to it and says, "Look, we're really struggling here", you will say no.

Alan Gray: I agree. Each portfolio has to balance its overall position. On financial planning, if a board will exceed the plan that we have agreed with it, we need to take various measures within our portfolio to ensure that we have sufficient provision to cover that deficit. My preference would be that we direct money where we can see a return, rather than fund a deficit position.

We need to address that issue. If a board exceeds its financial target or its brokerage agreement with us, we need to reflect that. It becomes my responsibility, with the DG, to manage that as part of our overall directorate budget and path to balance. It has consequences for the money that we can regard as being sufficiently available and flexible to support improvements in patient care or to direct towards investments in areas where we see need.

We need to address such deficits by managing them in a sensible way. We need to move away from brokerage, because the culture around it is wrong. Some people assume that brokerage will be made available. We do not have that money. Difficult choices must be made if a board exceeds its plans.

Graham Simpson: Those are difficult choices.

Back at the start of the meeting, Ms Lamb, you spoke about the announcement made by the First Minister and the health secretary earlier this week, in which they made a series of pledges. You said that there will be a delivery plan for those at the end of March. From that, it sounded to me as though the First Minister had made all those pledges with no idea about how they would be achieved.

Caroline Lamb: That is not the position. The pledges made by the First Minister are on areas and commitments that have been worked up, based on modelling and on engagement with the system. The detail will come when the delivery plan is published at the end of March. There is already quite a lot of detail in the GIQ that was published. As I have said, and as Audit Scotland recommended, we have been working closely with NHS boards to be absolutely clear about what, why and when we expect them to deliver and to assure ourselves that we are confident about that planning.

From the announcement of the draft Scottish budget, we have also been working on that additional investment in addressing waiting times and improving capacity.

There are two things here: how we ensure that we deploy the core allocation to deliver against those priorities and then how we deploy that additional funding differently from how we have in the past—we can certainly talk about some examples of that. It is really important that we work with our boards so that that is a joint plan and we have assurance in it. It is also really important that we reflect on the Audit Scotland recommendations and ensure that we are clear about the metrics that we will use and the milestones that the committee will expect to see.

Graham Simpson: Others will probably ask about the detail of what was announced earlier in the week, so I will leave that to them.

There has been talk for some time about having a national conversation on the health service. The Government loves that phrase, along with task forces and consultations. We have quite a lot of that. If we had a national conversation about the health service, the Cabinet Secretary for Health and Social Care would not have time to attend football matches because members of the public would be telling him a few home truths. Has that so-called conversation started, how long will it take and what will it cover?

Caroline Lamb: Since the cabinet secretary made his statement to Parliament in June last year, he and his officials have been focused on a number of engagements. In doing that, we have drawn on the intelligence gathered from previous exercises by organisations such as the Health and Social Care Alliance Scotland around being careful not to go out and ask people questions they have already been asked.

The ALLIANCE has done an exercise for us to gather the results of previous conversations and engagements with the public. We have also had a stakeholder reference group that the cabinet secretary met with. We have drawn on the extensive engagement with service users and others that was used to develop the proposals for the national care service. That was focused on social care, but a lot of primary community and other health services were referenced in it as well.

The cabinet secretary also engages regularly with staff through staff fora. We had the nursing and midwifery task force, which engaged in an extensive listening exercise with nurses and midwives over the past few months. There is also—John, can you remind me of it?

John Burns: There is also the Healthcare Improvement Scotland community engagement panel.

Caroline Lamb: That is the citizens panel that discussed our approach to realistic medicine and the use of NHS resources.

There have been a number of elements of work. As you will know, the First Minister is also convening a number of round tables. We will draw all that together to inform the work that we take forward.

Graham Simpson: Are you saying that the conversation has started?

Caroline Lamb: The conversation has started at every level.

Graham Simpson: Oh, it has.

Caroline Lamb: Yes.

Graham Simpson: Okay. It is just that there are various parts to it.

Caroline Lamb: Yes, and that is appropriate. We have a number of established mechanisms for engaging with people. We have been making best use of those and supplementing them with other mechanisms.

Graham Simpson: In that continuing conversation, are you considering things that are of limited clinical value? I point you to what the Auditor General says:

"The Scottish Government and NHS boards should:

Ahead of 2025/26, jointly identify areas of limited clinical value and consider how services can be provided more efficiently, or withdrawn".

When I asked him about that, the Auditor General told me:

"The Government itself, in its clinical strategy from 2016, cited a source that said that 20 per cent of medical interventions were of limited value. In our view, there needs to be transparency around what interventions exactly, in the Government's view, are of limited clinical value"—[*Official Report*, *Public Audit Committee*, 12 December 2024; c11.]

Can you tell me what medicines and procedures are of limited or low clinical value and whether you have decided which ones you do not want to proceed with?

Caroline Lamb: We need to separate a number of issues. The first of them is that that quote about 20 per cent comes from an OECD report, and the context is the extent to which value is added by resource in health systems internationally or in certain OECD countries.

Our approach to addressing that has been through realistic medicine and value-based medicine, which involves working with clinicians and recognising that they have a key role as custodians of NHS resources. A lot of decision making about the use of NHS resources is done by clinicians, so we work with clinicians and with people. John Burns referred to his citizen panel, which has been important because it has been focused on realistic medicine. People support that. They want to be involved in decisions about their care and they want decisions that are right for them. That is the approach that we take through realistic medicine.

As you said, the Auditor General also highlighted procedures of limited value in the recommendations. We picked up that recommendation and did a bit of work on it, and our initial approach has indicated that we should pull together a draft list. I do not have the details of that, but I can provide the committee detail as to some of the things that would be on that draft list.

Graham Simpson: Well, just give me an example off the top of your head.

Caroline Lamb: One of the areas that is under consideration is varicose vein treatment. Again, I cannot give you the detail of that, but I can provide it to the committee after the meeting.

We have had Public Health Scotland do some work on the issue and it has said that it sees limited indications of procedures of limited clinical value being carried out in Scotland, which is why I am struggling a little bit to give you examples.

Our approach in relation to the Auditor General's recommendation needs to go a bit broader than that. It is about the principles of realistic medicine, how we make sure that the medical and clinical interventions that we make are right for people, and how we ensure that we are delivering services in the best and most effective way possible. The right place, right time approach is critical too, as are the things that we have set out about working more closely with people in the community when implementing the national clinical strategy. We can talk about that work. The use of digital and innovation is also increasingly important.

Graham Simpson: You mentioned varicose veins.

Caroline Lamb: I am not a clinician, so I would need to come back to you about the list.

Graham Simpson: You mentioned it. Are we potentially talking about not treating people for varicose veins?

Caroline Lamb: The Audit Scotland recommendation was on procedures of limited clinical value. I cannot tell you what is on that list. There is a protocol on that and there are protocols being developed in a number of areas.

It will be a nuanced conversation, because it will depend on the clinical presentation in each case. So rather than me trying to pre-guess that, it would be helpful to provide the committee with some further information after the meeting.

10:30

Graham Simpson: Okay; that would be useful.

The Auditor General is always talking about the need to reform public services, and he says it again in this report. In paragraph 94, he says:

> "Over recent years we have regularly called for the NHS to drive forward innovation, reform and long-term fundamental change. Our NHS in Scotland 2023 report made clear the urgency of the issues faced. This year's report details a worsening financial position and ongoing performance issues."

He also says:

> "The need for reform is more urgent than ever."

Basically, he is saying that he is not seeing much sign of reform. Do you think that the First Minister's announcement earlier this week is a sign that the Government wants to reform? If that is the case, what does it want to change? Where is the reform?

Caroline Lamb: In his announcement on Monday, the First Minister set out a couple of areas. The Auditor General has made comments about driving forward innovation, so I will give you an example of that. The First Minister described how we have been rolling out a digital dermatology programme. That work has been on-going through the course of this year. It will be completed and that facility will be available in general practitioner services across Scotland by the end of April.

That is an example of innovation, and of that innovation being taken forward by NHS Scotland, as team NHS Scotland, rather than being dependent on individual boards. That programme has been driven through our accelerated national innovation adoption team, which is housed within the centre for sustainable delivery. A national approach has been taken, whereby a tried and tested innovation has been planned, implemented and rolled out across Scotland in a way that has enabled the First Minister to announce with confidence that it will be in place and that it will start making a difference. It is already starting to make a difference to the way in which patients are

being treated. That is a really clear example of innovation.

The First Minister also signalled a further shift in the way in which we think about how we address waiting times. For example, in the past, if additional money was available to address waiting times, we might have shared that out between NHS boards in a way that enabled them to manage that locally. He clearly signalled that we are taking a different approach to that, whereby that additional investment will be directed at centres where we know there is a level of protection from the pressures around unscheduled care. It is very much about directing the resources where we believe we will get the highest level of performance for that money.

John, do you want to say something about the specifics on that?

John Burns: Yes, I can. As Caroline has set out, the approach is to use this shift in a deliberate and intentional way to support the ambition of improving access and reducing long waits. To do that, we are working to optimise our national treatment centres, which are a core part of the protected planned care resource, as well as bringing on additionality so that we can protect a level of service for particular specialisms.

As was set out earlier, in addition to our NTCs, we are looking to bring on additional protected capacity in Gartnavel, and to maximise and optimise Stracathro, which is an elective facility that is important for the north of Scotland. We are also looking at facilities such as those at Queen Margaret hospital in Fife, which has effective ambulatory care, day surgery and 23-hour surgery. We are looking to focus on areas such as ophthalmology, where we know we can increase throughput.

We are deliberately funding those areas where we know we can deliver improvement and bring down waits.

Graham Simpson: The deputy convener will ask you about waiting times, so I will not do that. I will ask about GPs.

The Auditor General did not cover this subject in his report, but it is really important. The First Minister and the health secretary mentioned GPs earlier in the week. They referred to what is known as the 8 am rush. You will recall that, at a previous committee meeting in June, when we were discussing GP appointment booking practices, I mentioned that I had done a survey of GPs in Lanarkshire. The result was a pretty mixed picture. To be fair, not all GPs operate the 8 am rush model. Some of them used to but have moved away from it. There might be a perception that every GP operates a system in which you have to phone up at 8 am, but that is not the case. Not every GP is doing so, but some are—too many are.

I was in a position in which my GP operated that system. As someone who has to come to work every day, it proved impossible to get an appointment. I got on my bike—literally—and cycled around East Kilbride, found another GP practice that did not operate that model and managed to transfer to it.

However, too many of my constituents do not find it as easy as I did. It is too difficult for them to switch, even though GPs are private businesses. My view was, “I’m a customer of a business that isn’t serving my needs, so I’ve got the right to move.” I do not think that people find it terribly easy to do that. Do you not think that it should be made easier for people to switch GP if the service is not good enough?

Caroline Lamb: My focus is on how we can work with primary care to ensure that the service is what we want it to be and what people expect it to be. That is in line with the First Minister’s comments on Monday. The thing that we hear most often from people is concern about their ability to access appointments with their general practitioner at a time that is convenient to them. As you know, we have done a huge amount of work to increase support to primary care. We have developed multidisciplinary teams: more than 4,600 individuals work in professions that support GPs to be expert generalists in the community.

Equally, we know that general practice is under pressure. The changes to employer national insurance contributions will present a further challenge.

The First Minister has set out that we will work with the British Medical Association and the Scottish general practitioners committee to develop a quality framework. That framework is intended to provide greater consistency of approach, so that—to use your example—people in Lanarkshire can expect a similar service from their general practitioner regardless of where they are in Lanarkshire or, indeed, where they are in Scotland.

We want to address two things: access to appointments and appropriate ways to support people to access appointments; and continuity of care. There is a strong evidence base—not for everybody, but in particular for people with complex or multiple conditions—on the benefits of seeing the same GP or the same practice nurse or physiotherapist, and of having increased continuity of care to support them. The evidence base on that is strong, and we will take that up with the GP and primary care community.

Graham Simpson: GP practices are private businesses. On a practical level, you cannot make

them do anything. The cabinet secretary might have the ambition to end the 8 am rush, but, realistically, he cannot enforce that, can he?

Caroline Lamb: Although some GP practices are run by NHS boards, you are correct that GPs are, on the whole, independent contractors. We therefore need to work with their representative bodies, and we also need to work through health boards and their local medical committees. The Scottish Government has a role to play here in relation to the national contract for general practice. There are some different levers that can be used.

Graham Simpson: Okay. Finally, I want to ask about the NHS app. I have asked you about that before.

Caroline Lamb: Yes.

Graham Simpson: We do not yet have an app in Scotland. People in England are lucky enough to have access to the NHS app, but we do not have one here, which is a source of real frustration. I think that people in England can book GP appointments through the app. In Scotland, there might be one or two practices that have their own individual apps, but we do not have a national app.

In the announcement earlier this week, it was mentioned that the Scottish Government is getting round to launching an app, which will be rolled out first in Lanarkshire. From my point of view, that is good. Can you tell us more about that? Where are you at? What will the app cover?

Caroline Lamb: At previous committee meetings, I have talked about our commitment to deliver the first version of the app in March 2026, so I am delighted that we have managed to bring that date forward. You are right that the early roll-out will commence in Lanarkshire, because that is where a lot of the work is happening right now.

I would need to check, but I do not think that the NHS app is available across the whole of England; it certainly does not have the same functionality across the whole of England. Different aspects are available, depending on where people are and which systems have managed to link into it. Our approach, whether we call it the digital app or the digital front door, is aimed at providing consistency of experience and consistency of access to services across Scotland.

The work that has been done on the app so far builds on the national digital platform, which started off during the pandemic as the platform that held—and it continues to hold—all our vaccination data. We have continued to grow that platform. It sits at the heart of our work on digital dermatology, by holding the data on that.

There are two important bits of work in that area. First, there is the work to establish secure access to the app or the platform and to ensure that we are able to authenticate people. The Scottish Government's digital identity work has been critical for the programme's ability to do that.

The second bit of work, which is being tested in Lanarkshire at the moment, relates to the ability—once secure authentication is part of the platform—to deliver secure mail. As the app will enable digital communications, we want to be absolutely certain that it is secure. As you will appreciate, it is extremely sensitive information that is being shared. The intention is to start with hospital appointment bookings and then move to primary care.

We are working closely with the people who are developing the NHS app in England, and if there are aspects of their technology and their coding that we can use, we will absolutely do that. There would be some complexity in doing that, because we have different systems, different structures and a different underpinning information technology structure in Scotland, but we are looking into that.

Graham Simpson: The cabinet secretary's recent written answer did not mention that being rolled out to GP practices—it just mentioned hospital appointments, getting information about local services and people updating their personal information—so what you have said is interesting.

Caroline Lamb: The cabinet secretary announced what we are on track to deliver from December this year. That is the very beginning of a five-year programme that will be rolled out across many other areas. The potential is huge. We need to be careful about digital exclusion. We are very conscious of that issue, on which reports have been produced. We cannot have an exclusively digital approach, but we absolutely need to make a digital approach available to people who are comfortable using it, and to keep adding to that incrementally. There are opportunities for people to get all sorts of additional information and to be able to interact with health services in a very different way.

10:45

Graham Simpson: Thank you. I will leave it there, convener. I have taken up enough time. I hope that that was interesting.

The Convener: Yes—the Public Audit Committee is indeed very interested in tackling digital exclusion.

I am conscious of the time, so I will bring in Stuart McMillan.

Stuart McMillan (Greenock and Inverclyde) (SNP): Thank you, convener, and good morning. I

have some questions about paragraphs 50 to 56 of the Audit Scotland report, and about case study 1 on page 24. Paragraph 50 highlights the suggestion that the capital budget will fall again in 2024-25. Now that the Scottish Parliament has reached agreement on the budget and it is clear that it will pass, how will that affect the position on the national treatment centres and the plans to build more of them?

Caroline Lamb: As the committee will be aware, two things have happened—inflation in capital projects has risen exponentially and there have been reductions in our capital funding. Although we have a capital budget for 2025-26, the longer-term position is still uncertain, because we are waiting for the results of the United Kingdom Government's spending reviews. As a result of all of that, we had to pause the national treatment centres. Alan Gray can give you a bit more information in a second about what we are planning for our capital budget. However, as John Burns said, as well as seeking to maximise and optimise the use of our existing national treatment centres, we are looking at other facilities where we can adopt the national treatment centre model and protect the capacity for planned care. We might want to pick that up under another topic.

Alan Gray: As Caroline highlighted, the drop in the budget for the current financial year, 2024-25, meant that we had to pause the capital programme, which is clearly unacceptable to everyone. In the budget for 2025-26, there has been an increase of £139 million in the health budget, which we welcome. That will allow us to restart the capital programme for the three priority projects, the Monklands replacement project, the eye pavilion and the new Belford hospital in Fort William. It is good that we can progress those business cases. We will have to complete the business cases before signalling that we are moving to the construction phase of the programme.

We are also embarking on a whole-system review with all health boards of how we can maintain the existing estate. Although it is always good to replace, we have a large estate of 4 million square metres that we have to maintain and keep up to current standards. The review is likely to highlight a number of challenges with backlog maintenance and the need for buildings to meet current technical and clinical standards. We await the results of that review, which should be published shortly. Over the next quarter, the whole-system plans for the existing estate will start to come through.

Following that, and linked to reform, we will be looking at what type of estate we will need in future and how we redesign it to be able to meet the reform objectives. We will need to move more into a community approach and away from acute services. We recognise that the dip in the budget presented a challenge. The fact that we had to pause the capital programmes was not good, but it is good that we can restart now. It gives us an opportunity to think about the future, including what buildings we keep, what we maintain, what we exit from and what we repurpose. We can also use the estate in different ways, and there is an opportunity to look ahead.

It is still a small amount of money, given that the replacement cost of the estate is probably close to £100 billion. We forget, when we add it all up, that it is a large estate and a primary care estate. It also has some of the most technical equipment that you will see in any infrastructure.

It is a big challenge, but at least we have a start now; 2025-26 is a start in the process of building the capital plans and working with boards again to clarify how we address the risks and issues that they currently face.

Stuart McMillan: That is helpful. I was going to come back to Mr Burns with regard to Inverclyde and the Inverclyde royal hospital, because he missed out Inverclyde in his comments when he highlighted a few other areas earlier. However, on Mr Gray's point regarding the existing estate and investment into that, I have spent a huge amount of time engaging with NHS Greater Glasgow and Clyde with regard to the Inverclyde royal hospital. I know the condition of the IRH. Investment has gone in and it has been very much welcomed, particularly given the First Minister's comments on Monday with regard to the additional treatments that are to take place there. That is very much welcomed within the community.

However, on the fabric of the building, I cannot stress enough its two main challenges in relation to being wind and watertight. I will add a third challenge, in relation to its heating system. There are challenges in relation to extending the lifespan of that building. My preference would be to have a new build, but I know that that is not going to happen tomorrow. However, in relation to extending the lifespan of the building, it is about the investment that is to go in.

I know that the health board has been working on that particular project for a few years. However, because of the capital situation, nothing could progress.

Alan Gray: That is what we need to start to put our mind to: not only building new estate, but looking at how we start to invest in it.

There are real practical challenges around how we do some of that backlog maintenance on a live site that is operating 24 hours a day, seven days a week. Once we know what we need to maintain or build up, in relation to heating, light or water, doing

the work is challenging when we are working on a live operational site. We therefore have to work through how we do it, as well as how we find the funding.

We have an ageing estate: 25 per cent of the estate was built earlier than the 1970s. The estate is getting older every decade, and, with the amount of money that we have, we are not able to replace that at the rate that we would like.

We need to get into the backlog maintenance, but we can extend the life only so far. We also cannot always adapt existing infrastructure to meet full clinical or technical standards. It is simply not physically possible within the existing estate. It was not built for the types of technology that we have now, such as MRI scanners and electrical supply. There is a whole range and raft of issues.

I hope that the work that we are doing now will start to highlight what we have to do and how to then approach that challenge. It is a big challenge for us, because good infrastructure is essential if we are going to deliver efficient, safe and effective care.

Stuart McMillan: Building the IRH on the top of a hill in one of the wettest parts of the country—

Alan Gray: And the windiest part.

Stuart McMillan: —was not the wisest decision of the people of the past.

Alan Gray: What land was available at the time was maybe the factor.

Stuart McMillan: I know. I am very much aware of that.

To be parochial again for a moment, I know that the replacement of Port Glasgow health centre is a priority for the health board. I do not know whether that will come up in any report that it will make to the Government in relation to future investment.

Alan Gray: Yes, we will be looking at how we restart our primary care programme. We need to invest in, and extend, some existing infrastructure to deal with the population. We have populations with no infrastructure, and we have populations with old buildings that are not fit for purpose.

We are looking at the success of the schools programme and what it did to communities, and trying to see what we can learn from that in primary care. Health centres are still, clearly, expensive to build new, but they are more affordable than a new hospital.

As part of that reform work, it is about asking what part primary care can play and how we invest in the right infrastructure. It is about not just a replacement, but asking what Port Glasgow needs and how that can support some of the reform work.

That is a challenge that we will work our way through, but coming up with a strategy around primary care would represent a good value investment, consistent with the reform that we are trying to do. It would be a different type of infrastructure from what we currently have. I am keen that we do not just replace like for like, but look to see what we can do differently and what we can unlock in terms of that reform and change.

Stuart McMillan: Certainly, there is the hub model with regard to the replacement in Greenock—there is the Greenock health and care centre and there is the one in Clydebank. I do not get many people contacting me to complain about the quality of care and facilities at the new Greenock health centre, so I suggest that that model might be something to consider.

Alan Gray: We are about to open a hub on the east side of Glasgow. Again, that will show different ways of delivering a service to a community.

Stuart McMillan: On the consideration of what is required and what areas need attention, the first sentence of paragraph 100 of the report states:

> "The Chief Medical Officer's 2023–24 annual report highlights the need to focus on a health and care system that focuses on 'equity, prevention and early intervention'."

In the area that I represent, Greenock has the worst Scottish index of multiple deprivation data zone, and, sadly, Inverclyde is at the top of a range of negative health indicators. When it comes to additional investment or any potential additional utilisation of the IRH, I suggest that that would help to deal with the equity point, in contrast to centralising many services up to Paisley and Glasgow.

Alan Gray: One of the factors that we are looking at is the impact that investment would have on the community and the difference that it would make, because it is a key driver. If we are going to make an investment, what difference will that investment make to the population that will be served?

We hope that you will see that feature in our investment decisions. We are trying to build that in. We are not just looking at replacement in relation to the estate issue; we are asking what difference investment would make and what it would unlock. How could it bring together other resources to address a variety of needs, not just health needs? The east Glasgow hub is a good example. That is more than just a health building—it brings together many services that will support a population with similar attributes to that of Inverclyde.

Your point is well made. We assure you that that is what we are looking to reflect in our investment decisions and choices. We have examples of

similar populations in Fife where we could make a real difference with a relatively modest investment in primary care and community care infrastructure.

Stuart McMillan: Exhibit 7 on page 23 of the report shows the costs to the NHS with regard to private finance initiative contracts. Case study 1, which is over the page, refers to six contracts that are due to expire in the next few years, one of which is in my patch at Larkfield in Greenock. I am old enough to remember how controversial the PFI contract for that was.

The report indicates challenges when the earlier contracts come to an end. You will probably not be able to go into the details of each of those six contracts, but will you provide a bit of information on the challenges that NHS Scotland faces with regard to the end of those contracts? What additional costs will there be when they come to an end? How easy would it be to transfer the likes of the Larkfield contract to NHS Greater Glasgow and Clyde?

Caroline Lamb: Mr Simpson raised the issue with me last time I was at the committee, and we sent a letter with some detail on each of those contracts. We need to be careful not to get too much into the individual costs, because we are clearly in a negotiation process and it would not be good to put that into the public domain, so we would not want to do that.

Some of those contracts are coming to the end of their terms. Audit Scotland's recommendations are around how we share the learning. I read that as sharing the learning not just in health but around the public sector, which is why the engagement of the Scottish Futures Trust in that aspect has been important. It is also about how we provide certainty to boards and how we support them in their negotiations.

Alan, you might want to say something about how your teams work with boards that have those contracts.

Alan Gray: There are a couple of stages. First, does the health service still require to use and access that infrastructure? If it does, it has to look at the provisions in the contract. Each contract is unique, so it is difficult to get into individual details. I was involved in PFI contracts at the time, and I remember that each contract was unique and quite different.

11:00

There are provisions in the contract for what happens at the end of its life. What are the choices and options for both parties? We have a team of people—my own team and NHS Scotland Assure and the Scottish Futures Trust—providing support to the boards as well as legal advisers. We are trying to learn and help boards through an assessment of their state of readiness. We have given boards the tools to help them to go into a strong negotiating position and be able to work through what the best options are.

Stuart McMillan is correct that there are end-of-contract costs. There are two types of cost. One is from ensuring that, if we want the building to be handed over, it is in a fit state, and the maintenance obligations on the contract also have to be fulfilled. Part of the negotiation is about holding the contractor to account for delivery of the contractual arrangements. A commercial negotiation that is connected to the contract then has to be undertaken.

There are time periods within which that has to be done, so it is not just about waiting until the end of the contract. Advance notice has to be given, depending on which option you wish to pursue. There are some critical issues for the time path, such as ensuring that the board has the right advice and support as it works its way through, and there is shared learning. There is also the assessment of whether the board needs the infrastructure and, if it does, how it looks at the options available to continue to get access to it.

The two big ones are University hospital Wishaw and Edinburgh royal infirmary. They are pretty important for those involved, if you know the geography. They are important hospitals and there is likely to be some form of continuing need for them, so the negotiations on those are important. The others are not less important—they are important to the services that are provided there.

We are in quite good shape in being able to provide advice and support. The boards have to take legal advice, and it is up to them what decision they take. We are building that into the financial plan as and when we know the information. We have made some estimates around the options and what they would cost, but we will not know until the final negotiations are concluded. That will be in advance of the final end date or handover date, or whatever the next stage of the contract is.

Stuart McMillan: I am sure that anyone who is watching this meeting who has looked at the report will find exhibit 7 quite startling, to say the least, on the cost of PFI contracts. Between 1998-99 and 2023-24, £4.8 billion has been paid out, and a further £5.8 billion will be paid out between 2024-25 and 2045-46. That is a huge amount of money going from the public purse into company profits.

Alan Gray: The only thing that I would add is about the differentiation between the PFI and the non-profit distributing model. They were different types of contracts. The latter definitely learned

from the PFI. They were more favourable contracts but they still came with a cost, so I am not going to dodge your point about the cost. However, they are different contracts with different measures and mechanisms to hold the contractors to account.

We have a job to ensure that we deliver on those. We hold the contractors to account for maximising the benefits of those new types of contracts, while also trying to get to the best deals that we can in concluding PFI contracts, but there is a cost.

Stuart McMillan: Thank you. I will move on to another area. I refer you to case study 2 on page 29 of the report, which highlights the choice and partnership approach model. I found it quite interesting that NHS Forth Valley is implementing the CAPA model, which focuses on service users, with regard to child and adolescent mental health services. Is that model being considered for roll-out to other health boards? Is that discussion taking place?

Caroline Lamb: It is encouraging that you highlighted CAMHS, because that is an area in which we have seen considerable progress, and that is very welcome. In line with our overall approach, which is to look at what works and makes a difference, and then to seek to ensure that other boards look at those approaches, we expect other boards to look at the CAPA model, too.

Alan Gray: On supporting CAPA, I note that the board in Grampian implemented it. It makes a difference. I can say from first-hand experience that it is absolutely the right model to go with. It makes a big difference through engaging families and children and getting them involved in decisions about their care. That is really important because, if they are involved in and part of those decisions, they will engage, and the outcomes will be better.

Caroline Lamb: It is also absolutely in line with realistic medicine.

Alan Gray: It is, and I have seen at first hand the difference that CAPA makes. I thank Stuart McMillan for highlighting that. It is great that it is mentioned in the Audit Scotland report, as it is a good example. If that approach could be rolled out, it would make a difference not just to access and the timescales for access, but to the quality of what we offer and the outcomes at the end, which are really important.

Stuart McMillan: There was a discussion earlier regarding activity and productivity in NHS Scotland and various health boards but, judging by some of your comments, if the CAPA model were to be rolled out, that could have a hugely beneficial effect across the country.

Alan Gray: The example that I would give is that, where services were previously provided in four locations, those were co-located and brought into one repurposed building to start to deliver that model. In a small period of time, that board went from being the worst performing on CAMHS to being one of the better boards, so it can work. It is about a combination of using infrastructure and the right service model. That is a good example of how we can reform with a relatively modest resource base.

Caroline Lamb: On Stuart McMillan's general point, there are opportunities for us to increase productivity and efficiency. All the work that we do, and the work that the national centre for sustainable delivery supports boards with, is about making sure that we get the best performance that we can for the public purse.

Stuart McMillan: I will move on from CAPA to accident and emergency waiting times, which remain considerably below target. That is a huge challenge. A few years ago, I did a 12-hour shift with the Scottish Ambulance Service on a Monday morning. Before I went, I genuinely did not realise how busy the Monday would be or the logjam that would happen with ambulances at the Inverclyde royal hospital. I also did not fully realise that I would probably know somebody who would make a call and be picked up, and that proved to be the case.

What additional work has been considered on that issue? The First Minister spoke about it on Monday, but there is a real challenge in improving the patient journey when people get to A and E.

Caroline Lamb: I will ask John Burns to come in on that. Our focus is not just on what happens once people get to A and E but on what happens before that and how, if at all possible, we can keep them out of A and E. The Ambulance Service has been playing a huge role on that. I ask John to talk about that work.

John Burns: I will start with the redesigning changes that we have made, as a number of factors are picked up in the audit report that reference and reflect some of those. We have seen an increase in the role of NHS 24 as an important first point of contact, and in the use of NHS Inform as a trusted source of information for people—more and more people are looking to use that.

Through the Scottish Ambulance Service redesign and change, the service has an integrated clinical hub that is able to triage and assess people. Paramedics who arrive at incidents or respond can use their skills and expertise, linking in with our flow navigation centres, to consider whether a patient needs to be conveyed or can be supported at home, with care provided

there. We have seen significant success through those initiatives, which have resulted in a reduction in people being taken to hospital. That is important, because it is about the right care in the right place.

I referenced flow navigation and the ability to direct people to the right resource, which is not always hospitals or A and E departments. Alongside that, when people need to attend A and E, we have different flows at that point. People go through minor injury and minor illness pathways and can be directed into a same-day emergency care pathway. There is a strong commitment in our A and E departments to admit people only if they need to be admitted—about 26 per cent of people who attend A and E will be admitted.

Our clinical teams make tremendous efforts to support and manage people and assess their care needs. If they do not need to be admitted, the teams support them back into the community; if they no longer need care, they discharge them.

Mr McMillan described the challenge around A and E, and we tend to focus on A and E because that four-hour measure is really a whole-system measure that gives a sense of how the system is performing.

While recognising that we need to continue to support our A and E teams across the country, we have been focusing on how we manage the admitted pathway. When a patient needs to be admitted, how do we deal with the current delays? We have referenced many times the centre for sustainable delivery, which is a national improvement resource for us, and it is working with boards. In the audit report, there is reference to the work that the CFSD has carried out, by analysing data, working closely with boards and focusing on areas of improvement that each board and site can consider. Through that work, we looked not just at lessons from some boards, where we have seen the benefit of short-stay assessment episodes, but at how we can address longer stays in hospital.

Creating capacity in the in-patient space—to ensure flow from the A and E department—is a particular focus for us, and that links to the work that we referenced earlier on delayed discharges. There is considerable activity on that. Clinical leaders in the CFSD go out and engage with clinical colleagues across the country to share learning, to challenge and to support change in our sites.

Stuart McMillan: There was reference earlier to the national conversation and the discussions that take place with different specialties. I assume that they have input into the centre and that concerns, issues and suggestions from folk who are on the ground, attempting to deliver the outcomes, are being listened to.

John Burns: Yes, very much so. Our clinical teams on the ground know what changes could be made and where the challenges are. It is absolutely about empowering those teams and working with them. Not everything works, but our programme of taking an improvement focus to drive improved performance allows teams to try things. Those things might not work, but the teams can learn from them and try other things.

Our centre for sustainable delivery approach is very much to support improvement, to listen and to engage. We are very much about what the local teams can do. They are the ones who own the solutions, if they are empowered to deliver the changes that they think can work.

Stuart McMillan: The next time that I talk to healthcare professionals who are based at the IRH, if I make them aware of this contribution, can I be assured that they will indicate that they feel as though they have been listened to and that what they put forward has been considered and taken forward?

John Burns: I cannot speak for that specific site, but that is certainly the approach, and we expect clinical teams to feel engaged. I accept that it does not work every time, but that is certainly the way in which we will take change forward.

The Convener: Waiting like a coiled spring is the very patient deputy convener, Jamie Greene, who has some final questions to put to the witnesses. Thank you for your forbearance, Jamie.

Jamie Greene (West Scotland) (Con): Good morning. Ms Lamb, on Monday, the First Minister made a speech about the state of the NHS in Scotland. He described the NHS as being "fundamentally resilient, fundamentally robust." No sooner had he stood down from his place at the lectern than the director of the Royal College of Nursing in Scotland responded, saying:

> "Many nursing staff will not recognise the first minister's description of a resilient and robust NHS in Scotland. Their current experience is of a service struggling to meet the needs of patients and leaving them to carry the burden of not being able to deliver the care and treatment required."

Who is correct—the First Minister or the director of the Royal College of Nursing in Scotland?

11:15

Caroline Lamb: You might expect me to say this, but I think that they are both fundamentally correct. The NHS is resilient and robust. Across the country, as the Auditor General has recognised and as members have recognised in some of their questions, there are areas of really

good performance and there are areas that find things much more challenging.

That is reflected in the experience of staff as well. There is no doubt that there are some services and some areas that are under extreme pressure and where staff are feeling the impact of that, but that is not universal across every service. It is important that we recognise that and that we are not talking down services and the work that people are doing.

Jamie Greene: I am not talking down nurses.

Caroline Lamb: Absolutely.

Jamie Greene: I need to be clear about that, because I hear that comment made far too often in the chamber, and I would not expect to hear it in committee. No one is talking nurses down. I am quoting the body that represents nurses. That is their strength of feeling, not mine.

Caroline Lamb: I absolutely accept that. We recognise that there are areas of our services, particularly around the front door of the NHS and in areas of our hospitals that have far higher occupancy levels than we would wish, where people feel, are living with and are holding those pressures and a level of risk. That is why we are so focused on all the activity that John Burns has described to ensure that we do not admit people to hospital unless we absolutely have to, and all the work that we are doing with colleagues across local government and integration joint boards to try to ensure that people are able to get out of hospital as soon as they are ready to be discharged.

Achieving that flow through the hospital system is what will make a difference, and that is when people will start to see a reduction in the intense pressure that there is in some areas. That is what we are focused on.

Jamie Greene: Let us do a reality check. You agree with the First Minister that the NHS is “resilient” and “robust”, but not a single NHS board in Scotland is meeting its 12-week out-patient target or their in-patient target—not a single NHS board in Scotland is meeting its 18-week planned care target. One in six Scots is sitting on an NHS waiting list—that is nearly 900,000 people, of whom nearly 10,000 have been on a waiting list for over two years. To top it all off, Scotland has one of the lowest life expectancies in western Europe. Does that sound like a “resilient” and “robust” health service that is fit for purpose and that is delivering for the public?

Caroline Lamb: I accept that performance is not where we want it to be, and that—

Jamie Greene: You said that last year, and the year before, and the year before. This is an on-going theme, as the Auditor General has reported.

Caroline Lamb: I accept that performance is not where we want it to be. In his report, the Auditor General reflected on the amount of work that is going on to support services in the light of significant inflationary pressures and the continuing backlog from Covid. There is continued pressure that is still coming through the system due to Covid and it is taking the system longer to recover than we would have wished.

The Auditor General recognised in his report that we are starting to see some improvement. When we look at the information up to the last published quarter, which was in September, we have seen increases in activity and an 11,000 reduction in the waiting list for diagnostics. That is a reflection of the £30 million that we were able to invest in 2024-2025.

Going forward, what will be different is that we have secured a £200 million investment in the budget to focus both on bringing down waiting times and improving the capacity across our system, including in primary care.

Jamie Greene: What are you going to spend the £200 million on? That is a big number, and it is welcome, but I do not quite understand how that translates into getting waiting times down.

Caroline Lamb: We have earmarked £100 million of the £200 million investment to devote to waiting times. John Burns has already described some of that work, and I will hand back to him to go through where we are. We are still in the detailed planning phase, but I think that John can give you some of the headlines around how that money will be deployed.

John Burns: We are doing a number of things to reduce long waits and improve access for patients. The first is to focus not only on the £100 million of funding, but on optimising the core planned care activity across Scotland.

As Caroline referenced, the data that was published last September shows that there have been welcome increases in the number of in-patients and day cases that are being treated in Scotland. However, we need to go further, hence the investment.

The first thing that we will do is optimise that core activity. We will work closely with health boards on delivering that and on bringing the plan and the detail forward.

Secondly, the £100 million that is being made available will not be spread across Scotland—that is, it will not be an allocation to boards. I have made that clear to my chief executive colleagues. We are working with our chief exec and board colleagues to ensure that we bring forward a plan that, as I said earlier, optimises our national treatment centres, particularly for orthopaedics

and ophthalmology, which are the principal focus of many boards. Boards have also said to us that they have other capacity that they can bring on if they can secure the funding for it. This is not just about giving money; it is about being clear about what the money will deliver, and we will come in behind that.

Earlier, I referred to Gartnavel hospital and Inverclyde royal hospital in relation to orthopaedics. We are supporting our colleagues in NHS Greater Glasgow and Clyde to deliver additionality through the plan that they have brought to us—it is their plan. We have invested on a recurring basis in Stracathro hospital in the past couple of years, to maximise and optimise that facility for the north of Scotland—the principle is the same principle as that for a national treatment centre. We have identified other capacity for ophthalmology in Queen Margaret hospital and the Golden Jubilee hospital.

Our approach is local, where we can deliver locally and where we can be committed to delivery. We have a regional, collaborative approach through our NTCs, and a national approach to supporting boards to treat patients and thinking about where that can be delivered. Our plan is taking a very different approach, but a very focused one.

Jamie Greene: Let us look at some of the detail on that. In orthopaedics in particular, there are huge numbers of people waiting for treatment—many for more than 18 months. Let us cut to the chase: those people are in pain. You will be aware that there are various models for treating people. In England, there is a more flexible approach, which includes the use of private care funded through the NHS. If a patient is waiting on a new hip or knee, do they really care where they get it, as long as they get it sooner? If they have the choice of getting it in three months or in three years, which would they choose? How open are you to new ways of delivering service to people more quickly?

Caroline Lamb: Orthopaedics is one of our biggest challenges. We want to shift the position and ensure that people are seen quickly. We are open to doing whatever is necessary to bring down those lists, as long as we can be assured of the cost-effectiveness of the approach.

As John Burns has described, we are focusing on what we can do using NHS capacity. Currently, mobile units provided by independent providers are part of the solution, helping us to bring down waits for diagnostics.

John Burns: We have periodically used independent provision for CT and MRI scans. At the moment, we have around 10 mobile units across Scotland. That has been enormously helpful in supporting access.

At the same time as doing that, we are looking at how we build sustainability into the NHS, because we cannot rely on that as a long-term model. We have referred to in-patients in the main but, as part of our diagnostic plan, we also need to be mindful of new out-patients and our diagnostic radiology and endoscopy waits.

We are focusing not just on how we bring the backlog down—that is important—but on sustainability going forward. We are taking a parallel approach to ensure that we also consider sustainability.

Jamie Greene: The figures are atrocious. I point you to page 48 of the Audit Scotland report, which I flagged at a previous meeting of the Public Audit Committee. What you would normally expect to see on that page—as I am pleased to see in other tables—are little green ticks where targets have been met. However, there is not a single green tick anywhere on that page.

The numbers speak for themselves. The targets are 95 per cent, 100 per cent and 90 per cent for beginning treatment within given timescales. They are ambitious. I get that. I know that the health service is very challenging across the UK, but look at the performance measures on that page. Look at in-patient treatment within 12 weeks of a decision to treat. The poor people in Grampian are sitting at 46 per cent of the 100 per cent target. Fife and Forth Valley are at 47 per cent. For the three targets, Lanarkshire is at 61 per cent, 46 per cent and 60 per cent—nowhere near the targets. There are huge numbers of people waiting for far longer than they should, and £100 million is not going to scratch the surface, is it?

Caroline Lamb: We absolutely accept that the figures are not where we would want them to be.

Jamie Greene: You keep saying that, but how are we going to fix it?

Caroline Lamb: The reason why planned care is particularly challenging is that it was particularly badly hit during the pandemic and we have still not been able to recover from that backlog. As John Burns described, the approach that we are taking is to maximise our core capacity. That includes innovations in areas such as theatre scheduling, which helps us to improve the productivity of our theatres. That is all about developing the more sustainable approach that John Burns described; at the same time, having secured some investment that will make a difference, it is also about starting to bring those lists down and tackle the longest waits.

We need to keep going with that. We need to keep the parallel track approach that John

mentioned, which is about tackling the backlog as far as we can in a way that helps to increase the service's capacity and resilience.

Jamie Greene: For the sake of all our constituents, I hope that we do not have to have that conversation in 12 months, on the next report.

Let us look at two metrics. The first is ambulance waiting times. Last week, across five health boards, including two in my region—NHS Ayrshire and Arran and NHS Greater Glasgow and Clyde—the waiting time for yellow calls exceeded three hours. People waited three hours for an ambulance. We have heard horrific anecdotes about people waiting far longer.

Clearly, people who phone for an ambulance do so as a last resort, having exhausted other avenues and, perhaps, having given up on NHS 24—more than 100,000 people hung up on that service last year, waiting to be answered. I presume that when a person calls 999 to ask for an ambulance, the situation is serious. Why are people waiting three hours for an ambulance to turn up? What is going wrong in the Scottish Ambulance Service?

Caroline Lamb: For the record, we need to be clear about the triage process at the Ambulance Service. I do not have the performance metrics in front of me, but we can provide them to the committee. It is important that we focus on the people who are most acutely ill and that we ensure that they get an ambulance in the shortest possible time. That might mean that people who are not so unwell need to wait a bit longer, especially when services are particularly busy, but that is in the context of the Ambulance Service having gone through a triage process.

John, do you want to add anything to that?

John Burns: I met the Scottish Ambulance Service's senior team yesterday. We looked at the service's overall performance and position, and at the changes that it is making. As Caroline Lamb said, it is important to recognise that the service responds quickly to immediately life-threatening situations.

11:30

I have referred to the service's triage model and its integrated clinical hub. The service engages with patients who call and it tries to ensure that there is the right response for them. I agree that there are patients, such as those whom Jamie Greene has referred to, who wait too long, but the Ambulance Service is doing everything that it can do to respond. When it cannot do so as quickly as it wants to, it stays in close contact with the patients.

Jamie Greene: Why is the service not able to respond more quickly? Does it not have enough ambulances or staff, or has demand increased exponentially? Is it all of the above?

John Burns: One very specific thing is the hospital turnaround time. You mentioned some sites: in parts of Scotland there are significant challenges with ambulance turnaround times exceeding the standard that we have set. That impacts on the Ambulance Service's responses, and it has to manage the consequences.

Jamie Greene: Is that because accident and emergency departments are chock-a-block? Ambulances are queuing outside with people in the back of them. What sort of experience is that? If someone is sitting in the back of an ambulance for hours, or even being treated in an ambulance because there is no space elsewhere, that ambulance cannot be freed up to go out to someone else and it is not a good experience for the patient. It is a lose-lose scenario. What are you doing at the other end to unblock that?

John Burns: That is the work that I described earlier about looking at the admitted pathway from A and E to an appropriate specialty bed. The centre for sustainable delivery has been engaged in that work with boards across Scotland. Where there are particular challenges at sites, people in clinical leadership in the centre for sustainable delivery, which I referenced earlier, meet and talk to local teams to see how they can support improvement that helps the ambulance situation at the front door.

I agree that what you described is not the experience that we want for anyone, and we are absolutely committed to doing all that we can to improve the situation.

Jamie Greene: The target for A and E treatment is that 95 per cent of people are dealt with within four hours. That can mean that someone is admitted to hospital, if that is considered necessary, then discharged, or treated then discharged. The current average performance is 69 per cent, which exactly marries up with what you have just said—far too many people in A and E are not being treated, moved on or moved out of that environment, which has a knock-on effect on ambulances.

What is the issue in A and E specifically? Are people turning up when they should not? Is it understaffed? What is the problem? What is causing the delay?

John Burns: I referenced the redesign of urgent care in 2019, elements of which are mentioned in the audit report. I want to acknowledge the way in which our communities have responded to our right care, right place, right time message and have accessed a range of

services, including NHS 24, community pharmacy, their GP or out-of-hours services. Our communities across the country have responded positively to that message.

The report references the fact that we have seen a reduction in the number of people who are presenting at A and E. We recognise that some people are coming as planned attendances. Those are quite small numbers just now, but they will be built into the numbers from, I think, 4 February. They are scheduled attendances that are usually for a minor illnesses or injuries. I pay tribute to our teams in A and E, because they are managing various flows.

Because of the challenge in the admitted pathway, they have to provide care for people who would normally be admitted to a specialty bed. The admitted pathway is the issue that we are focused on trying to address. From our data, we know that if we can address the admitted pathway, that will improve the position in our A and E departments, which are dealing with the consequences of the challenge in that pathway.

Jamie Greene: It has already been mentioned, but one of the issues at the other end is delayed discharge. We have talked a lot about the flow of people going into hospital, but getting them out is key. However, I am afraid that the statistics on that are equally atrocious. In 2023, 658,000 bed days were taken up by delayed discharge. Those are days on which beds could have been occupied by all those people who were sitting in A and E waiting to be admitted. We do not have the full statistics yet for 2024, but doing a year-on-year analysis from November to November, there was a 7 per cent increase in delayed discharge days. My fear is that the number for 2024 will not be great, either.

Of course, the Government promised to eliminate delayed discharge completely, but I do not know how on earth it thought that it was going to do that. It was an admirable ambition, but it is clearly not happening. We had a conversation earlier in which you admitted to being the accountable officer for NHS health and social care, but many of the levers that are required to deal with delayed discharge are entirely outside your control. It must be a huge source of frustration that you cannot really fix that problem, can you?

Caroline Lamb: It is a challenging problem to fix, and the position can be improved only by working across systems. As I have referenced a number of times, getting the flow through hospital, and getting people out of hospital when they no longer need to be there, are critical for improved performance and for the people who are in hospital.

We need to improve the rates of discharge of people who are not dependent on social care packages to get out of hospital. Fundamentally, we need to remember that 97 per cent of people are discharged without delay from hospital because they do not need any further support. However, for people who do need further support, we need to work with our local authorities and through integration joint boards to improve that.

We do not have the same levers, but we have taken exactly the same approach as we have taken to improvement in other areas, which is about getting the data. That has been a challenge, but I acknowledge that we have made significant progress on access to and sharing of social care data, not just in Government but with every bit of the system, and on making sure that every element in the system has access to that data so that we are able to understand variation across the country.

I think that in Renfrewshire, 13 people per thousand of population are delayed; in areas such as Highland the figures are much higher than that. We need to get underneath that, so there is further work to be done to understand what is driving it. We need to ask what it is that the good systems are doing well.

Questions could also be asked about whether the level of investment matches the demographics. All that could be unpicked.

You are right—the levers are different, but at the end of the day, it is all about people working together, because it is an end-to-end system through primary care, community care, acute care, social care and so on. All the partners who are engaged in that need to work together to make it work effectively, and we all need to learn from the areas that are doing it well. As John Burns said, sometimes we try things and they do not work, but when we try things and they do work, we absolutely need to spread and scale them.

Jamie Greene: I am all for people working together and agencies working collaboratively. We hear a lot about that—it is civil service lingo—but the reality is that the numbers speak for themselves. Something is not working, and it is clear that the Government is failing to meet its objective in delayed discharge, which is causing a huge number of issues. Have you had any feedback at all?

Let me ask a more fundamental question. Do you think that the IJB model is broken? I ask because it does not seem to be delivering for folk.

Caroline Lamb: I think that the principles behind the IJB model are absolutely valid in terms of providing the interface between health and social care, and integrating the system. I do not think that anybody in the system today would say

that they do not understand the absolute importance of integration and of making sure that everybody understands their responsibilities in the system.

The challenges have been around capacity in social care. As has been rehearsed elsewhere, there are issues around workforce capacity, and around financial sustainability in social care, which will impact on the smooth operating of the whole system.

Jamie Greene: That is a whole other committee session, is it not?

Caroline Lamb: It is, indeed.

Jamie Greene: My final question is slightly off-centre. What has been done to improve whistleblowing in the NHS? Many MSPs will have been contacted by constituents, particularly those who work, or who have worked, in the NHS, with complaints or anecdotal evidence of malpractice that has led to patient safety being put at risk. What has been done to improve the process? I have dealt with a number of cases in which NHS practitioners feel that the current process is simply not working, and I know the levels of frustration that they feel as they go through us, then to ministers. They feel that the responses that they get when it comes to dealing with complaints or allegations are extremely poor. Do you think that the situation is better than it was?

Caroline Lamb: A lot of work has been done to try to ensure that people are confident about raising concerns and are confident that, if they raise such concerns, they will be acted on. With regard to the range of measures that we have put in place, we have independent whistleblowing champions appointed in every NHS board. That means that, at the top layer of governance in NHS boards, there are board members who are responsible for championing a culture of openness and transparency, and for ensuring that people feel that they are able to raise concerns.

We also have confidential contacts in every NHS board. As a result, if staff members have a concern—I understand why people would feel anxious about raising concerns—they have somebody whom they can go and talk to. We have also established the independent national whistleblowing officer. Because the officer is independent, people who feel that they are not getting the responses that they feel they should be getting, or who feel that they cannot raise certain matters, have an additional layer that they can approach.

As for how we monitor all that, I referred earlier to the iMatter survey. Since we established the various processes, we have added a couple of additional questions to that survey to monitor exactly those things. For example, on the question whether people feel confident about raising complaints or concerns, and whether they feel confident that they will be acted on, I think that the figure is in the 60 per cents—66 per cent is a figure that has stuck in my head, when it comes to people's feelings on the issue. Clearly, we will need to monitor trends, given that the question is relatively new.

I think that we are working very hard on the matter. I add that the culture in organisations is one of the things that we discuss with boards, chairs, chief executives and leadership, because it is so important that people feel that the NHS is an organisation in which they can raise concerns.

Jamie Greene: Thank you very much for that.

The Convener: We have covered an awful lot of ground this morning. If the budget is passed in a few weeks, the NHS budget will rise to £21 billion, for which you, Caroline Lamb, will be the accountable officer. Because it constitutes 40 per cent of the entire Scottish budget, it is important that we, as the Public Audit Committee, scrutinise what you are doing and examine areas where things are not going quite as well as we would like.

There is also a great deal of public interest in health and social care, and I think the national health service remains probably the best-loved public institution that we have.

I thank Caroline Lamb, Alan Gray and John Burns very much for their time and co-operation this morning, in answering our questions.

11:43

Meeting continued in private until 12:15.

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