OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit Committee

Wednesday 11 June 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 11 June 2025

CONTENTS

	Col.
DECISION ON TAKING BUSINESS IN PRIVATE	1
"NHS IN SCOTLAND: SPOTLIGHT ON GOVERNANCE"	2

PUBLIC AUDIT COMMITTEE
19th Meeting 2025, Session 6

CONVENER

*Richard Leonard (Central Scotland) (Lab)

DEPUTY CONVENER

*Jamie Greene (West Scotland) (LD)

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:

Stephen Boyle (Auditor General for Scotland)
Alison Cumming (Audit Scotland)
Bernie Milligan (Audit Scotland)

CLERK TO THE COMMITTEE

Katrina Venters

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Public Audit Committee

Wednesday 11 June 2025

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Richard Leonard): Good morning, and welcome, everyone, to the 19th meeting in 2025 of the Public Audit Committee. Under agenda item 1, the committee must decide whether to take agenda items 3, 4 and 5 in private. Do we agree to take those items in private?

Members *indicated agreement.*

"NHS in Scotland: Spotlight on governance"

09:30

The Convener: Agenda item 2 is consideration of the Auditor General's report "NHS in Scotland: Spotlight on governance", which was published late last month. I am very pleased to welcome our witnesses: alongside Stephen Boyle, the Auditor General for Scotland, we have, from Audit Scotland, Alison Cumming, executive director of performance audit and best value, and Bernie Milligan, audit manager.

We have questions to put to you, but, before we get to those questions, I invite the Auditor General to make an opening statement.

Stephen Boyle (Auditor General for Scotland): Many thanks, convener. Good morning. As you mentioned, I am bringing you my report on governance of the national health service in Scotland. The report covers governance arrangements across NHS Scotland and NHS boards, and it follows on from my December 2024 report on the financial and operational performance of Scotland's NHS.

NHS Scotland is not a legal entity, per se, but an umbrella term for the 22 health boards in Scotland. It is overseen by a chief executive and a chief operating officer, who are part of the Scottish Government. The chief executive of the NHS in Scotland is also the director general for health and social care in the Scottish Government and the portfolio accountable officer. That dual role means that responsibility for the strategic and operational direction of NHS Scotland and for holding the NHS to account on its performance lies within the same department of the Scottish Government.

Our audit found that there is a need to strengthen the Scottish Government's governance and assurance arrangements to address risks that arise from that dual role and to reflect the extent of reform that is required in the NHS in Scotland. That includes the need for non-executive directors to have a greater role in providing independent scrutiny and challenge.

The way in which healthcare is planned and governed is becoming more complex. A range of local, regional and national partners are involved, which makes lines of accountability and decision making difficult. A number of changes are taking place in the planning for healthcare services. The Scottish Government has announced an increased focus on population-based planning, which will involve more collaborative working across boards and working at national, regional and local levels.

However, how that population-based planning approach will operate has yet to be confirmed.

A new NHS Scotland executive group has recently been introduced to support collaboration and reform across Scotland. That has been welcomed by boards, but it is perhaps too early to say how effective the group will be in practice.

Along with the Accounts Commission, I have reported previously on some of the issues and difficulties that integration arrangements and the operation of integration joint boards have presented. That reporting will provide important learning for NHS Scotland as it adopts a more collaborative working approach in order to deliver reforms.

Providing good scrutiny and setting a clear direction are essential functions of NHS boards. Boards have used "The Blueprint for Good Governance in NHS Scotland" to review and improve their governance arrangements, but there is scope for the blueprint to be developed further so that it focuses on innovation, reform and collaborative working. There is also a need for independent external review of blueprint self-assessments so that they can play a key role in identifying boards in which governance is not yet as effective as it needs to be.

As ever, the report makes a number of recommendations, which are for the Scottish Government and NHS boards to consider as part of their assessment of today's report.

As ever, Alison Cumming, Bernie Milligan and I will do our utmost to answer the committee's questions.

The Convener: Thank you very much for that introduction.

Key message 2 in the report describes

"weaknesses within the scrutiny and assurance processes at the Scottish Government level."

As an example, you cite the

"combined role of director general for health and social care and the chief executive of NHS Scotland",

which are titles that are borne by one person. It would be useful for the committee to understand why you believe that that poses a risk. Perhaps you can point to some examples of that presenting a conflict of interest.

Stephen Boyle: I am very happy to do that. I will start and then bring in Alison Cumming to say a bit more.

I will signpost a couple of relevant parts of the report. In exhibit 1, we set out NHS Scotland's overall structure and accountability arrangements, including how the 22 boards operate and the flow of responsibilities from the director general and the chief executive, and the chief operating officer—who also has an important role—through to ministers and, ultimately, the Parliament and the people of Scotland.

I draw attention to the fact that that dual role involves a strategic and direction-setting role for the NHS and a role in holding health boards to account. Typically, those functions would be separated. There are clear and extensive governance arrangements within NHS Scotland and the Scottish Government—we set out many of them in the report, and Alison Cumming might want to touch on them—but our audit identified that, although Scottish Government non-executive directors are present, their ability to provide an independent voice is not as prominent as we might have expected in relation to some governance settings.

We are clear that we do not identify that as presenting a conflict of interest. It is for Government ministers to determine, as a policy matter, how the structure operates, but we highlight that there are risks that need to be managed and that the arrangements would be strengthened by Scottish Government non-executive directors having a stronger presence and role in supporting the director general with her important twin responsibilities.

Alison Cumming (Audit Scotland): We would characterise the risk as relating primarily to scrutiny and assurance. As the Auditor General said, the director general has the dual role of holding the NHS to account and delivering against the strategic and operational direction that has been set.

We have looked at the various governance groups that exist. As is usual in the Scottish Government, the assurance board is chaired by the director general, whereas, in an NHS board, the equivalent audit committee would be chaired by a non-executive. Non-executives are present in the forum of the assurance board, which is about providing assurance in the civil service context, but there is no great presence of non-executive voices at the Scottish Government level when decisions are being made. For example, there is no line from the national planning and performance oversight group, which is chaired by the chief operating officer and oversees the support and intervention framework for NHS boards, into the assurance board.

We believe that the risks that are associated with that dual role would be better managed if there was increased input when decisions were being taken and during post hoc scrutiny of whether governance and risk management processes were operating through the assurance board.

The Convener: Do you take a view on whether it would be better for those two roles to be decoupled?

Stephen Boyle: Not directly. We are clear that the decision on how Scottish ministers wish to structure the responsibilities is, ultimately, for them, but we go as far as saying that there are risks with the current arrangements. As Alison Cumming mentioned, the director general has an operational role and a role in setting the strategy, but responsibility for holding boards to account resides with the same person. That inevitably increases the degree of risk.

The risk would be offset by having clear and effective underpinning scrutiny arrangements. The gaps in that regard heighten the level of risk. There is more than one way to set up the responsibilities, but that decision is, ultimately, for Government ministers to take. As I said, we are clear that there are risks and that those risks are heightened when the assurance process is not as effective as we would want it to be, as we found during our audit.

The Convener: This is the biggest spending department of the Scottish Government, is it not?

Stephen Boyle: Absolutely.

The Convener: Can you think of any other Scottish Government departments in which the strategic leadership role and the operational role are similarly combined?

Stephen Boyle: Not off the top of my head. Alison Cumming might have a more up-to-date impression than I do, but I think that we are talking about a particularly unusual set of circumstances. As I said, NHS Scotland is not a legal entity; it is an umbrella term relating to how the NHS in Scotland operates.

I will bring in Alison Cumming to say whether there is an appropriate comparator.

Alison Cumming: There is no direct comparator. The recent Scottish Fiscal Commission "Fiscal Sustainability Report" said that about 40 per cent of the Scottish budget is spent on health and social care. There are no other areas in which the director general has the same extent of spend and is involved at the top of the delivery system—in this case, with front-line NHS boards. There is a unique set of circumstances for health and social care.

Stephen Boyle: I should say that, although the director general for health and social care is the portfolio accountable officer, clear and well-defined governance arrangements exist in the different parts of the NHS in Scotland, including the territorial and national boards, which also have accountable officers and their own governance boards. It is not the case that the NHS in Scotland is undergoverned; it is just a question of whether the Scottish Government's existing arrangements are as strong as they could be.

The Convener: Okay. I am sure that we will return to the issues during the course of this morning's evidence session. I now invite Stuart McMillan to put some questions to you.

Stuart McMillan (Greenock and Inverclyde) (SNP): I thought that the report was very helpful, and I will touch on the point about governance.

Exhibit 1 on page 10 is very helpful in setting the wider scene, and exhibit 2 on page 12 outlines the new way of working with regard to the national, regional and local levels. I understand why the Western Isles is in with the west, but the boundaries struck me, as the region is clearly not all together, unlike the other two regions. The new way of working, with population-based planning, is a major shift away from what has been in operation so far. Has the Scottish Government given you an indication of how the population-based planning will work?

Stephen Boyle: I will bring in Bernie Milligan to say more about the specifics of how the system is likely to operate, but you will probably hear in my initial response that there are some caveats because we are not yet clear, as we note in paragraph 24.

The approach is designed to be potentially a significant level of change in population health delivery, supporting collaboration and the reform of how parts of health services will operate. What comes next is important and we are awaiting that level of detail.

One thing that we are clear on in the report, given the focus on governance arrangements, is raising a flag that governance arrangements as they currently operate are not designed to operate in the reform-based environment that population-based health planning might bring us into. As we move into that environment, it is important that governance arrangements keep pace with the level of changes.

09:45

I referred to some of our previous reporting and—as I hope exhibit 2 captures—there are a lot of planning levels within health and social care services in Scotland: national, regional, collaborative working, community planning partnerships and integration joint boards. The Accounts Commission and I have reported that that system has not always operated effectively, and there will be a real need to get it right if we are moving to a different style of population-based service delivery models in Scotland.

I will bring in Bernie Milligan to say more on this point.

Bernie Milligan (Audit Scotland): Planning is becoming more complex. It was only in November 2024 that the Scottish Government announced a renewed approach and increased focus on population-based planning. In essence, the approach is that it will align planning for services with the size of the population that will make use of those services.

The approach builds on a principle that was set out within the national clinical strategy in 2016, which is still guiding the work of the NHS. That is that appropriate clinically led planning for services is undertaken at a level that is best aligned to the size of the population that will make use of those services. That requires a great deal of collaboration across the NHS. The NHS executive group that has been brought into being is a key lever in realising that population-based planning. It builds on the statutory duty on boards to co-operate and collaborate, so collaboration is intended in that regard.

I will just say that the approach is not completely new: it is a renewed approach. On population-based planning, the paper that was produced in November last year supersedes a paper that goes back to 2002. That paper set out specialised services that are planned not just regionally but nationally, and for the United Kingdom as well.

The approach marks quite a big change, but we do not have any further detail. We expect that there will be some further detail in the service renewal framework that is due in the next few weeks. The Government has said that a list of the particular services that would be planned will be published annually, but that is not yet available.

Stuart McMillan: With regard to the collaboration, you indicated that there is already a statutory requirement. Have you been confident that the governance arrangements for collaboration that exist so far operate well? Looking forward with a new way of working, are you confident that the governance arrangements will keep up?

Stephen Boyle: I am happy to start and then Bernie Milligan might come back in.

We will probably see a mixed picture. The report touches on and refers to some of the previous reporting that the Accounts Commission and I have done on the point. As you say, some collaboration is statutory, such as through community planning partnerships and integration joint boards—I will perhaps come to the more positive recent examples in NHS Lanarkshire that we mention in the report.

We remind readers of this report and some of our previous reporting on integration joint boards that, in some cases, collaboration works very well. There is representation from both the health boards and local authorities, and a sense of parity in planning for health and social care within their areas, with sharing of chairing and vice-chairing responsibilities.

We also noted from our evidence gathering on this report that there can be a partisan approach in some boards. There is not a sense of shared ownership by the integration authority of the ambitions for the population; instead, there are more cases of individuals looking after the interests of either the local authority or the board. That issue was touched on in a joint report from the Accounts Commission and me on adult mental health—the committee took extensive evidence on that report—that similarly challenged the notion that the governance arrangements are right for times of reform and change.

That is one of the themes of today's report: governance arrangements are not necessarily just for a moment in time but will need to continue to evolve. I know that there are many and complex arrangements. We have not seen sufficient examples consistently for us to suggest that we have absolute confidence that governance arrangements can support the level of reform that we have been pointing to in many of our reports.

I mentioned NHS Lanarkshire, which is an example of an organisation that has sought to evolve its governance arrangements to support effective planning. There is an interface committee working with its partners that can be satisfied that it is putting a whole-system approach into place. We are seeing that some organisations are responding to the challenges that they face but, as I mentioned, in some pockets, there is still a sense of responsibility more towards the host organisation rather than on a shared and integrated basis.

Stuart McMillan: When I read the report, it struck me that the health is a very complex policy area and that governance arrangements will always be challenging, whether it is for a large or small health board area. I think back to when NHS Argyll and Clyde was shut down and moved mostly into NHS Greater Glasgow and Clyde, with some in NHS Highland. I appreciate that it is very difficult. It will equally be a challenge to keep up with governance, but, with a new way of operating, it is clearly incumbent on the Government to ensure that the arrangements are in place.

Do you consider that the new way of working will make the landscape more complicated to govern, or should it make some of the lines of engagement and governance a bit easier?

Stephen Boyle: That is the challenge to be addressed.

As we say in the report, governance is complicated. The complexity of the planning arrangements and the fact that accountability can be unclear can make decision making more challenging. As the Government is moving to an environment where it is introducing more population-based planning, together with the challenge that we have touched on in many of our reports about the need for faster, more sustained reform of the NHS to support population requirements and meet some of the financial challenges, that is the challenge to be addressed.

At the heart of the recommendations that we make in the report is that delivering the sustainability that the NHS in Scotland needs will require collaborative working. It is clearly part of the Scottish Government's requirements that there is embedded collaborative working across NHS boards and regional planning models, together with Scotland's local authorities, to deliver a system of health and social care. However, decision making, accountability and governance will need to evolve at the same pace so that all the ambitions can be met.

Stuart McMillan: You touched a few moments ago on the integration joint boards. In your view, what more can be done to ensure that there is clearer accountability and better decision making within the boards?

Stephen Boyle: I will bring in Alison Cumming on some of the integration joint board activity.

As mentioned, this is not entirely a question of structural issues. Indeed, the Accounts Commission has reported extensively on some of the challenges within integration joint boards, particularly some of the financial positions that some IJBs find themselves in. It is worth mentioning to the committee that the Accounts Commission and I have further ambitions to deliver joint reporting on integration joint boards. We will look to do that later this year so that there is a complete picture of how the system operates. It will not be just reports on IJBs, which remain local government bodies, and then the NHS, but a system-wide assessment of what can be done.

I will bring in Alison Cumming to say a bit more about where the boards might go next.

Alison Cumming: The key point is how the governance relationships and structures are set out on paper and what we see in practice. That tends to be where we see the variation, as so much relies on there being effective, trust-based relationships between the parties. The governance will only take us so far if the parties do not have the will and commitment to work together towards shared aims and objectives. When we have seen some of the greatest challenges—in areas such as budget setting, for example—it is because the partners are perhaps looking more towards their own individual interests rather than the collective interests of the health and social care system in their local area.

That is an issue that the Accounts Commission will continue to look at, potentially jointly with the Auditor General, taking stock of the fact that we are coming up to the 10th anniversary of the creation of integration joint boards. With developments in the reform of care services, it feels timely for us to look in greater depth at the extent to which the structures are operating as designed, as well as looking more closely at what outcomes are being delivered and some of the softer elements around leadership and relationships that need to be in place to ensure that they are fully effective.

Stuart McMillan: Thank you.

The new NHS Scotland executive group could play an important role. I am keen to get an understanding of your assessment of whether that group will have the necessary tools to drive the change that is needed.

Stephen Boyle: I am very happy to start on that. I will bring Alison Cummings in, as she has looked at that closely.

There is no shortage of senior leaders on the NHS Scotland executive group. Represented on it are the chief executives of the territorial boards together with senior officials from the Scottish Government. In terms of transparency, the minutes are published on the Scottish Government's website. We have probably reached a view that it is maybe too early to tell. We are only eight months in, and I suspect that the group will have to find its place among the governance arrangements that exist across NHS Scotland.

I direct the committee to exhibit 4 on page 17 of the report. The NHS Scotland executive group is a planning and decision-making group among a number of governance groups that exist within the system. The extent to which the group is able to deliver on its ambitions, which we give a bit more detail on in exhibit 3, has yet to be seen. As ever, this is a complex system in operation. The group's ability to drive the level of change that is necessary is a vital part of its responsibilities. As I say, it is perhaps a bit premature for us to give an assessment. If the committee so wishes, it may be for the director general herself to give a view on the group's effectiveness and how it is fulfilling its role.

Alison Cumming: To give the committee a taster of the NHS overview that is coming later in the year, we will look specifically at the operation of the group. It has met five times.

10:00

In terms of our initial observations, I would say that we welcome the intent behind the group's creation. There was a previous iteration of an NHS chief executive group. Formalising that in this way is intended to provide clarity of decision making and clear structures for delegation back to boards to implement and approve actions—those structures were not necessarily in place in any previous iteration of the group. The developments are welcome in better facilitating boards working together and providing greater consistency of approach to particular issues. We know that the initial focus of the group has been on planned care; there has also been a particular focus on activity plans in orthopaedics.

Where we would be cautious—we will watch this with interest—is in relation to the size of the group. You will see from the minutes, which are publicly available, that there can be over 40 people participating in each meeting. That is a product of bringing all the chief executives together with senior representatives and senior officials from the Scottish Government. However—and this remains to be seen—our objective assessment is that it can be difficult to make decisions when large numbers of people are around the table, so we will watch with interest to see how that operates in practice.

Stuart McMillan: There were two comments that you put on the record, Auditor General. You said that "there is no shortage of senior leaders" on the group, and that the group needs to "find its place". Ms Cumming highlighted that a formalised approach is being taken, in comparison with what happened previously. I will take it back another level. With regards to the new way of working and the emphasis on cross-boundary collaboration, I would imagine that a body or an organisation such as the group should, in effect, help to make that collaboration better. Planned care has been mentioned. Have you seen any other examples of that collaboration working?

Stephen Boyle: There are many examples. Alison Cumming and Bernie Milligan might want to come in with some specifics on where planned care is being delivered regionally. The committee will of course be familiar with the post-Covid example of ambitions around national treatment centres. Some of those are in operation, so we are seeing that NHS Scotland is not just operating locally. People will be offered treatment in centres of excellence around the country, where that is appropriate and notwithstanding all the principles that healthcare is best delivered closer to home, and primarily in a primary care setting rather than on an acute or reactive basis.

To go back to your point, the group has a vital role in supporting effective reform changes, in terms of not just regional planning but the sustainability of the models and principles that the NHS in Scotland was set up to deliver and is charged with delivering. It is a large group. I will finish on this point and then pass on to colleagues. It really matters that it finds its place, that it can cut through how the NHS in Scotland operates and the multiple other responsibilities that those leaders have, and that it can set that direction for the future of health and social care.

I will pause there and turn to colleagues for any specific examples that they want to share with the committee.

Bernie Milligan: I have no specific examples. That collaboration is already taking place across boards. Service level agreements are in place, with people going from one board to another.

This approach is a significant change; it is a ramping up of the population-level planning approach, and it will have an impact on delivery, funding and so on. We will see much more collaboration across boards. That is the intent as we understand it.

Stuart McMillan: Okay. My final question is about the framework document, which has been welcomed by the territorial NHS boards. From their perspective, the framework seems to be bringing greater clarity to their relationship with the Scottish Government. Can you share your assessment of how well the framework is working in practice so far?

Stephen Boyle: I think that you are right. I would characterise it as going some way towards filling a gap that there had been, especially with the territorial boards' assessment of the clarity of their relationship with NHS Scotland. The sense from our audit work is that territorial boards in particular have welcomed the framework's introduction. It has brought renewed clarity to the relationship with the Government in terms of the sponsorship responsibilities that reside in the Government and how those are discharged in work with the territorial boards.

To some extent, the territorial boards are playing catch-up with the national boards, and maybe that is not surprising—maybe the national boards are more aligned to the interests and activities of Government.

The framework was introduced just over a year ago. I would not wish to be premature and give false assurance to the committee that all is well now that we have a new framework agreement. The committee has seen many examples over the years where, although framework documents exist, they have not necessarily been the safeguard that ensures that all governance, leadership and decision making are effective in a public body. However, it is important, and it is

worth highlighting, as we do in the report, that such things are not always welcomed. They are not always seen as providing the parity or clarity of relationships that is necessary. I would say that it is off to a good start.

Stuart McMillan: Is the framework helping with the alignment of national priorities and local planning?

Stephen Boyle: That is a fair assessment. There is an acceptance that it provides the clarity of sponsorship roles and responsibilities. It is not the only mechanism where accountability exists. Again, we reference in the report—I know that the committee is familiar with this—some of the escalation arrangements around roles, responsibilities and service standards. The Scottish Government engages very clearly with its health boards and has that ranking system of where boards are on the intervention and escalation framework.

The framework looks like it is finding its place, but as Alison Cumming mentioned, it is something that we will keep a close eye on, both in our overview report and in our individual reporting on NHS boards.

Stuart McMillan: Okay. That is helpful. For the record, I will err on the side of caution and declare that I chair Moving On Inverclyde, a local recovery service. Thank you.

The Convener: Thank you very much. I move straight on and invite the deputy convener, Jamie Greene, to put some questions.

Jamie Greene (West Scotland) (LD): Good morning to our guests. Auditor General, you talked a bit about Government intervention or escalation. There are 14 territorial NHS boards. The intervention levels range from stage 1 to stage 5—stage 1 is the most hands-off and involves the least intervention, and stage 5 is the highest level. I understand that nine of the 14 boards have been elevated to an intervention level of stage 3 or stage 4—eight are at stage 3 and one is at stage 4. Does that surprise or concern you?

Stephen Boyle: It does not surprise me. Like you, I am familiar with the statistics. The general basis for escalation is set out by the Government under the different categories of the escalation framework, whether that involves leadership, governance, service performance or the financial position. I am clearly sighted through the audit work that the external auditors undertake each year. As we set out in our annual report on the NHS in Scotland at the end of last year—we will be reporting again in the autumn of this year—there are real financial challenges in some NHS boards, and there are local issues. The challenges that NHS Grampian faces have been reported on publicly. It has recently prepared a recovery plan, which it has shared with its board and the Scottish Government.

The scale of the challenges that NHS boards face is well documented, so the situation does not surprise me. The most important thing is to translate the approach into a clear plan to face and address the challenges. Some of that will be done by the boards, but it will also happen in partnership with integration authorities and the Scottish Government. The position is indicative of the pressures that some territorial boards are facing.

Jamie Greene: Is the situation also an indication of the relationship between the Scottish Government's sponsorship teams and the individual boards? How can things get to the point where the Government has to escalate a board to stage 4? According to the Government's description, that is when the Government has identified significant weaknesses that pose a risk to things such as quality of care, patient safety, institutional reputation and financial sustainability. What is your gut feeling as to whether the Government is maintaining adequate oversight of individual boards? Surely things should not get to that point before the Government intervenes.

Stephen Boyle: There are a range of factors; Alison Cumming might want to talk about this. First, it would be rare for an NHS board to be escalated straight from stage 1 to stage 5. Usually, the process is iterative, and in many cases, sponsorship, support and interventions at an earlier stage will work. The Scottish Government engages with the health system involved and comes up with a plan to support sustainability and operational performance delivery, which delivers as expected.

Given the complexity that exists, or where governance or leadership issues exist, it is perhaps no surprise that there are examples of action that has not delivered as hoped, which results in an escalation—maybe from stage 2 to stage 3 or from stage 3 to stage 4. When that level of action has not delivered, there are examples—thankfully, they are still rare—of level 5 being used, which is akin to being in special measures or having intervention arrangements.

Before I pass over to Alison Cummings, I will make the point that there can also be unsighted interventions—for example, as a result of a health inspection, Healthcare Improvement Scotland might undertake work that raises concerns that would not have been known about otherwise and which are of such significance that they result in an intervention. All those things can be true, and perhaps different parts of the system are operating as intended. I hope that the balanced point to make is that sponsorship can still be effective, although it results in an escalation level.

The last thing that I will say—I think that I said that my previous point was the last thing—is that, as we say in the report, territorial health boards have varied experiences of sponsorship. Some think that it is working well, but some smaller boards have reported that they experience variation in the sponsorship experience. It is important to put that on the record for balance.

10:15

Alison Cumming: I will add briefly that, as Stephen Boyle set out, when the Scottish Government has identified that boards need more support and intervention, that can be a sign that sponsorship is working. It would be a concern if there was a sustained position of a large number of boards sitting at a particular level and if boards were not moving back down or coming out of the framework altogether. Through the overview report, we look closely at that, because the real test of how the sponsorship arrangements interact with the support and intervention framework is in whether we see such movement and see the effectiveness of interventions. We look at whether boards are accepting the support and implementing the changes that mean that they do not need enhanced support.

As today's report says, some smaller boards have the perception that they have had less engagement. We have not looked at the reasons for that. An assessment might have been made that they do not need the same level of support and intervention, but we do not have evidence of that either way. Through the overview report, we will look at the sustaining of boards that require extra financial assistance, for example, in order to meet their in-year financial targets, and we will be seeing what difference such support and intervention is making for the future.

Jamie Greene: I hear what you are saying—the idea is that, if a board's level is escalated, that is a sign of success of the oversight from the sponsorship team, but it is also a sign of weakness or failure on the part of the NHS board. If a board gets to stage 3, I presume that it is put on a plan to remediate that and bring it back to stages 2 and 1 and be fully sufficient. If a board's level is constantly being escalated, there is clearly a failure in the system—in the board, the leadership, the management team or the oversight and governance in the board. Where do things go wrong? What requires the Government to keep escalating a board's level up and up?

Stephen Boyle: The issue is multifaceted, and there are a range of individual reasons for escalating an NHS board to the top of the intervention and support framework; Bernie Milligan will say a bit more in a moment. It would not be entirely fair to say that escalation occurs because of a failure in a board. You are right that the issue is probably more general and might involve failures or severe challenges in the system—for example, key specialists might not be available to deliver a service. I mentioned that deficiencies in care or delivery in a part of the system can trigger an escalation. We touched on how relationships and agreements with partners can also be a huge factor in why a part of the health system is not functioning as intended. It is also the case—as in some escalations—that the reason is that leadership and governance have not operated as intended. All those things can happen.

As I have said, the reason for escalation could equally be that something has gone badly wrong in an NHS board or be that a range of pressures has accumulated that the health board cannot manage on its own. If that is the case, a system and framework are in place that allow the Scottish Government to provide support and intervention, with the intention of de-escalating a board's level and moving that part of the system back to a more stable footing. Bernie Milligan will say a word about that.

Bernie Milligan: In the report, we say that there is no clear link between the support and intervention framework and the blueprint for good governance, and there is an opportunity for the assessment process for governance to bring governance issues to light earlier. That is a self-assessment process; there was intended to be external assessment of boards and their governance arrangements through the blueprint, but that is not in place yet. We have made a recommendation on that.

We have included a case study about NHS Forth Valley. There are a host of reasons for escalating boards, including performance issues in a particular area such as mental health services, financial issues and leadership and governance issues. At Forth Valley, quite a number of performance issues came to light, such as not meeting targets; Healthcare Improvement Scotland raised serious concerns about how care was being delivered; and there were failures in how integration arrangements were working. When that was looked at, the underlying issues were shown to relate to leadership and governance. If an external review of governance was in place, that would provide an opportunity to allow such issues to be raised at an early stage, which would have an impact.

Jamie Greene: One of my colleagues is going to delve into that issue a little bit more, so I will park it and let others come back to the blueprint for good governance.

I want to come back to the issue of oversight. Auditor General, you said in your opening

comment that NHS boards in Scotland are certainly not undergoverned. Does that imply that they are overgoverned? I will maybe pose a simpler question: is there a piece of work that could be done to see whether we need 14 NHS boards in Scotland? We are a country of 5.5 million people, but we have 22 different authorities managing the health service.

I am sure that most members of the public would not know the difference between NHS Scotland and Public Health Scotland if you were to ask them in the street. The point is that some of the issues that have come up and some of the escalation problems have clearly arisen from issues of leadership and governance, yet we have 14 chief executives, 14 boards, 14 board chairs and a raft of leadership positions in each board, presumably costing huge amounts of money. Do we simply have too many NHS boards?

Stephen Boyle: The very straightforward answer from me is that it is a policy matter for the Scottish Government to determine the size and structure of how it wishes health services to be delivered in Scotland. What our report looks to do is assess how effective the delivery arrangements are within that setting. As Bernie Milligan mentioned, we make a range of recommendations, but we do address the point about complexity. We say that, for the system to operate effectively within the structures that have been determined, there has to be careful collaboration and accountability and the right frameworks have to be in place. What we say especially is that, in order to move to a sustainable basis for health and social care, weaving in how reform is undertaken as part of governance will be an important next step. However, the wider point that you make is a very clear policy matter and not one that I am able to comment on.

Jamie Greene: Leading on from that, what is the relationship between what would be a national plan for Government and local delivery across NHS boards? We often hear about the so-called postcode lottery in the delivery of service or access to services. There is clearly no universality to services, given that access to services depends on where you live in Scotland, as a direct result of the fact that there are 14 health boards operating differently and performing to different levels of governance. In producing your report, have you identified any conflicts between the national mission, strategies or targets, for example, and local delivery? Has there been any pushback from local NHS boards as to their ability to deliver on what are clearly Government national targets?

Stephen Boyle: I am happy to start and then I will bring colleagues in. What we see in the statistics is that there is variation in performance. Our annual NHS overview sets that out against some of the key performance measures for the NHS in Scotland. Performance is not entirely consistent and there will be a range of reasons behind that. It probably speaks to the point that we touched on to an extent this morning about the ambition for regional planning to fill some of that gap. Some health services will be delivered locally through primary care and some will be delivered through health boards, but doing that entirely on a territorial health board basis across the 14 boards requires more in-depth collaboration and more thinking around how it might be delivered regionally.

As Bernie Milligan has mentioned, what we need to see now is that level of clarity about what comes next and how that will be delivered so that it delivers on the Government's ambition for collaboration and consistency of performance. Alison Cumming might want to say a bit more about it, but we are clear that it will be a key part of our on-going audit work, especially through future iterations of the NHS overview.

Alison Cumming: I would just add that we know that the Scottish Government sets the parameters—the planning and the policy, and the financial parameters within which NHS boards operate. Building on the point about variation, I note that different boards are able to deliver within those parameters to different degrees. Some of them see them more as an enabling environment and they do what needs to be done to meet their targets. Others find it harder to deliver within them. The changes that the Scottish Government is seeking, which we have touched on this morning—changes to sponsorship, the creation of the NHS executive group and a move to population-based planning—underline an intent to address some of that in order to bring greater clarity and consistency across the piece.

The external audits are under way across all the NHS boards and should all be concluded by the end of this month. We are engaging very closely with the external auditors of the NHS boards to assess whether there are organisations that are finding it harder than others. Those are the types of issues that will come through in our NHS overview report later in the year.

Jamie Greene: I look forward to reading that. Do you have a sense of whether any of the external auditors are facing challenges in carrying out their duties given that, of the 14 territorial NHS boards, eight have required brokerage loans? That is surely a reflection on their ability to manage their ingoings and outgoings financially. There are various numbers kicking around about the overspend across many boards. It is hard to pinpoint exactly what the total is, but it is in the hundreds of millions for sure although, presumably, there will be variation from board to

board. How comfortable is Audit Scotland that the external auditors are able to do their job to get a proper and accurate picture of the state of the finances of boards?

Stephen Boyle: We are very confident that the auditors have access to all the information that they need in order to, first, give an opinion on the annual report and accounts of the board. The opinion is that there are no material misstatements, so the financial position at the end of March will be set out clearly. As Alison Cumming mentioned, it is our expectation that all the NHS audits will be completed by the end of this month, which is only a few weeks away, so we are keeping a very close eye on that. We have the right structures. Alison Cumming might want to say a bit more about how Audit Scotland engages with the auditors on an on-going basis.

I will just touch on the point that you make about the level of brokerage and financial support that some NHS boards are requiring this year. We are thinking very carefully about that, as Alison Cummings mentioned, through reporting on the NHS overview but also by giving a bit of thought to whether any of that merits a section 22 report on the circumstances that have come through the audit reporting on individual health boards. We are looking carefully at that. We will see the individual health boards' annual audit reports before making any assessment and, if we decide that a section 22 report is merited, we will of course engage with the board and then, ultimately, report publicly to this committee.

Alison Cumming: We have an NHS sector grouping of auditors that we meet with about four times a year. We had a meeting at the end of May in the Audit Scotland offices with representatives of all the external auditors for the NHS boards, which gave us an opportunity to hear in real time the issues that are coming through in financial management, financial sustainability and other areas. Such meetings also provide an opportunity for dialogue and, more than that, group participation to build an understanding of the system and where we can see there are potential outliers or thematic issues coming through.

We also have strong relationships with the auditors individually. If there are issues emerging of concern during the audit process, they will bring that to our attention, and we will have more detailed engagement with them. Certainly, we have that strong intelligence coming through from the local work that feeds through, and we had a session with them, for example, earlier in the year that fed into this governance report; we were able to get an assessment from the external auditors about their experience of seeing how governance arrangements are operating at a local level.

10:30

Jamie Greene: That is very good, and it is very helpful to hear that it is an issue that you are looking at and will be paying close attention to.

My last question is a brief one. It is about something that you flagged concern about in your report and have mentioned twice today. It is that some of the smaller NHS boards feel that the sponsorship relationship is not as good as it could be. Do you think there could be a place for a more in-depth audit of NHS sponsorship effectiveness and arrangements? I know that the issue is touched on at a very high level in the report, but could there be a bigger piece of work in which someone—perhaps even Audit Scotland—could look at the direct relationship between the Government sponsorship team and individual boards and see whether there are any specific issues that need to be addressed, because it is unclear as to what the underlying issues are behind some of those concerns?

Stephen Boyle: Yes, you are right, deputy convener. We highlight that but do not go much further in the report to ask why it is the case. There are potentially a number of different avenues, but one is for the Scottish Government—if the committee chooses to take evidence on this report—to give its perspective on that more clearly and, indeed, for boards to do so too.

There are a couple of options for us. I will not go into too much detail on the blueprint for good governance now—perhaps we can go into that in a moment or two. We know that self-assessment plays an important role in governance, but it is not what we call validated self-assessment, which has a level of underpinning that might get into some of how that relationship works.

We are also seeing that many of the arrangements are still quite new. I am thinking about the new national partnership for planning and the NHS executive group, so the issue is something that we will absolutely return to in the NHS overview in due course. More generally in the Scottish Government, how sponsorship operates will be a key feature of our section 22 report on the Scottish Government consolidated accounts. The effectiveness of sponsorship governance in the round remains on our list of potential topics to return to and, obviously, we will think carefully about whether there are any gaps in what we are doing as we pull together a programme for future years.

Jamie Greene: I appreciate that. Thank you.

The Convener: Thanks, Jamie. I invite Colin Beattie to put some questions to you on governance in NHS boards.

Colin Beattie (Midlothian North and Musselburgh) (SNP): Auditor General, for quite a lot of years now, we have had concerns about the quality of leadership across the public sector, with, of course, specific concerns quite often arising about the national health service.

I note that your report lays out some issues with regard to recruitment. That is not a new thing; indeed, as far back as 2019, our predecessor committee called on the Scottish Government to take urgent action to address the leadership challenges across the public sector.

There are a number of issues in that respect. The previous committee looked at the apparent insufficiency of people putting themselves forward for, say, chief executive posts and so on, and at a round-table meeting that was held, there was a feeling was that there was a problem with the environment that some of these people were expected to be promoted into as chief executives and that that was a deterrent in itself. I do not know whether that was a valid statement; it simply came up at the round-table session.

Has that situation improved? Are there more people coming up who have the skills and ability—and, indeed, the willingness—to take on chief executive posts?

Stephen Boyle: Good morning, Mr Beattie. I well remember the previous committee's reporting on this matter and indeed the round-table evidence session that it held on NHS leadership.

I want to highlight a number of points in the report that we are discussing today, which, I hope, will address the points that you have made. The first thing to say is that these are difficult roles, and there is no question but that the demands placed upon executive leaders and chief executives in the NHS are significant. Of course, some of what they are dealing with are life-and-death decisions.

The report contains evidence that some of the earlier concerns have been heard, and some of the infrastructure in the NHS is now stronger in supporting people coming into executive leadership roles. In particular, the report references some of NHS Education for Scotland's work and its leadership for change programme, which, in effect, supports aspiring leaders and chief executives and equips them for some of the environments that they might find themselves in.

A couple of statistics might help. There remains a lot of turnover at senior levels within the NHS in Scotland, with 12 new chief executives between 2023-24 and 2024-25.

Colin Beattie: Is that not a red flag?

Stephen Boyle: It is absolutely noteworthy that there are 12 new chief executives, 10 of whom are at territorial boards. However, it is not like the situation that we might have had previously, with some vacancies lasting a long time and some posts hard to fill. The posts have been filled, and half of the appointees have come through the aspiring chief executive programme. One of the questions that arose from the predecessor committee's evidence taking was this: where do you get the candidates to take on these demanding roles? Yes, one would absolutely look at that level of turnover and see it as something that one would want to pay careful attention to or something that you would not want to be repeated on any enduring basis, but there are people coming through to fill the roles.

NHS Education for Scotland and the Scottish Government need to pay close attention to ensuring that the relationships are right and that the conditions exist for people to be as successful as we need them to be in these roles. I do not think that the situation is something that we would recommend, and indeed we are not seeing evidence that the NHS has been complacent about it; it is going some way to address the concerns that were known and heard about as a result of the previous committee's work. However, the level of turnover is significant, and you would not want to see such a position sustained.

Colin Beattie: Given that significant turnover in senior management, has there been any analysis of the reasons for their departure? Is it simply coincidence—that is, a lot of them are retiring at once—or is it rather more difficult to evaluate?

Stephen Boyle: I will bring in Alison Cumming to give you some assessment of that, but there will be, as you will expect, a range of local factors. Some of it will be to do with the age and stage of people's careers and the point at which they have come into these roles, and there is a question whether their length of stay in post is different from that of other senior levels or whether it is something to do with the environment that they are dealing with. All of these things have to be got right; their relationship with their chair and their board and their having the levers to be able to do the job effectively will all be part of it, as will the relationship with the Government, too.

Alison Cumming: Of the 12 chief executives whose positions have rotated in the past two years, seven have done so on account of retirement. We are also seeing a bit of a chain effect; four of the appointments have been chief executives moving, in effect, to larger boards, and when people move through the system, it creates vacancies. Eleven out of the 12 new chief executives who have been appointed have come from within the NHS system, so a lot of the situation has arisen as a result of things cascading down.

We did not look directly at the reasons for the turnover, although I can say that it is not isolated to the NHS. There has been a trend of people exiting senior roles following the Covid pandemic and some of the pressures in that respect; turnover has been particularly high, and the Scottish Government has recognised that and put in place initiatives such as the aspiring chief executive programme to seek to create a pipeline. However, it is almost inevitable that, when there is recruitment to senior roles within a system and there are one or two vacancies at senior level, a lot more vacancies are triggered as the system resettles and people move into new posts.

Colin Beattie: Given that this is a bit of an anomaly, what is the situation like in the rest of the UK? Are the issues similar? Is turnover of senior staff similar?

Stephen Boyle: We did not, as part of our audit, draw a direct comparison between turnover levels in Scotland and those in other parts of the public sector across the UK. I would recognise Alison Cumming's point that we are perhaps still playing catch-up in moving to a stable place post the pandemic, with people making lifestyle and financial choices about their careers. However, we are seeing evidence that the NHS in Scotland is taking the issue seriously with the aspiring chief executive programme and some of the support that chief executives are receiving as they move into new posts. The ambition would be for that to translate into a period of stability for health boards and leaders, giving them the opportunity to develop and apply their expertise in their role. The answer to your question, though, is no, we did not do a direct comparison with other parts of the UK.

Colin Beattie: If you are recruiting internally, having a pipeline of skilled people coming up the line is absolutely essential. The previous committee commented that there was a relatively small number of people in that pipeline and that, among that small number of people, there was an even smaller number of people who were interested in taking on chief executive posts. Has that situation changed?

Stephen Boyle: You are right. This is always going to be a select group of people, and many will self-select out of being chief executives, even if they have the skills and experience to take on such roles. You can take some confidence in the fact that, through the work of NHS Education for Scotland and the clarity with which the Scottish Government has recognised the issue, they are doing what they can to have a deep enough candidate pool to address the skills requirements of these jobs. Inevitably, it will be challenging to move into that sort of leadership role someone who has expertise in another sector of the economy and is not familiar with how the NHS operates.

That said, the candidate pool is perhaps broader than it might have been five or 10 years ago, with, for example, some integration joint board chief executive officers moving into executive posts within the NHS in Scotland. One of the by-products of health and social care integration is that there is now a bigger pool of people who can move into these posts. There is absolutely no room for complacency, but it is perhaps going some way to address some of the predecessor committee's concerns.

Colin Beattie: In your report, you highlighted the challenges that exist in recruiting board chairs, and you raised concerns about time commitments and pay, although I believe that there has recently been an uplift in remuneration. Will the changes, which will be phased in over four years, be made quickly enough or go far enough to address your concerns?

Stephen Boyle: We do not yet know whether the changes will be sufficient. The next source of evidence will be the report that the Commissioner for Ethical Standards in Public Life in Scotland publishes on the survey that he undertook earlier this year as part of his assessment of why some non-executive positions—we have been speaking about executive positions—have proved challenging to fill. When the commissioner undertook a survey on the issue in 2021, as you mentioned, the feedback was that the remuneration levels were not sufficient in the view of current or potential non-executive board members. They felt that the remuneration was not commensurate with what was expected of them.

As you will know, an indicative level of time commitment is given for most non-executive posts, which might be one day a month. For chairs, it is usually three to four days a week. However, many people reported that they were spending far more time delivering the role than had originally been advertised.

As you mentioned, there has been an increase in the remuneration, which is being phased in. The next source of evidence on that will be the Ethical Standards Commissioner's report. As we mention in paragraph 51, the intention is to update the results of the 2021 survey to find out whether the increase in remuneration has made a difference in giving NHS boards the stability that they need from the point of view of the level of expertise that is required.

We also mention in the report that there remain concerns about the level of diversity of the membership of some boards and about whether they fully represent the communities that they serve. The most important first step is that there is

an acknowledgment of some of the issues that need to be addressed. However, we do not yet have all the evidence to enable us to assure you in relation to the question that you asked.

10:45

Colin Beattie: You mentioned stability, which is tremendously important. Given the number of movements that we are seeing, is it not inevitable that some instability will feed into the system, given that so many people have taken up their posts over such a short time? Surely it will be difficult to provide continuity.

Stephen Boyle: Yes, I agree. During periods of change, it is inevitable that that will bring some instability in the transfer of knowledge, skills and experience. Corporate memory is also affected by such changes.

Alison Cumming looked at the issue in detail. It is important that the underpinnings remain solid and that the good governance framework is applied appropriately, induction is effective and self-assessments on the effectiveness of governance are undertaken and validated appropriately. Those safeguards exist for when there are periods of change within individual organisations.

Alison Cumming: One of the positives of the recruitment to senior executive positions from within the system is that people are not new to NHS Scotland. Although they might not have experience of the specific organisation that they have been recruited to, they have a level of understanding of how the system operates and of the overarching governance and planning frameworks.

Given that the Scottish Government has struggled to recruit to NHS board chair positions in recent years, we welcome the action that it has taken, which builds on the evidence from the Ethical Standards Commissioner's survey, to address the issues of consistency of time commitments and remuneration.

We have recommended that the Scottish Government should evaluate the impact of those changes, but we observe that they have helped to bring the remuneration for non-execs in an NHS context more into line with the remuneration of non-execs in other significant public bodies. That has needed to happen for a period of time to ensure that the NHS attracts the right calibre of leaders into non-executive positions at a time when the NHS needs to drive through significant reform.

Colin Beattie: You mentioned all the changes that the NHS needs to drive through. Are you satisfied that internal recruitment will achieve that? Although there are benefits to internal recruitment, we want there to be competition so that we get the best people into post. Are we losing out from the point of view of cross-pollination in getting the skills that we need?

Alison Cumming: We are not sighted on the evidence to give a definitive view on that. The issue is certainly one that the Scottish Government will have a view on. We cannot comment on the degree to which there have been external candidates for the recruitments in question, for example, but the internal candidates have been the strongest performers through the assessment process. Although I appreciate your point, we do not have any audit evidence to reach a conclusion either way at the moment.

Stephen Boyle: There is an understanding among board chairs of the level of skills that they consider is necessary for their boards to function effectively and to support organisational objectives. How skills relating to reform and transformation fit into that is less well defined. We can see that from the skills matrix analysis that boards are undertaking. It feels as though an important next step will be to bring that in through the existing board cohort or appointments.

It is worth remembering that appointments to NHS boards are made through the public appointments process. How expertise in reform and transformation skills is captured in that process is clearly defined. Ultimately, that feeds through to the recruitment and appointment process for non-executives.

Colin Beattie: I want to come back to the leading to change programme. Are you confident that it will address the challenges that have been highlighted? Could you give a bit more detail on that and its ancillary project?

Stephen Boyle: Alison Cumming might want to add a bit more detail. I do not think that I could give you a full assurance that that programme will be sufficient to address the challenges that the NHS is facing with leadership and governance, but there is evidence that it is making a difference in producing the pipeline that is needed. This is a volatile environment, and it is a demanding one for leaders. The triangulation of pay, demand and other opportunities that candidates might have could create real pressures in the system at some point in the future.

I would say that the leading to change programme is a positive development and a welcome start, but there will need to be constant monitoring of the volume of candidates coming through to ensure that it can address those challenges. It has perhaps come through the first stress test. Given the volume of turnover that there

has been in NHS leaders, it has played its part in producing candidates to fill those vacancies.

Alison Cumming: The aspiring chairs programme is about to enter its third cohort. It commenced in 2023-24. It is a 10-month programme that includes development days and support from a host board. We know that earlier iterations did not achieve significant numbers of suitable candidates, so it is only with the chair posts that are being advertised now that we will see whether those programmes have succeeded in developing candidates to come through.

I have been invited to attend the latest cohort of aspiring chairs in a couple of weeks' time to present our findings from the report. I might be better informed after I have attended that session.

The Convener: This might be an unfair question, given that you have not attended that session yet. Do you have any sense of what pool those people who aspire to be chairs are drawn from? In other words, are they typically existing members of NHS boards who wish to step up to become chairs of boards or does the net go wider than that?

Alison Cumming: My understanding is that the programme is focused on existing non-executive members of NHS boards, but I do not have the details of the 2025-26 cohort in front of me.

The Convener: Is it advertised widely or is it just advertised to that group in quite a targeted way?

Alison Cumming: I think that the focus is on supporting people who are already NHS non-executive board members to transition into chair roles.

The Convener: It is interesting as to whether the approach should be exclusive in that way or more open. One of the broader questions—I will bring Graham Simpson in shortly—that is raised in your report is the extent to which non-executive board members are properly representative. How many users of NHS services are on those boards? You spoke about a population-based approach to the planning of services and so on. How many older people are members of boards, for example?

It is interesting for us to understand whether the people who are coming through the system—through the Commissioner for Ethical Standards' net and so on—are truly diverse and representative because, as you say, they have an important role to play in not only scrutinising but challenging the executive team running a health board. Do you get a sense of whether boards fulfil the job that is required of them?

Stephen Boyle: In general terms, convener, the answer is that boards recognise that that is a live issue for them. They have to do both things. They have to bring in the skills that they would typically want on a traditional board: expertise in running an organisation, whether in the public or private sector; people skills; and the right cultural fit—we have spoken about people needing to bring the right values that are consistent with the delivery of NHS services. Some boards will want financial experience as well.

Pulling all that off at the same time as being representative of the people that they serve is the issue that boards are identifying. We set some of that out at paragraph 60 in our report. Boards' ability to be diverse, both in terms of protected characteristics and consistent with the people who are using their services, is the other factor that they all need to pay close attention to. We are not pointing that out to boards: they are recognising that and some are saying—particularly those that are in some of Scotland's rural areas—that they find it difficult to access skills and diversity and bring the population into the boardroom. That is the important step that they need to take.

We comment in the report—it is important to say that these are not mutually exclusive—that some boards are looking to adopt what we call stakeholder engagement mechanisms. It is important to say that that is not at the expense of further ambition to deliver and become more diverse entities, but it is a recognition that they do not want to lose sight of their need to engage with the populations that they serve, while still looking to tackle the complete diversity of the board. There is no doubt that that is an on-going challenge for some of Scotland's health boards.

Bernie Milligan: Boards are definitely aware that that is an issue and of the importance of bringing in the perspective of those who use services, particularly given the health inequalities that exist. There is something around the challenge of the public appointments system and the formality of that. However, there is broader experience in other public bodies on the use of lived-experience panels and so on, and insights on issues such as poverty. There is broader experience that could be brought in and there are things that boards are doing. We heard about the Forth Valley anchor board that works with other stakeholders and brings in local insights. It certainly is an issue that boards are aware of, but there is wider learning from other public bodies as well.

The Convener: In the Parliament, the debates on health typically focus on inputs versus outcomes, with a lot of emphasis on how many people are being employed to carry out work or how many more appointments there will be, and whether the outcomes are changing as a result of that. It seems to me that this issue is about the

inputs, because unless you get the inputs right, you will not get the outcomes that you want.

Stephen Boyle: I think that that is a fair analysis, convener. We spend perhaps too much time in a skewed conversation about the inputs to public services. What matters more is of course what experience people get, whether services are delivering for them and the outcomes that they get. However, unless you get some of the inputs right, there will always be a challenge or accusation that you are not representative of or do not understand the needs of the population because there is not a broader range of people sitting on the board.

The Convener: Thank you. I will ask Graham Simpson to put some questions to you.

Graham Simpson (Central Scotland) (Con): Thanks, chair. Have you finished your questions, chair?

The Convener: I have.

Graham Simpson: Right, because I was going to follow on from your line of questioning—

The Convener: You are the finale today.

Graham Simpson: Let us see how well I do on the issue of boards and board chairs. There was mention of Forth Valley. NHS Forth Valley's current interim chair is Neena Mahal, who was the chair of NHS Lanarkshire. Is there an issue there? There is clearly a problem recruiting new chairs. Alison Cumming mentioned the aspiring chairs programme, which appears to consist of people who are already in the system. Do we need to be doing more to attract new people who are not in the system? Do we risk having this almost revolving door of chairs jumping from one board to another—the sort of cross-pollination that Colin Beattie mentioned?

11:00

Stephen Boyle: It is important that the right person is appointed. The committee can take some assurance that these appointments are made through the public appointments process, which is regulated by the Commissioner for Ethical Standards. They are subject to a fair, open, public recruitment process. While the aspiring chairs programme, which Alison Cumming mentioned, is part of the process that develops people who are already in the system, it ought not to be a closed shop, as it were, so that you have to have gone through part of the process to get promoted to be the chair of the board.

Unfortunately, I do not have examples to hand, but if it will be helpful to the committee, we can certainly look into examples of where people have been brought in and appointed as chairs. My colleagues may have some examples to share with the committee. The point that I would make is that it is a balance. It matters that people can become chairs, but with the right skills and experience to do so.

Alison Cumming: We would need to come back to the committee with some more specific examples. The judgment that appears to be made in the NHS is that it is beneficial for people to have served some time as an ordinary member of a board before moving into those chair roles. However, it is not exclusive. Some people will come in with experience of chair positions elsewhere, but we can come back to the committee with more detail on that if you would find it helpful.

Graham Simpson: Okay. That would be useful.

A letter was published yesterday by the public policy institute, Enlighten. It was written by 13 senior medical professionals and executives in Scotland. It was an open letter, published in the press and, I think, on Enlighten's website. Top people have signed up to it. It says:

> "We recognise that many people are well served by the NHS in Scotland, and that thousands of dedicated and hard-working people ensure that compassionate and effective, sometimes lifesaving, care is provided on a day-to-day basis. And yet, as has also been acknowledged, the current system of delivering health care and social care in Scotland is unsustainable, often stretched beyond capacity, overly complicated, difficult to navigate, often inefficient and is perceived as not always meeting the needs of people living in Scotland."

There is a lot more to the letter, but it says—and this is where it relates to your report—that the NHS is "overly complicated". The letter is potentially touching on governance, which is what your report is about. Could you explain why you think that governance is so important and why changing the governance and simplifying it will make a difference to the people who use the NHS in Scotland?

Stephen Boyle: Thank you for that. I have not seen the letter, but the themes are those that I would recognise from our own reporting, in which we have consistently, over many years, talked about the need to change and reform health and social care services to support a sustainable model that serves a changing demographic in Scotland and that can deliver health and social care within the financial circumstances. You mentioned Enlighten. One of the other important contributions that we have seen in recent weeks is from the Scottish Fiscal Commission, pointing out some of the downstream challenges to be addressed as Scotland's population changes.

Governance is part of that, absolutely. I suspect, Mr Simpson, that the delivery of health and social care and the models that we adopt will be

complicated and might just remain complicated by virtue of this being a complicated business. This is a system of public service that requires collaboration. You can see that absolutely clear recognition from the Scottish Government and the health boards that collaboration is at the heart of how they want public health and social care to be delivered.

Governance matters. I recognise that it can be a bit of an off-putting term, especially for those of us who just want public services to operate and could not care less about their governance and management. However, this is about the system of decision making or the application of decisions about how, in this instance, health and social care are run. Our report sets out that there are opportunities to strengthen those governance arrangements. We talk about, for example, the role that non-executives could play within the Scottish Government to support decision-makers there.

At a more local level, there is not just the appointments process that we have spoken about, but important documents—"The Blueprint for Good Governance in NHS Scotland" is at the heart of how some of local governance operates. Although self-assessment is welcome—it is a hallmark of best value that the committee would be interested in—we are not seeing validated self-assessment take place that can support NHS organisations to apply some of those principles and avoid any accusation that people are marking their own work. We think that that is an important next step and we reflect that in the recommendations.

As ever, the last point that I would make, if I may, is that applying reform effectively might demand the presence of an additional skill set on some of the NHS Scotland boards, in addition to all those other valuable skills. Reform and the intention to go forward might need some experience and a new application of skills to support effective delivery.

Graham Simpson: You mentioned self-assessment and talked about people marking their own homework, which is what self-assessment can be. Your report highlights variation in how boards carry that out. Why is there variation? Should there be greater consistency?

Stephen Boyle: Bernie Milligan looked at that carefully, and I will bring her in on getting the best value. As we say at paragraph 68, there is inconsistency in the use of the blueprint for good governance, although it is generally well received by boards. There is inconsistency between the scoring that national boards have undertaken and that of territorial boards, and national boards reported more favourably on their arrangements than territorial boards did. We do not have enough evidence about or understanding of why that variation exists. At the risk of repeating myself, I note that that suggests that there is a gap in supporting insight and understanding, which a validation process might fill. I bring in Bernie Milligan to say more.

Bernie Milligan: On the blueprint for good governance self-assessment process, we know that every board has used the blueprint and has carried out a self-assessment. To do that, boards have often involved an external facilitator who has come into the board. For the second round, we understand that there was a bit more scrutiny of the evidence that boards were using to reach their conclusion about how to assess themselves against the criteria.

We think that external review of self-assessment is still important and that it would validate assessments further. It would also ensure that there was consistency across the evidence base that has been used and that information was used much more consistently.

It is hard for us to tell exactly from the self-assessment process whether there are any issues of boards marking themselves more harshly or otherwise. However, we recommend that external review would be a supportive part of the process that could also raise wider governance issues, which support could be provided on.

Graham Simpson: How do you think the blueprint for good governance is going? How could it be improved?

Stephen Boyle: Our main assessment is about the external contribution that could be made to the improvement mechanisms. As Bernie Milligan said, we have seen an evolution of the blueprint, which we reference at exhibit 8 on page 28. That suggests a recognition, as times move on, of what the areas for focus need to be; we contrast the 2022 version with that of 2019. In general terms, we see that the blueprint has been used and welcomed by NHS boards and is seen as an important and helpful tool for them to improve their governance and their approach to risk management.

The evolution between 2019 and 2022 shows that the risks that boards need to manage do not stand still. As we have touched on, the complexity in the system remains, and we have set out at paragraph 75 and beyond some thinking about external validation and about the next stage. Given the Scottish Government's emphasis on reform and collaborative working, there is the opportunity to strengthen the approach to that, as it becomes embedded in the blueprint for good governance. There are two or three examples of next steps that we hope that the blueprint for good governance can gravitate towards, so that it

becomes an effective contributor to supporting boards to deliver their services.

Graham Simpson: Are all the boards using the blueprint? When you suggest external validation of blueprint self-assessments, who are you thinking of to carry that out?

Stephen Boyle: I ask Bernie Milligan to share a bit of insight.

Bernie Milligan: All boards have used the blueprint, and all boards have carried out self-assessment and prepared improvement plans. In exhibit 8, we highlight key areas for development that came out of the self-assessment process for both iterations of the blueprint.

Boards were expected to report in the spring of this year on the progress that has been made, and we did not have an opportunity to look at that as part of the audit. However, we have provided case studies where we can see that boards used the blueprint process to develop their governance arrangements.

After NHS Lanarkshire had a governance review, it made quite a number of changes to its committee structure—it created sub-committees to allow deeper dives into certain areas—and it produced better data that can be used across the board, as well as taking a new approach to risk. Similarly, the Scottish Ambulance Service placed a bigger focus on risk in the board.

I am sorry—what was the second part of your question?

Graham Simpson: Who should carry out the external validation?

Bernie Milligan: We do not have a particular view on that—it is to be considered. In the first round, there was an intent to have external validation but, because of the Covid interruption and so on, the only board that has had an external validation review process is NHS Forth Valley, and that was part of its improvement activity. We understand that Forth Valley commissioned someone to do that. We do not have a fixed view on who should do such validation.

Stephen Boyle: There are options for the Scottish Government. We are not positioning one organisation or another as one that might be best placed, but internal auditors, Scottish Government teams and appropriate experts with insight on governance could all provide such a service. The point is to have the right skills, expertise and experience to deliver a validated self-assessment process.

I will go back to one of your earlier points, Mr Simpson, which was not about validation of self-assessment but about the self-assessments that have taken place. Paragraph 73 stands out for me, because it mentions that five NHS boards consistently score themselves lower on their arrangements, and we do not understand why. I hope that being able to gather up validated self-assessments would provide a useful tool for sharing examples of good practice across the country. It feels as if there are opportunities for boards and for the Scottish Government to capitalise on governance arrangements in order to support improvement and make any adjustments that might be necessary.

Graham Simpson: That makes the point. You have five boards that have marked themselves down, and maybe they deserve to be marked down—I do not know—but having someone external to make sure that they are not being too hard on themselves would be useful. I will leave it there, convener, thank you.

The Convener: Thank you very much indeed. That is a useful point to conclude proceedings at. There are a number of areas where it might be useful to get a bit more information, if the witnesses are able to supply it.

Thank you very much for your evidence, Auditor General. I also thank Bernie Milligan and Alison Cumming for their input, which has been greatly appreciated.

11:16

Meeting continued in private until 12:20.

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

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba