OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit Committee

Wednesday 26 November 2025

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Session 6

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PUBLIC AUDIT COMMITTEE
31st 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)
*Joe FitzPatrick (Dundee City West) (SNP)
*Graham Simpson (Central Scotland) (Reform)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Stephen Boyle (Auditor General for Scotland)
Alison Cumming (Audit Scotland)
Leigh Johnston (Audit Scotland)
Fiona Mitchell-Knight (Audit Scotland)

CLERK TO THE COMMITTEE

Katrina Venters

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Public Audit Committee

Wednesday 26 November 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 31st meeting in 2025 of the Public Audit Committee.

Under agenda item 1, do members of the committee agree to take agenda items 4, 5, 6, 7 and 8 this morning in private?

Members *indicated agreement.*

The Convener: Thank you.

"The 2024/25 audit of NHS Ayrshire and Arran"

09:30

The Convener: Item 2 is consideration of the 2024-25 audit of NHS Ayrshire and Arran. I am very pleased to welcome this morning the Auditor General, Stephen Boyle. Good morning. Alongside the Auditor General are Fiona Mitchell-Knight, who is an audit director at Audit Scotland, and Leigh Johnston, who is a senior manager at Audit Scotland.

We have some questions to put to you on the section 22 report, Auditor General, but before we get to our questions, I invite you to make an opening statement.

Stephen Boyle (Auditor General for Scotland): Many thanks, convener, and good morning. I have prepared this report on the 2024-25 audit of NHS Ayrshire and Arran under section 22 of the Public Finance and Accountability (Scotland) Act 2000. As the committee will know, a section 22 report allows me to bring to the Parliament's attention matters that have arisen from the annual audit of a public body.

As reported by Fiona Mitchell-Knight in her annual audit of NHS Ayrshire and Arran, the board is not in a financially sustainable position. In 2024-25, the board required a £51.4 million loan, known as brokerage, from the Scottish Government to break even. It now has the highest amount of outstanding loans across the national health service in Scotland, at £129.9 million.

The scale of the financial challenge that the board faces is unprecedented. The board's three-year financial plan from 2025-26 through to 2027-28 projects a cumulative deficit of £112.1 million. The Scottish Government has said that NHS Ayrshire and Arran's

"forecast position for 2025/26 does not demonstrate sufficient improvement in the board's financial sustainability",

and it concluded that it

"could not approve the"

board's

"three-year financial plan."

The Scottish Government set a target of a £25 million deficit for the current financial year 2025-26, but the board is forecasting a higher number than that—a deficit of £33.1 million. The appointed external auditor reported that the board is relying on "overly optimistic" savings plans that might not be achievable.

Further, NHS Ayrshire and Arran has been at level 3 on the NHS Scotland support and intervention framework since 2018 because of its financial position. It is receiving tailored support from the Scottish Government to support its financial recovery, and the Scottish Government asked the board to create a financial recovery plan that sets out a five-year path to balance. The board has not yet prepared sufficiently detailed plans to show how it will achieve financial sustainability in the future.

Our position is that there is no evidence yet that the board can achieve financial sustainability. It is relying on optimistic assumptions that it will achieve recurring savings of 3 per cent each year until 2027-28, and that forecast deficits will also continue to be funded by the Scottish Government. The board has what it refers to as a whole-system plan, but that does not yet sufficiently demonstrate how services will change or how efficiencies will be realised to meet the growing needs of patients within the financial constraints that we have outlined.

The external auditor has, quite reasonably, recommended that the board needs to continue to seek Scottish Government support for more radical reform if it is to achieve financial sustainability. Board members and the corporate management team need to continue to work together to provide effective leadership to secure the sustainability of services, and the recent appointment of an interim chief executive officer of the board provides it with an opportunity to help to address those challenges.

Lastly, it is clear that the board needs to set out a clear, realistic recovery plan to address the forecast deficit for 2025-26, and it also needs to agree how it can implement an improvement plan with the Scottish Government to achieve its financial sustainability objectives over the next five years.

As you mentioned, convener, I am joined by Leigh Johnston from our NHS performance and best value team, and by Fiona Mitchell-Knight, who, as I referred to, is the appointed external auditor of NHS Ayrshire and Arran. As ever, we will do our utmost to answer the committee's questions.

The Convener: Thank you very much for that comprehensive summary of the report, which touches on many of the areas that we want to ask you about.

You mentioned in that opening statement—and it is a stand-out conclusion of the report—that NHS Ayrshire and Arran has the highest level of outstanding brokerage of any territorial health board in Scotland. You say in the report that the figure for the audited year 2024-25 was £51.4 million, which represents 4.3 per cent of revenue resource limit.

Can you tell us how that compares with other health boards? Is NHS Ayrshire and Arran a real outlier or are there other health boards that are in a similar position or going in that direction?

Stephen Boyle: I am happy to start and then bring in Leigh Johnston to say what we can at this stage about the wider picture. As the committee will be familiar with from our forward work programme, we will be setting out much of the detail that you are interested in in our annual report on the NHS in Scotland, which we will be publishing next week, if memory serves me correctly. That will also set out some of the context of the wider financial challenges and the support that NHS boards are receiving.

Part of the rationale for carrying out a section 22 report on NHS Ayrshire and Arran was because the scale of the financial support that it is receiving is at the end of the spectrum of all the boards. You mentioned territorial and national boards. If we add both together, the support for NHS Ayrshire and Arran is the most significant in terms of outstanding brokerage. The additional context that I touched on in my opening statement is that there is not yet clarity around whether it has a route to balance or a plan to resolve the scale of financial support that it continues to receive from the Scottish Government.

I will pause there and ask Leigh Johnston whether there is more detail that we can offer at this stage, short of giving you the detail that we will present to the committee very soon on the overview report.

Leigh Johnston (Audit Scotland): As the Auditor General said, we will cover this in detail in our NHS in Scotland report, which we will publish in a couple of weeks. As the committee will be familiar with, NHS Highland, for example, has about £106 million of outstanding brokerage, and it received about £49 million or £50 million of brokerage in 2024-25. Of course, NHS Grampian, which we will talk about shortly, received more brokerage in value, but not proportionately, than NHS Ayrshire and Arran did in 2024-25—it was £65 million. NHS Ayrshire and Arran, NHS Highland and NHS Grampian have the most outstanding brokerage that is still to be repaid.

The Convener: You have said a couple of times already this morning that your concern is that there is no evidence that the board can achieve financial sustainability. How has it come to that?

Stephen Boyle: For some of the history, it would be useful for the committee to hear from Fiona Mitchell-Knight about the work that she and her team have been doing for the past three years of this audit appointment round.

You are right, convener—such financial support and the challenges are things that do not happen overnight. If I may first answer my own question of why this year, what we are not seeing through the audit process is a path or a route through to financial balance. As I mentioned in my opening remarks, none of this is new to either the board or the Scottish Government. NHS Ayrshire and Arran has been on the support and intervention framework for eight years. It has been receiving support from the Scottish Government, but it is hard to form a conclusion that that support is making an effective difference.

We seem to be in a recurring pattern or cycle, in the context of what is now £130 million of outstanding balance, of brokerage support from the Scottish Government to support financial balance. I mentioned breaking the cycle in my opening remarks, but maybe neither the Scottish Government nor the board thinks that the cycle needs to be broken—that is just the model that they are in. However, that does not seem a sustainable position with regard to service delivery or quality for the patients of NHS Ayrshire and Arran.

I will bring Fiona Mitchell-Knight in to set out some of that additional context.

Fiona Mitchell-Knight (Audit Scotland): As the Auditor General said, this is a long-standing position—the board has been on escalation for a number of years—but the scale of brokerage that has been needed in the years since I was appointed as the auditor has increased. For the first year of my audit appointment, the brokerage was £25 million, it then increased to £38 million and, this year, as we have already said, it was £51 million. Certainly, the position is deteriorating with regard to the support that is needed.

Over that time, we have reported that the pace of transformation in the board has been slow. In 2023-24, I reported in my annual audit report that although a number of areas for discussion relating to short, medium and longer-term service reform options had been discussed with the performance governance committee, many of the measures were not costed. Therefore, we did not consider them to be credible options for closing the budget gap. At the time, we recommended that more focused leadership was needed to drive the change and to enable costed financial plans to be presented that would show how the financial gap had been closed. Such plans have not been produced. The plans that have been presented to the Scottish Government this year projected a deficit of £33 million. Currently, the financial monitoring reports are showing that it will be challenging for the board even to achieve a £33 million deficit.

There are particular cost pressures on the acute services. When it comes to meeting the demand for those services, the length of stay for unscheduled care is longer than it is in other boards. Delayed discharges are high and increasing. All those things are putting cost pressures on the acute services. As a result, the board is filling more beds than it can afford to fund in the acute sector.

The Convener: The traffic-light system at the end of the report, which indicates which services are exceeding the targets and which are falling below them, is a very useful addition. On the face of it, if a health board was overspending its budget and achieving much better outcomes for its population, one could say that there might be some merit in that, but, in the report, you portray a health board that is overspending its budget and relying on bailout loans from the Scottish Government and which, even then, is still not meeting targets on accident and emergency waiting times and so on.

Stephen Boyle: Our intention is to present a rounded picture, through not just the section 22 report but the annual audit report from which the section 22 report is drawn. In the annual audit reports, I ask the appointed auditors to present, in addition to their important opinion on the financial statements, a broader suite of judgments on financial management, value for money, use of resources and financial sustainability.

There seems to be a pattern of the board continually requiring brokerage. It is clear that that is difficult for the board—we recognise that that is not where it would want to be. However, the context for that extends beyond its own boundaries. The picture is a challenging one for all the territorial boards; we will set that out in more detail in our annual report on the NHS. However, the fact that NHS Ayrshire and Arran is receiving brokerage when neighbouring boards are not and when those boards are making harder decisions around service arrangements than NHS Ayrshire and Arran has perhaps been able to do up until now draws attention to the board.

The Convener: In theory, at least, brokerage loans are loans that are expected to be repaid, but when it is projected that NHS Ayrshire and Arran will have a cumulative financial deficit of £112 million, and it has outstanding loans of £129.9 million, is it realistic to expect that any of that money will be paid back? Indeed, would that be the right thing to do?

09:45

Stephen Boyle: I do not want to steal the thunder of the next report, but, in that report, we will refer to the fact that we think that the Scottish

Government needs to be more transparent about what its expectations are when deficit support arrangements are put in place for NHS boards, not only for the benefit of the boards but to aid the public's and Parliament's understanding.

A variety of arrangements have been used over the past 10 years. With brokerage, as Fiona Mitchell-Knight mentioned, there is a long history of amounts being paid to support boards to achieve financial balance. Theoretically, those funds have been provided as loans, but the committee may recall that, when Covid came along, the slate was wiped clean. We are now seeing a new cycle of brokerage or support being accumulated.

As is referred to in the report that the committee is currently considering and in the one on the NHS that it will consider, health boards are making assumptions about whether they will or will not have to repay loans. Today, I will inevitably stray into highlighting other issues that exist elsewhere in the country. There are next to no examples of health boards actually repaying brokerage—I think that there is only one health board that has ever repaid brokerage—so it is perhaps not an unreasonable assumption for health boards to think of brokerage as less of a loan and more of a grant to support their financial position. However, we think that it is important that the Scottish Government should be clear in saying what is expected of boards and whether they should be factoring repayment into their considerations.

Leigh Johnston might want to say a bit more about that, if she is able to. The issue of the need for transparency and clarity is a theme that we will return to.

Leigh Johnston: I do not have much to add, except to say that, when we ask the Scottish Government, it is very clear in setting out that there is still an expectation that the brokerage loans will be repaid by boards once they reach a break-even position.

The Convener: The other issue that comes into this picture is the requirement on all health boards to find recurring savings of 3 per cent. I have always found it a little incongruous that, in an era in which we are seeing historically high levels of spending in the national health service, we are expecting health boards to make 3 per cent savings. Could you talk us through how that is supposed to work, especially in the context of a health board such as NHS Ayrshire and Arran, which, as we have just discussed, has massive brokerage, a massive projected cumulative financial deficit and so on?

Stephen Boyle: You are right. I will bring in Leigh Johnston and Fiona Mitchell-Knight to talk about some of the detail in the annual audit report and their judgment on how realistic the savings targets are for NHS Ayrshire and Arran. I know that the committee is very familiar with the concepts of recurring and non-recurring savings. It is important that NHS Ayrshire and Arran has taken reasonable steps to use a traffic-light system for its savings plans to set out what is realistic, what is optimistic and what might be more pessimistic.

On the history of the 3 per cent target, you make an important point about compatibility. In some ways, the savings target is important, because all public bodies that spend public money should go through a process of challenge with regard to how efficient they are being. It is important to bring a culture of savings into the use of public money. However, the issue of sustainability is important. Any savings target must be realistic. It is a process that has been around for a number of years.

I will bring in Leigh Johnston first, to set some of the national context.

Leigh Johnston: The 3 per cent target was brought in last year, if I remember rightly, but it was not met. There is an on-going deficit each year, and that is what the 3 per cent savings target is about. Those savings should be recurring savings. The committee has discussed the difference between recurring and non-recurring savings many times.

As we will mention in our report that is due to come out in a couple of weeks, unprecedented levels of savings have been made this year, and there has been an increase in recurring savings. A lot of the increase in funding for the NHS is to pay for the pay awards, so it is still necessary for boards to make on-going savings.

Fiona Mitchell-Knight: Specifically on NHS Ayrshire and Arran, the target for savings for 2024-25 was £26.5 million. The board reported that it had delivered savings of £26.8 million, but £8.9 million of those were non-recurring savings, which means that they do not count against the target. In relation to the target of £26.5 million, £17.9 million was what the board actually achieved.

Significant savings are included in the board's plans for this year, but we have reported that we are concerned that the savings plans are overly optimistic and will not be achieved. There are high risks against some of those items. As I mentioned earlier, the signs in the financial monitoring reports are that the board will struggle even to achieve a £33 million deficit, so it will be a big challenge to achieve the savings that have been set out.

The Convener: Just for completeness, does the report talk about savings being wrongly classified as recurring when they were non-recurring savings?

Fiona Mitchell-Knight: Yes. The distinction between recurring and non-recurring was not always clear in the reports, and it is very clear that the target relates to recurring savings. One of the recommendations in our report is that that should be clearer in the future for board members.

The Convener: That is an issue of transparency for us, but, as you say, it is also an issue for the people who have responsibility for the safe governance and effective leadership of the board.

Fiona Mitchell-Knight: Yes.

Stephen Boyle: That is very much the case. In any organisation, it is fundamental that clear reports are provided to those who are charged with governance. Especially in an organisation such as NHS Ayrshire and Arran, which is experiencing financial difficulties and is faced with making difficult and potentially unpalatable decisions, such reporting must be clear and precise. As Fiona Mitchell-Knight has highlighted in her report, the quality of the reporting was not good enough to enable board members to make the decisions that they had been asked to make.

The Convener: I am conscious of the time, so I will move things along by inviting Colin Beattie to continue to pursue the fctheme of financial sustainability.

Colin Beattie (Midlothian North and Musselburgh) (SNP): Auditor General, in your opening remarks you quoted from paragraph 11 of your report in connection with the board's three-year financial plan, which was submitted to the Government in March 2025. You commented then that the Government did not accept it and that another three-year plan should be produced for 2025-26 with a new financial deficit of £25 million. Your report also said that that plan had not yet been updated—it had not been presented to the board, I think. That was supposed to happen in June 2025. Are you aware of any updated plans that have come forward since then? If so, what do they look like?

Stephen Boyle: I will bring in Fiona Mitchell-Knight to share that detail with the committee.

Fiona Mitchell-Knight: A revised plan was submitted, but the revised plan also projected a deficit of £33 million. The board said that it was unable to produce a plan that met the Scottish Government's expectation of £25 million.

Colin Beattie: So, what is happening now?

Fiona Mitchell-Knight: The board is monitoring its performance against its plan, and the Scottish Government is continuing to work with the board on any ways in which it can try to improve the position for the year.

Colin Beattie: So, the board is working to the plan that has been rejected because it projects a deficit of £33 million.

Fiona Mitchell-Knight: It is working towards the achievement of its own plan, but it is also looking for any ways in which, on top of the current plan, it can realise any further efficiencies. It is working with the Scottish Government on that.

Colin Beattie: Has that revised plan gone to the Scottish Government?

Fiona Mitchell-Knight: Yes, but it projects a £33 million deficit.

Colin Beattie: The Scottish Government came back and told it—what?

Fiona Mitchell-Knight: The Scottish Government told it that it needed to continue to look for further ways to realise efficiencies. As part of the escalation model at level 3, the Scottish Government is working with the board to identify ways in which those can be achieved.

Colin Beattie: But the Scottish Government rejected the second plan.

Fiona Mitchell-Knight: Yes.

Colin Beattie: It told the board to continue working with its existing plan in the interim, while looking for other sources of savings.

Fiona Mitchell-Knight: It told it that it should be seeking ways to realise further efficiencies.

Stephen Boyle: This highlights a difficult position, which may be unsatisfactory for both the Government and NHS Ayrshire and Arran, in which two numbers for the projected deficit are being operated to. I think that there has to be realism as to what the board can achieve, not just this year but over the next three to five years, under a realistic plan. As ever, it is not just a plan for a plan's sake, with an arbitrary number on it; it is underpinned by clear, costed steps and actions that will produce a sustainable model of healthcare for NHS Ayrshire and Arran.

The board and the Government could dance around whether the deficit is £25 million or £33 million, but that does not address the bigger picture of whether there is a sustainable financial position for the health board. Even if the deficit is £25 million, that is still financial support that the board requires, and that is real money—resource that could be being used to deliver healthcare in other public services. We need clarity around what the board can and cannot do and a clear plan with the Scottish Government.

Colin Beattie: Auditor General, you used the term "arbitrary". Is the figure of £25 million based on anything, or is it just a notional target?

Stephen Boyle: I am not sure that we will be able to give you that detail. It is potentially a question for the Scottish Government as to how it arrived at that figure—why it is £25 million and not £26 million. What we are not clear on—and it is something that Fiona Mitchell-Knight and her team will follow up during this year's audit—is whether there was an incremental basis for that. Was there £8 million of savings that the Scottish Government asked NHS Ayrshire and Arran to deliver that the board felt it was not able to deliver because of risks to service delivery or patient safety? I do not think we have that detail today, but it is certainly something either that we will follow up during this year's audit or that the committee could ask the Scottish Government about.

Colin Beattie: Let me summarise it for my own clarity. At the moment, the board is working towards a deficit of £33 million. That is what it is budgeting against, but there is a notional £25 million deficit that it has to achieve by as-yet-unspecified means. That was the position in June. Has there been any indication that it is likely to improve on the present situation?

Fiona Mitchell-Knight: No. The latest financial reporting to the board shows that it is challenging for the board to achieve the £33 million deficit. There are currently no signs that it will be able to deliver an improved position.

Colin Beattie: So, at the moment, the board has committed only to a £33 million deficit. Has it accepted a £25 million deficit as a valid target? It seems a very confused way to do business, to be honest.

Fiona Mitchell-Knight: Its financial plan is based on a £33 million deficit and was clearly compiled as part of its budgeting process. As I said earlier, we feel that it is overoptimistic and that that target will be hard to achieve.

Stephen Boyle: That is an important point. There is lack of clarity about which target the board is being held to account for—is it the £33 million deficit or the £25 million deficit? If, as Fiona Mitchell-Knight has mentioned, the board is already indicating that a £33 million deficit will be challenging for it, that captures the lack of precision and realism about the financial position of the board and what it can achieve this year. That does not allow for the level of medium to longer-term planning that is required to deliver a financially sustainable health service in NHS Ayrshire and Arran that, rather than having this model that jumps from one year to the next with a debated savings target or deficit target, can get itself out of the very difficult position that it has found itself in a loop of for a number of years now.

10:00

Colin Beattie: It certainly seems a very unsatisfactory approach.

In paragraph 13, you explain that the board has been at level 3 of the NHS Scotland support and intervention framework. Can you briefly explain what the Scottish Government's tailored support to the board for financial recovery actually looks like in practice, especially in the context of what we have just discussed?

Stephen Boyle: I am happy to do so, and I will turn to Leigh Johnston to set out a bit of detail. Later this morning, we will speak about another board—one that is at level 4 in the escalation framework—and Leigh may be able to explain the distinction between them.

It is touched on in paragraph 13 of the section 22 report that NHS Ayrshire and Arran has received seven years' worth of tailored financial support at level 3. It is a matter for the Scottish Government to determine which level it is at, but I do not get a clear sense that it is delivering a sustainable path to balance or service delivery requirements. I think that it will be an important question for the Scottish Government to decide whether the level of support that it is providing to the board is making the difference that can support financial sustainability and clarity of service models within the area.

Colin Beattie: From the audit point of view, do you consider that there is an adequate level of support?

Stephen Boyle: What we highlight in the report is that, whether they are on the escalation framework or the funding arrangements, the decisions that are being taken either by the Government or by the board do not seem to be making the difference that would provide a clear financial plan into the medium term and the longer term for NHS Ayrshire and Arran.

It will be important for the board and the Scottish Government to take a view as to whether they can produce a three-year plan—or a plan over five years, or however long it takes—and for there to be realism in that financial plan, so that it does not bring us back, six or 12 months from now, to a further debate at the margins of very large numbers—one large number relative to another large number—regarding the brokerage or deficit that is required. I do not think that that is healthy for the board, and I am sure that it is stressful and proving a real distraction from what it is there to do, which is to deliver health services for its population.

Leigh Johnston: Level 3 of the intervention framework brings significantly enhanced monitoring as well as tailored support, as we have

outlined, which tends to come from the Scottish Government. A senior Scottish Government official will go in and help the board, whereas at level 4 it tends to be external senior support, with an assurance board being put in place. Fiona Mitchell-Knight might be able to offer more detail about the specific tailored support for NHS Ayrshire and Arran.

Colin Beattie: While you are responding, you could maybe refer to what the actual support is. If the Scottish Government is giving support, what is it actually doing? Is it giving advice? Is it intervening? Is it making suggestions? It is a wee bit vague.

Leigh Johnston: Fiona Mitchell-Knight is probably in a better position to say what specific support NHS Ayrshire and Arran is getting.

Fiona Mitchell-Knight: One of the challenges that the previous chief executive had was that, between November 2023 and August 2024, there was a vacancy in the acute director role, which is clearly a key role in the board. To help with leadership capacity, working with the Scottish Government, the board secured external support from Viridian Associates. Viridian Associates has been working with the board to support the delivery of efficiency savings and other transformational work and to identify projects through which savings could be made.

Colin Beattie: It does not seem to have been too successful over the past few years. Has it actually made a difference?

Fiona Mitchell-Knight: It was appointed in August 2024.

Colin Beattie: It has still been in place for more than a year, and you would expect to see something coming down the line. What is the assessment of its effectiveness?

Stephen Boyle: That is an important question for the board, Mr Beattie. I guess that it goes back to the point that I made in my opening statement and that I touched on a minute or two ago. Level 3 support has been provided to the board for seven years, but, whether it is support from Scottish Government officials or from appointed consultants to look at the cost base, it does not seem to be achieving the traction that would give NHS Ayrshire and Arran a route to balance. I should also point out that such decisions will not necessarily be ones that NHS Ayrshire and Arran itself can take. As we touched on in the report that we produced earlier this year on governance in the NHS, some of the decision making will rest with the board but some decisions will be about how services are provided regionally or nationally, and those will have a direct bearing on its cost base. For completeness, I note that the committee has received correspondence from the chief executive of the NHS in Scotland about some of the thinking that the NHS is doing about national planning arrangements, which I am sure will be relevant to some of the thinking that NHS Ayrshire and Arran will be doing about its cost base.

I apologise, Mr Beattie—I do not wish to labour the point, but seven years is a long time to receive financial support, and I am sure that both the board and the Government will want to reflect on whether that support has achieved its objectives.

Colin Beattie: What you are talking about moves us on to the next question that I wanted to ask. In your report, you said that the board is still to prepare sufficiently detailed plans to show that it will achieve financial sustainability. My question was going to be about the lack of progress on those plans and whether anything jumped out at you.

Stephen Boyle: I will bring in Fiona Mitchell-Knight.

We touched on aspects of that in paragraphs 15 and 16 of the section 22 report, and in more detail in the annual audit report. At a high level, we are saying that the board does not yet have a clear enough plan to support financial sustainability. It will not necessarily reach the £33 million deficit target. Fiona Mitchell-Knight has touched on some of the risks in moving to its planned deficit, never mind the Scottish Government's target.

Nevertheless, the board is looking at savings. As we referred to in the section 22 report, there is discussion around service redesign for surgery, emergency services and clinical support services—and around the workforce, too. I am quite sure that the board is considering some difficult decisions in order to support service redesign; the issue is whether it has the detail to translate an overall plan into specific actions in order to take the important next step.

I will bring in Fiona Mitchell-Knight to say more on that point.

Colin Beattie: When Fiona comes in, perhaps it will be possible for her to comment on this. After seven years at level 3, getting all the support during that period, and presumably after exploring every conceivable possibility of achieving savings—non-recurring savings, in particular, must have been explored by now—what is left for the board to do? Where does it go? We are also talking about its making recurring savings of 3 per cent. How feasible is that? Is it realistic, or is it just pie in the sky?

Fiona Mitchell-Knight: It is not expected that the board will be able to deliver a balanced financial position over the short term. The Scottish Government has laid out an aim for a five-year plan for the board to return to financial balance.

However, as yet, we have not seen any detailed costings around the proposed savings that show how that will work over the five years.

As the Auditor General said, the board has plans in place for some efficiencies and some service reform. Indeed, it did deliver substantial savings in 2024-25, as it has done over a number of years, but it is just not enough. That is really where we are on that—I think that is all there is to say. There are no credible plans at the moment.

Colin Beattie: I guess that brings me back to what we have talked about before. We have talked about the board working to a £33 million deficit, and we have talked about what the Auditor General describes as an arbitrary figure of £25 million—simply because we do not know the basis on which it was reached. The board is supposed to be moving towards that target as well. Now, we have another Government plan over five years—is that what you said?

Fiona Mitchell-Knight: That is the target, yes.

Colin Beattie: That is layered on top. It all seems a bit confusing.

Stephen Boyle: That is a fair assessment.

It is a difficult environment for NHS boards to deliver services in. There is growing demand for services from the public, and boards are trying to meet that demand in the context of service redesign requirements. In some cases, with tailored support from the Scottish Government, boards are also supporting the financial position of integration joint boards, which is a relevant factor in their financial position. There is then a lack of agreement about the financial target that is to be achieved.

All of that makes for a very difficult environment for NHS leaders and for the Scottish Government to work in. We absolutely support the principle of medium-term financial planning, and for me, Mr Beattie, this is one of the clearest examples of why it matters. If there is a continual debate about the in-year financial position, it will not help to address the challenges that they are facing at the moment. There has to be a path that allows them to move, over the next three to five years, to a sustainable position for the finances of NHS Ayrshire and Arran.

Colin Beattie: Thank you.

The Convener: I will now invite Graham Simpson to put some questions to you.

Graham Simpson (Central Scotland) (Reform): Listening to the questions and answers so far, I was reflecting that we have had NHS Scotland at the committee before and my recollection was that it told us that there was to be no more brokerage. I hoped that my memory was not playing tricks on me, so I looked it up. The response to a freedom of information request on brokerage was published in September. Eight health boards needed brokerage in 2023-24. The response confirms that

> "Alan Gray, Director of Health and Social Care Finance, wrote to Chief Executives of NHS Scotland on 04 December 2024 to provide the details of the indicative funding settlement for NHS Boards in the Scottish Government Budget 2025-26. The letter confirmed that brokerage would not be available for 2025-26 and that NHS Boards would be expected to work towards a breakeven trajectory in their three year financial plans"—

not five-year plans, as we have heard mentioned here, so I do not quite know how that figure has come about.

The Scottish Government's stance appears to be "no more brokerage". As you have said, no board has repaid any brokerage money, therefore there seems to be very little incentive to even save money—the boards have got used to having brokerage. NHS Ayrshire and Arran, as you have said, has had seven years' worth of brokerage. Where is the incentive? It is all very well the Government saying that there will be no more brokerage, but if boards cannot meet their savings targets, there will be some more, will there not?

Stephen Boyle: I guess that your question illustrates that clarity is important and the need for transparency from the Scottish Government. Whether you call it brokerage or year-end funding, and whether it is repayable or not, I do not think that the Parliament has sufficient clarity.

There were circumstances, as I discussed with the convener, where brokerage was accumulated towards the end of the last decade and then written off, and we have seen that that has restarted.

There is not sufficient clarity about whether amounts have to be repaid, as you referred to. Only one health board has ever taken steps to repay brokerage. We have the letter from the former director of finance with a clear message to boards that there will be no brokerage. NHS Ayrshire and Arran has been asked by the Scottish Government to operate to at least a £25 million deficit budget, and that deficit budget will have to be supported financially by the Scottish Government.

It is a matter of transparency, clarity and some realism. Whether it is three years or five years is a matter for the Scottish Government to determine, but a path to financial sustainability for territorial health boards is a key next step.

10:15

Graham Simpson: There is just this line from the Government, which we have heard and it has

been confirmed in writing, that there is to be no more brokerage. The reality is that health boards will be running deficits. The health board that we are talking about now will be running a deficit. That is the reality, is it not?

Stephen Boyle: That is borne out by its financial plans. There is a planned deficit, as Fiona Mitchell-Knight mentioned, of £33 million for the current 2025-26 financial year. That is not unique to NHS Ayrshire and Arran. Other health boards in different parts of Scotland will also be running deficits.

Graham Simpson: Who would fill that gap?

Stephen Boyle: The straight answer is that the board will either fill it itself or it will receive brokerage or deficit support in one guise or another from the Scottish Government to support its financial position. If it is the former, that is really difficult because, as the committee is well versed in, the majority of NHS costs are staff costs. Service provision is a key factor that boards will have to consider.

To return to the point that Mr Beattie raised, which I think is related, savings are not a new feature of NHS financial planning. Many of the more straightforward savings will have been made many years ago. It will be a matter of considering, at both local and national level, what the financial position across the piece will look like, how productivity will play into it, the use of technology and making decisions about staffing, the estate and service provision. Those will all be factors. It is important to recognise that there is an acknowledgement in the chief executive's letter of the need for wider consideration of planning of service provision. Of course, that needs to dovetail with the financial position of individual health boards.

Graham Simpson: Okay. Paragraph 15 on page 7 of the report—which we have mentioned already—states:

"NHS Ayrshire and Arran's savings plans for 2025/26 are overly optimistic and are unlikely to be achieved."

Could somebody explain what is overly optimistic about them specifically?

Stephen Boyle: Fiona Mitchell-Knight might want to take that question because there is quite a lot of detail in the annual audit report about the board's own assessment of how realistic some of the savings are. As I mentioned earlier, it has identified 33 per cent of the savings schemes as high risk. If a third of the savings put forward are at risk, that perhaps illustrates the starting point and the scale of some of the proposals put forward. I will bring in Fiona Mitchell-Knight to share some of that judgment.

Fiona Mitchell-Knight: As the Auditor General said, the board in even setting out that financial plan for the year already assessed 33 per cent of the savings schemes as high risk, 50 per cent as medium risk and 17 per cent as low risk. So, there was high risk already built into those.

On the specifics of some of the larger savings schemes, based on our experience we feel that the board is overly optimistic on how much it will achieve in this time period. Indeed, based on the financial monitoring reports to date, it seems that it will be challenging for the board to achieve the £33 million deficit that reflects that level of savings.

Graham Simpson: Do you have any examples of high-risk savings?

Fiona Mitchell-Knight: One example would be the bed reduction plan, which was originally in place but has been replaced with workstreams. It is about the lack of specific detail about how those will be delivered in the current year to deliver the level of savings that is included in the financial plans.

Graham Simpson: So, the board has basically said, "We will cut the number of beds", but it has not said how or where.

Fiona Mitchell-Knight: Certainly, many of the savings programmes are not adequately costed with the timescales laid out on what will be achieved when.

Graham Simpson: Okay. Your report says there is a need for "more radical reform". What did you have in mind when you used that phrase?

Fiona Mitchell-Knight: That is something for the board to determine with Scottish Government support. Clearly, the position as it is is not sustainable. I have mentioned the particular challenges on the acute side of the service: the length of stays in hospital, the increase in delayed discharges and the number of beds that the board had planned to close over a long period but has been unable to.

Graham Simpson: I want to ask about staffing and workforce. Paragraph 20 of the report states:

"The board also continues to face workforce challenges. The rate of sickness absence in 2024/25 was 5.6 per cent ..., well above the ... national standard, and reliance on temporary staff continues to come at a high cost to the board. This will have a significant impact on the board's plans to achieve the savings needed for longer-term financial sustainability."

That is something that we have discussed before at this committee. It continues:

"nursing pay was overspent by £13.5 million, £7.9 million of which was on agency nursing in acute services"

and

"medical pay was overspent by £7.7 million, £5.8 million of which was on agency doctors."

Do you know whether the board has done any work to identify the underlying reasons for staff sickness levels? Is there any way that it can cut the reliance on agency and locum staff?

Fiona Mitchell-Knight: I do not have specific details on the work done on sickness absence, but in my annual audit report I refer to a number of actions being taken by the board to reduce reliance on bank and agency staff. There have been reviews of nursing to see how the board can reduce agency staffing. There is an on-going review of the acute workforce. There has been a review of how rostering of staff has taken place. I would say that the use of bank and agency and locum staff does provide the board with the flexibility to staff the extra beds that it has open, which it really needs to close to reduce its cost base. There is no evidence yet of that being successful.

Graham Simpson: It gives the board flexibility but it also costs it a lot of money. It is surely better to reduce the use of agency staff, is it not?

Fiona Mitchell-Knight: That would certainly reduce its cost base, yes.

Graham Simpson: Have you seen any plan to do that?

Fiona Mitchell-Knight: It is tied into the number of beds that the board is filling. Effectively, it plans to close a number of beds and therefore would need less staff to be able to staff those beds. However, as yet, it has not made progress on that.

Stephen Boyle: You are right that sickness absence is a flow through to sustaining services and therefore the use of bank and agency workforce. I do not think that we have the detail as to whether there are any wellbeing initiatives, for example, or any underlying causes within the board that are resulting in its sickness absence being above the national target. If we have any more detail on that, we will come back to the committee, but it may be that the board itself can give that insight to the committee.

Graham Simpson: Okay. This is the final question from me on this. How does NHS Ayrshire and Arran compare with other health boards in terms of its use of agency staff?

Stephen Boyle: We might need to collate that information from our records. We have certainly covered it a number of times in overview reporting. Leigh Johnston might have detail on it. It is probably something that we can check, and we will share with the committee any up-to-date information or signpost you to it.

Leigh Johnston: All I would add to that is that there has been a real focus across NHS Scotland on reducing agency staff. We will bring more detail on that in our report in a couple of weeks. I do not know about individual boards, but nationally NHS Scotland has really driven down its use of agency staff. There has been some very focused work, particularly from the Scottish Government and the financial delivery unit, to try to drive that down.

The Convener: I will now turn to Joe FitzPatrick, who has some questions to put to you.

Joe FitzPatrick (Dundee City West) (SNP): I want to ask some questions about leadership and governance, but first I will pick up from Colin Beattie's question about the acute director role. He was focusing on what has happened since that position was filled in August 2024, but we have a remaining question. That critical position in the leadership team was empty for nearly a year between November 2023 and August 2024, when it was finally filled. Why was such a critical role left for so long? Do you have an understanding of why that was?

Fiona Mitchell-Knight: I am not sure why that was the case. You would need to ask the board about that.

Joe FitzPatrick: Okay. It seems to me that, if everything was going wrong and the leadership team was not fully resourced, that would only add to the challenges.

The other challenge for the leadership team is that the chief executive announced her retirement in August 2025 and, as you have said, Stephen Boyle, an interim chief executive is in place. Can you give us an indication of the timescale for appointing a new chief executive? What are the immediate priorities for the interim in that stopgap period?

Stephen Boyle: Fiona Mitchell-Knight might want to talk about the timescale for that, but it is key. The interim chief executive comes from an NHS background, from the Golden Jubilee hospital, to support NHS Ayrshire and Arran to address its financial position, and to come up with a credible plan for effective governance arrangements and the relationship between clinicians, the board and NHS Scotland. He has to move it from the tricky position that it is in and—I am at risk of repeating myself—not just come up with something for this 12-month cycle but move it to a sustainable model of health service provision in Ayrshire and Arran. Fiona will say a bit more about that.

Fiona Mitchell-Knight: I do not know the timescale for the appointment of a permanent chief executive but, clearly, the prompt appointment of the interim chief executive was a very positive step. He has come in with a very

clear focus about what he wants to do. Many of those things will take longer than the current financial year and will not be seen in this year's financial outturn. However, it is a positive step that that individual is in place.

Joe FitzPatrick: Is the board looking at this for the longer term, trying to get things back on a more sustainable footing in order to pass it on to the next chief executive?

Fiona Mitchell-Knight: The board is working with the Scottish Government towards this five-year path to financial recovery.

Joe FitzPatrick: Which gives the transparency.

My other question is about the wider board and the chair. This has been going on for a long time. I can remember that, when I was a junior health minister, this was one of the boards that we talked about often, and we are still in the same position. Do the wider board and the chair have the skills that they require to challenge leadership? It is difficult if the leadership team is not full, but do they have the skills, or is there something more that the Government needs to do to make sure that they are providing the challenge that Government ministers have to rely on them for?

Stephen Boyle: They do. It is multifaceted. There are a couple of things that I will start with and then I will bring Fiona Mitchell-Knight in. As I mentioned earlier in the meeting, I ask auditors to make judgments about the effectiveness of governance in public bodies as part of the wider-scope approach to public audit in Scotland. Fiona has captured those judgments in her annual audit report. What is important is that we are not saying that there is a governance deficit in the organisation in the way that there is a financial deficit. It is important, though, to highlight for the board to consider that, as is referenced in the annual audit report, it has not always received information in a clear and transparent way to support its understanding and the decisions that are being asked of it. I think that Fiona said that "misleading information" was provided to the board.

We also reference, if it is helpful, "NHS in Scotland: Spotlight on governance". It presents a picture of a complicated governance process in the NHS in Scotland with boards. You will be familiar with boards and with NHS Ayrshire and Arran, but it is not always the case that the problems that are experienced financially reside only in the board and its decisions. Many of the decisions, which are potentially very difficult and unpalatable, will be known, but it is not necessarily the case that the responsibility and the levers for them exist solely within the board.

We would characterise the complexity by saying that it is not always clear that you can point to the board and say that it ought to have done better and there ought to have been better non-executive leadership. I think that it is broader than that.

10:30

Fiona Mitchell-Knight: It is over the past two years that the financial position has deteriorated greatly, and in 2023-24 we began to be concerned that the board probably did not appreciate the severity of the situation. At that point, in my annual audit report, I drew attention to the fact that, in my opinion, the board had been "slow to transform services" and that future plans were needed to demonstrate how services would be delivered within the funding that would be available in the future. In my recommendations, I specifically tasked the chief executive, directors and board members with ensuring that those plans were in place. I specifically said at that point:

> "Effective leadership is required to drive the changes needed and progress should be challenged by the Board."

I also made the comment that the board should not be "passive" in that.

As a result of that, I saw board members in the audit committee being more challenging in their scrutiny of the board's financial position but, as I say, even though proposals were being put forward on change and savings programmes, they were not being costed and they were not sufficiently detailed for the boards to be able to scrutinise them and demonstrate that there was a sustainable position going forward. That remains the case now.

Joe FitzPatrick: There is an opportunity here for the board to grasp what you have been saying about increased transparency and drive that home, so that it can get the change and the information that it needs to do the job that it is expected to do. I guess that that is what audit should be about.

The Convener: Thank you. We now have a final couple of questions from the deputy convener, Jamie Greene.

Jamie Greene (West Scotland) (LD): Good morning and thank you for your evidence so far. I have been listening to the session and I read your report with great interest, particularly as a member who has covered the region of Ayrshire and Arran for some nine years now. These issues are not new to anybody who lives in the constituencies that I represent.

I am extremely concerned by the outcomes of your report on a whole range of levels. The most important one that I am worried about is not necessarily the financially precarious position of the board but what it means for patients and people. Ultimately, the health board is not a

business. I know that we are using audit language here and talking about operating losses, but we are also talking about health outcomes. What effect does operating at such a loss have operationally on the board's ability to deliver quality healthcare to the people of Ayrshire and Arran?

Stephen Boyle: I am very happy to start. We touched to an extent on what the correlation is between the deficit that the board is operating with and its service performance. As we captured in the appendix to the section 22 report, there is a fairly crude traffic-light system and there are some green indicators across some service provision and some reds. That will be borne out in health boards across the country. The deficit that you refer to, deputy convener, is not necessarily directly impinging on service provision, because that deficit is being funded; the board is being supported by the Scottish Government through brokerage and other means to operate at an expenditure level higher than the Scottish Government thinks it should be. NHS boards in Scotland are funded by the Scottish Government almost exclusively and that is done on the basis of the national resource allocation formula—NRAC—funding methodologies. There is a process by which the Scottish Government determines what different health boards across the country need to deliver health services and those amounts are uplifted through funding and budget decisions that the Parliament makes.

It is not like in a business context, where a £25 million deficit would impinge on a body's financial position or status as a going concern. Fiona Mitchell-Knight will have considered going concern issues carefully, but in a public sector context it is very different, because there is certainty of financial provision; if anything, it is perhaps the opposite. If the health board were operating as a commercial entity and it had to meet a break-even position each year, that would be money that would not be being used in the way it is in NHS Ayrshire and Arran.

Jamie Greene: Surely it costs what it costs. I am confused by the language around saying that it is spending more than it should. If people are unwell, they are unwell and they need to be treated. I do not understand this countrywide approach that we are taking to the NHS—the suggestion is almost that it is living beyond its means. That seems outrageous.

Stephen Boyle: I think that that is the assertion that the Scottish Government is making—that it is living beyond its means. The Scottish Government has said that this is the funding that the individual territorial national boards receive and that NHS Ayrshire and Arran is not delivering its services in a way that is affordable and sustainable.

Jamie Greene: What is it doing wrong? Where are the gaps here? What is it spending money on that it should not? I cannot work it out.

Stephen Boyle: Fiona Mitchell-Knight can come in with that detail, but we have talked a little bit about bed and ward provision as part of the model. For me, it is a question for the Scottish Government more than the audit team. The Government has said that this is what NHS Ayrshire and Arran thinks necessary to deliver health services. Mr Simpson referenced the letter from the former director of finance that said, "This is your funding allocation. There will be no brokerage," so I think that it is a reasonable assumption to make that the Government has considered what it thinks is necessary.

As the committee knows, you could always increase public spending. To help people deliver in any way they want, you could almost have an unlimited amount of public spending, but the Scottish Government has told NHS Ayrshire and Arran, "This is your financial pot to deliver your services," and it is going beyond that. Certainly, Fiona Mitchell-Knight will have details to share with the committee. I think that that context is where the Government's view is.

Jamie Greene: I am trying to get my head around who is to blame here. NHS Ayrshire and Arran has been on level 3 for eight years, so there is financial intervention every single year. The idea that that is a loan is nonsense; I would put money on the fact that it is never going to pay this stuff back. The model is broken, in my view. Something is clearly going wrong, but I cannot quite work out who is to blame. Is it governance issues? Is it the board? Is it the management team? Is it the Government? Is it ministers? Is it all of the above?

Stephen Boyle: It illustrates the fact that, clearly, the Scottish Government has taken a view for seven years that NHS Ayrshire and Arran needed a combination of support and intervention. It is safe to say that it starts at support and then trips into intervention the higher you go up the five-point scale. Support on its financial position and financial plans is part of it. We have touched on governance as being a factor, with the board not receiving the right information or being too passive, but to an extent it is also questionable. You could go round this loop again about who is to blame, but it will not necessarily deliver the sustainable model for the people of Ayrshire and Arran. It must be a suboptimal use of management and governance time to be focused on delivery of an in-year financial position, rather than medium-term planning about how to deliver the wider health outcomes that are spoken about so regularly and the ambitions in the service renewal framework from the summer to move to a preventative model and keep people healthier for

longer. It is hard to reconcile that ambition when you have the financial loop that seems to be played out repeatedly in NHS Ayrshire and Arran. Again I will pass to Fiona Mitchell-Knight.

Fiona Mitchell-Knight: It is worth reflecting on the fact that we are not always talking about cost cutting and efficiencies in our annual audit report. We reflect on the fact that the board has been slow to reform services—the reform of services that the board itself has set out to achieve and then has not delivered on. It is not us saying that it needs to do these things; the board itself recognises it could do things differently. Of course, some of the cost savings and service changes could impact on patient delivery, but some could just be about doing things differently and more efficiently.

Jamie Greene: I am sure that is true across the NHS—thank you for that.

The other issue that concerns me greatly is staffing. I deal with a lot of casework from that part of the world, particularly related to Ayr hospital and Crosshouse hospital. My understanding is that Unison, which represents many of the staff there, has surveyed the staff and that the outcomes are worrying. The last statistic I read in the *Ardrossan & Saltcoats Herald* was that 32 per cent of NHS Ayrshire and Arran staff felt that they are so short staffed that patients' lives are at risk. That is nearly one third of the workforce.

Those staff are working in an environment where they are struggling. The board is spending huge amounts of money on agency staff to fill in gaps at both a consultant level and a nursing level. That is costing huge amounts of cash, while the staff themselves are frustrated because they cannot deliver the quality of service to their patients that they think they need to—and ultimately that is putting lives at risk. We are not just talking about numbers; we are talking about people's lives. What evidence is there that the board is taking the issue seriously or doing anything about it?

Stephen Boyle: Again, it is a question for the board, rather than us, to respond to the Unison survey. As we do not have the detail to hand, that is perhaps the safest route to follow.

I absolutely recognise your point that we are talking not about abstract numbers but, very clearly, about a vital public service. The point of our report is to capture that continuing around a loop of unsustainability and in-year savings does not provide the platform from which to plan services and to deliver a sustainable, affordable model that best meets the needs of patients of today and those in the years to come. We are talking about NHS Ayrshire and Arran, but it could be other parts of Scotland, too.

The specific question is for the management. Clearly, because of the nature of how health services are delivered, staffing is central to the model, and the board must be clear about and sensitive to the requirements that its staff are telling it about.

Jamie Greene: Can we cut to the chase? Are we just dancing around the issue that the current model is not working? The unsustainability that you highlight in your audit is a long-term issue; it is not a one-off. It has been happening for nearly a decade, and it is probably going to continue in the same direction, if not get worse.

The idea is that the Government is somehow helping out by stepping in and plugging financial holes, painting the picture of it saving the board. Do you think that the Government needs to have a fundamental look at the entire model to rephrase it, reframe it and be a bit more honest with the public and the health board about how it is funded and what it expects of the board?

Stephen Boyle: This is not new territory for me. I have said for many years that the sustainability of health and social care in Scotland is in doubt and that we need a more detailed reform process to move from the models that we have now to support better outcomes for people and provide clarity around financial challenges. I have said that in many overview reports and section 22 reports, and we will say more—as Leigh Johnston and I have mentioned—in the overview report that we are publishing in the next couple of weeks about building on the ambitions that were set out in the summer.

Much of the sustainability points were recognised in the Government's ambitions through the service renewal framework and public service reform strategies to move from the models that we have today to a more sustainable future. As ever with strategies, the more mundane parts are just as important in translating the strategy into clear milestones and deliverable plans. That applies just as much to NHS Ayrshire and Arran as it does to the service across the country.

10:45

Jamie Greene: I have one final question. The idea of brokerage is political lingo, but is there a reason why the Government frames it in that way? Essentially, it is saying to boards that, if they are spending more than they have, the Government will make up the difference in the form of a loan. Are there financial or audit reasons why it would do that? Is someone sitting in a civil service room saying, "Minister, do not just give them cash—give them loans", because it has a financial benefit or some knock-on effect down the line or in the way that the Government reports its accounting?

If we multiply the approach across all boards, it is a substantial sum of cash. Why would ministers not simply say, "Look, if you need £30 million to meet your health objectives, we will give you that", rather than continue a pretence that the money is a loan? It is never going to be paid back.

Stephen Boyle: I would not want to second-guess ministers' intentions, but I do not think that there is any audit rationale for it. I think that it is more one of incentives for health boards, rather than providing a year-end funding allocation or bailout. My assumption is that the Government considers the funding allocation appropriate to deliver health services in different parts of Scotland. To vary the approach and not call the money repayable probably debases the funding formula model that has been in use.

I think that that response creates an issue of equity across the country if some parts of Scotland are delivering services within their funding allocation—and no doubt making really hard decisions to do so—but other parts are not. I can see why brokerage, or continuing to say the funding is conditional and not just a grant—

Jamie Greene: It is not really a loan; there is no expectation that it will be paid back.

Stephen Boyle: Yes—that is very much our point as well. There needs to be clarity and transparency, because to continue going through the loop of considering whether or not there is brokerage or whether or not it is repayable is not providing transparency to Parliament in its consideration of how services are performing and how funding is allocated.

Jamie Greene: I have just spotted some figures in your traffic-light system. The 12-week outpatient target is 95 per cent. The Scottish average is 61 per cent, which is shocking anyway, but in March 2024 it was around 61 per cent in NHS Ayrshire and Arran. Over the summer—in July and August—that number dropped to 35 per cent. That basically means that one in three patients were seen within the target. I have a genuine concern that people are dying while waiting for treatment. Is this costing lives?

Stephen Boyle: We have not done any audit work on that in the current year. I think that it is a question better directed either at the board or the health regulatory bodies, rather than us as auditors. Are they looking or concerned at that number? What we will do is to consider the statistics of performance and, as you will know, audit can be a retrospective activity at times. I do not have the insight for the numbers that you are referring to, and it may be for the board or regulators to comment on.

Jamie Greene: We will ask them. Thank you.

The Convener: Thank you very much indeed.

We have another evidence session up and coming on NHS Grampian, which was also the subject of a section 22 report. Before we turn to that, I will take this opportunity to thank Fiona Mitchell-Knight, the Auditor General and Leigh Johnston for the evidence that you have given us on the position of NHS Ayrshire and Arran.

I suppose that, for context, we need to understand the point that you made towards the end, which is that not all the 14 territorial health boards have required brokerage. The question for us as the Public Audit Committee is why some boards have required it and others have not. Maybe there are fundamental issues about the funding formula—who knows? I think that there are some wider points that we need to get a better understanding of.

Thank you very much indeed for what has been a very useful session for us. I will now suspend the meeting while we change witnesses.

10:49

Meeting suspended.

10:53

On resuming—

"The 2024/25 audit of NHS Grampian"

The Convener: Welcome back. We will now turn to agenda item 3, which is consideration of the 2024-25 audit of NHS Grampian, which has warranted the production of a section 22 report. I am pleased to welcome back the Auditor General, Stephen Boyle. I also welcome back Leigh Johnston, who is a senior manager at Audit Scotland. We are joined for this session by Alison Cumming, who is executive director, performance audit and best value, at Audit Scotland.

Before we ask our questions, I invite the Auditor General to make an opening statement.

Stephen Boyle: As you mentioned, convener, I have prepared a report on the 2024-25 audit of NHS Grampian under section 22 of the Public Finance and Accountability (Scotland) Act 2000. For the second successive year, NHS Grampian required brokerage to help it achieve financial balance. It received £65.2 million from the Scottish Government in 2024-25 in addition to £24.8 million that it received in the previous year, for a total of £90 million. The level of brokerage that it received in 2024-25 was the highest of any health board in Scotland.

NHS Grampian successfully delivered savings above its targets during 2024-25 but that, in itself, did not enable the board to reduce the in-year overspend. This was mainly as a result of significant overspends across the local integration joint boards. NHS Grampian provided £22.4 million of additional funding to IJBs at the year end in line with what is known as its agreed risk-share arrangements.

NHS Grampian's medium-term financial plan reveals that the board's cost base is also unsustainable based on its current funding levels. It projected a £68 million overspend for 2025-26, which resulted in its initial budget not being approved by the Scottish Government. The Scottish Government set an overspend limit for the current financial year at a lower figure of £45 million, resulting in NHS Grampian having to identify a further £23-million worth of savings. The Scottish Government's expectation is that NHS Grampian will develop a recovery plan to reduce expenditure and operate within that set limit.

In May 2025, NHS Grampian was escalated to stage 4 of the NHS Scotland support and intervention framework for reasons of financial sustainability, leadership and governance. Alongside the issues around financial management, the board was escalated due to rising concerns about local services and performance against national priorities and standards, including some quality concerns raised by regulators.

NHS Grampian has experienced significant operational pressures, including the fact that it had to declare a critical incident for three days in November last year, leading to the board formally registering what it referred to as "intolerable strategic risks".

In June 2025, the Scottish Government commissioned KPMG to undertake a diagnostic review of the financial position of the board. An improvement plan is being developed, which will incorporate the board's response to these recommendations and include measures around performance improvement, financial sustainability and transformation for a sustainable, affordable future. The appointed external auditor of NHS Grampian notes that it will not be possible for the board to return to financial balance without either significant redesign of services or a fundamental change to its funding model from the Scottish Government.

Leigh Johnston, Alison Cumming and I look forward to answering the committee's questions.

The Convener: Thank you. To get us under way, I invite Graham Simpson to lead off.

Graham Simpson: Auditor General, at the end of the earlier evidence session you rightly said that not all boards need extra money from the Government. For 2023-24, there were eight boards that needed that money: NHS Ayrshire and Arran; NHS Borders; NHS Dumfries and Galloway; NHS Fife; NHS Grampian; NHS Highland; NHS Orkney; and NHS Tayside. Do you know whether that is the position for 2024-25?

Stephen Boyle: I will bring Leigh Johnston in to answer that. As I said, we will set out that detail together with some of the analysis and commentary on it in our NHS overview report, but Leigh Johnston has the numbers to hand so we can share that with the committee.

Leigh Johnston: In 2024-25, seven boards required brokerage. The only one of the boards that you listed that did not require brokerage was NHS Tayside.

Graham Simpson: I know that we are not here to talk about NHS Tayside but do you know why it did not? What happened?

Leigh Johnston: NHS Tayside would have met its financial targets. That health board will be considered at this committee in a couple of weeks, so the Auditor General will be able to give you some more insight into that at that time.

Stephen Boyle: Just for completeness, Leigh Johnston is referring to “The 2024/25 audit of NHS Tayside”, a section 22 report that I published last week. We can set that out in more detail for the committee in the coming weeks, but the report is primarily about its provision of mental health services rather than its financial position.

Graham Simpson: Okay. The report into NHS Grampian’s overspend says that it has the largest overspend by value of any health board in Scotland and the fifth highest in percentage terms. Do you have figures for the overspends of other boards that could give us an indication of the extent to which NHS Grampian has the highest overspend?

11:00

Leigh Johnston: I have figures for the levels of brokerage that different boards received. In 2024-25, NHS Grampian received £65.2 million, as we have just discussed; NHS Ayrshire and Arran received £51.4 million; NHS Highland received £49.7 million; NHS Dumfries and Galloway received £26.2 million; NHS Borders received £13.3 million; NHS Fife received £21.5 million; and NHS Orkney received £3.9 million.

Graham Simpson: Okay. Thank you for that. NHS Grampian recorded the largest overspend by value of any health board in Scotland. Do you have comparative figures for the next highest overspends? I am asking about the largest overspend by value.

Leigh Johnston: By value, the next largest overspend would be NHS Ayrshire and Arran.

Graham Simpson: The report also says that

“One of the key areas of financial pressure was staff costs.”

We discussed that earlier in relation to NHS Ayrshire and Arran. Do you know the extent to which NHS Grampian relies on agency staff?

Leigh Johnston: I do not have that detail with me.

Alison Cumming (Audit Scotland): We know that agency staffing has been an area of focus for NHS Grampian in its savings plans over the past few years. It has been reducing its reliance on agency staffing and that has contributed to some of the savings that have been recorded for 2024-25 and are projected for 2025-26.

Stephen Boyle: I will just come in on staffing in the round. Staffing was a key feature of the KPMG review of NHS Grampian’s service model. For example, the review highlights that NHS Grampian’s workforce grew by nearly 14 per cent from 2019-20, predominantly in relation to nursing, medical and dental staff. In contrast with that, the activity metrics declined in the same period. As I mentioned in my opening remarks, it is for NHS Grampian to assess and analyse that. We are referring to productivity, which is a complex topic, and to why increased staffing is not then translating into increased activity, so there is a key need for the board to do that analysis to be satisfied as to why that is the case. The improvement plan and the consideration of the recommendations will be a fundamental next step for the board.

Graham Simpson: Do we know how it has managed to reduce the amount of money that it spends on agency staff?

Stephen Boyle: We may be able to come back to you on that if we have more on the issue in our records. We can certainly share more detail across the piece. In the earlier evidence session, I think that we mentioned the concerted efforts that have been made across the country to reduce agency costs, particularly in nursing services. Leigh Johnston may want to say a bit more about that.

Again, convener, we will give more detail on the issue in the round when we come back to the committee with the overview report, but if we have more insight, we can offer that to the committee.

Leigh Johnston: As I said, there has been a real drive from the Scottish Government. During the pandemic in particular, there was a massive increase in the use of agency staff. As we have come out of the pandemic, there has been a real focus, particularly in the financial delivery unit, the Scottish Government’s finance department and the health and social care finance department, and a real drive to have a grip on and control of the use of agency staff. There have been attempts to find other ways to reduce the use of agency staff, such as using more bank staff instead, which generally enables better continuity of care but is also more efficient when it comes to the cost of additional staff.

Graham Simpson: This is my final question. Looking ahead, given the situation that NHS Grampian appears to be in, how realistic is it that it will ever break even? In paragraph 21 of your report, you say that the board is predicting an increase in costs of £370 million over the next five years. That seems to be a massive challenge. The board must cut costs, but costs are going to rise by £370 million.

Stephen Boyle: It is essential that a realistic plan is prepared that is not driven by a budgetary cap from one year to the next but reflects available resources and service provision models. I do not wish to avoid addressing your question, but it is a question for the board. Do the board and the Scottish Government have confidence that they can produce a realistic, affordable model for

services? I support the auditor's finding that that will be delivered through either a reform of the funding base or a reform of services—or both.

Graham Simpson: I agree. These are not really questions for you; they are questions for the Government and the board. I shall leave it there.

The Convener: I have a question before we leave this area. Auditor General, you have mentioned the KPMG report a couple of times. One of the key messages that the auditor attached to the report is that staffing levels are out of kilter with the number of beds in NHS Grampian. The report goes on to cite different grades. It says, for example, that there has been a 16.4 per cent increase of nursing whole-time-equivalent staff in the past three years, a 17.8 per cent increase of medical and dental WTEs, an 18.2 per cent increase among the administrative staff, and an increase of over 33 per cent when we get to other therapeutic staff. KPMG's argument is that there are far too many people employed by NHS Grampian and that its cost base is out of line; it says that that is a deficit driver that it would not expect and so on. However, if the narrative is that these are positions that were previously outsourced to agencies at great expense and have now been brought in-house, that might be a good thing. Do you have a view on that?

Stephen Boyle: Alison Cumming may want to come in on this, but I am not sure if there is a direct correlation between services that were all staffed by agency workers and services that are now being provided in-house by the health board itself. I would not say that KPMG has made a judgment; I think that it is pointing out, as an area to be investigated further, that workforce numbers and costs have increased but that, as you mentioned, convener, the ability of the board to deliver services is somewhat constrained. That is not new from NHS Grampian, but it is relevant in relation to its bed capacity. Paragraph 26 of the section 22 report says:

> "NHS Grampian has the lowest bed base in Scotland, approximately 1.4 beds per 1,000 population. The next closest mainland board has approximately 2.0 beds per 1,000 population,"

Some of that will be about physical capacity within the NHS Grampian estate, but I think that it is worth the board exploring whether it is satisfied that its staffing models—whether based on agency staffing or directly employed positions—are appropriate to deliver services for its population.

Alison Cumming: It is exactly as the Auditor General has said. KPMG has found two things that it cannot reconcile between the reduction in beds and the increase in staffing. It points to reasons why nursing staffing levels in particular would have increased over time, including the introduction of safer staffing legislation, increased acuity in terms of how patients are presenting and changes to care models. We think, and the auditor thinks, that the board would benefit from some form of independent peer review to better understand how its staffing position, compared to activity levels and bed levels, compares to what happens in other boards and see what further action it may wish to take in response.

The Convener: I am not quite sure that that is what I took from the KPMG report. You have said, and it is in your section 22 report, that NHS Grampian has the lowest bed base per 1,000 population and so on, yet one of the things that is highlighted in the KPMG report is that there has been a further reduction in the number of beds available in NHS Grampian. It also goes on to talk about how artificial intelligence could be brought in to replace some of what it describes as lower grade staff. I am not quite sure whether we would sign up to that, but there are some ideas out there about how things can be streamlined, are there not?.

I guess that there are broader questions here about bed numbers, which is an issue that came up in our discussion about NHS Ayrshire and Arran. Is reducing the number of beds one of the Government's targets as a means of driving down the cost base in territorial health boards?

Stephen Boyle: I do not think that I have seen a direct target from Government to do that. It is a question that needs clarity about what the service model is and what the planning provision is. Again, building on the detail from the service renewal framework and both financial plans and service delivery plans, it is about having that precision about what the service from both acute and primary care is going to look like in the years to come.

On NHS Grampian specifically, I would not necessarily align myself with all the analysis that KPMG has done, but it is important that it is considered by the board, together with the Scottish Government.

Perhaps this is a contrast with the previous evidence session. NHS Ayrshire and Arran is at level 3, whereas NHS Grampian is at level 4. This is one of the models of difference. There is a comprehensive independent analysis of some of the drivers for NHS Grampian's cost and service provision model. I think that it is important that the board, together with the Government, takes a considered view of whether there are any levers that it can then use that can help it to move to that sustainable model that the auditor is recommending.

The Convener: Fine—thank you. I will now invite Colin Beattie to put some questions to you.

Colin Beattie: Auditor General, I would like to look at IJBs. Clearly, they are a very significant factor in the particular case of NHS Grampian, although that is probably true right across the board, given previous reports that we have had from you.

In paragraph 8 of the section 22 report, you talk about NHS Grampian successfully delivering £15.6 million of additional savings in 2024-25. However, over the same period, it provided extra funding of £22.4 million—a huge sum of money—to the IJBs in its area. Where does the responsibility lie for addressing overspends in IJBs, and what actions are being taken to manage that?

Stephen Boyle: I will bring in Alison Cumming, who will be looking at some of this in detail—and not just for NHS Grampian. The committee will know that, on my behalf, Audit Scotland has been doing some joint work with the Accounts Commission to look at IJBs' financial results. We will publish that work early in the new year.

Alison Cumming is well placed to address the specific points that you raise.

Alison Cumming: It is about the IJBs and their local authority and NHS board partners coming together to ensure that they are financially sustainable. NHS boards and local authorities also deliver services on behalf of IJBs, so they need to look at whether they are driving out all the opportunities for efficiencies and savings within the services that they are responsible for.

However, we see questions arising, and NHS Grampian is not alone in having had to provide additional in-year contributions to its IJBs, although the situation was particularly acute for NHS Grampian. The Accounts Commission has been encouraging a real focus on getting budget setting right for IJBs, so that there is certainty at the start of the year over what needs to be done to deliver balance.

11:15

There have been particular pressures and issues in IJBs in terms of demand for care services being greater than estimated. They are also dealing with the same issues that face other public services of pay inflation, national insurance employer contributions and so on; they also often have to deal with the budgetary implications around primary care prescribing.

What has probably changed in the past couple of years is that although IJBs often built up reserves in their first few years of operation, those reserves are increasingly being depleted. Across Scotland, we saw IJB reserves fall by 40 per cent in 2023-24, which is the last year for which we have completed analysis. In relation to the three IJBs of which NHS Grampian is a partner, Aberdeenshire IJB's reserves were depleted to zero in 2023-24, and Aberdeen city IJB and Moray IJB were holding reserves at the end of that financial year that were below 3 per cent of their annual net costs. For Moray IJB, the only reserves that were left were earmarked reserves, so there were no contingency reserves left to meet overspend. The Accounts Commission has been encouraging more proactive financial management and financial planning, because the reserves are no longer there for IJBs to rely on.

We know that NHS Grampian has responded by creating an increased risk provision for IJB pressures in 2025-26 of as much as £38 million. The most recent reporting to NHS Grampian's board indicates that the board considers that that will be sufficient provision to meet additional contributions within the current financial year.

Colin Beattie: It is probably worth noting at this point that local councils also report making considerable contributions to IJBs, which frequently impact heavily on their budgets. That said, there is a reference in your report to agreed risk-share arrangements. How do those apportion the amount of money that gets paid in by the different component parties, which are, basically, the councils and the NHS?

Alison Cumming: It is a matter for each IJB to agree how overspends are dealt with. Some will have a formula, and my understanding is that there is an agreed risk-share arrangement for the NHS Grampian IJBs. It may be that the partner that delivers the services that incur the overspend then bears the consequence of that overspend, whereas the risk-share arrangements pool the risk more between the council and the health board.

Colin Beattie: Given that there are different component parties in IJBs, where is the most stress coming from in IJBs that result in these demands?

Alison Cumming: It really is around increasing demand for care services resulting from the pressures of an ageing population. The Auditor General referred to that as being a particular issue for NHS Grampian, where a particularly ageing population is forecast. It has already seen an increased proportion of over-65s, which will soon become an increased proportion of over-75s at a time when the overall population is not increasing. The relative pressures on the care system are increasing in the NHS Grampian area, and there will be particular issues there around acute bed capacity and a particular need to ensure that patients are receiving the care that they need in the most appropriate setting.

Colin Beattie: Is there not a circular issue here for the NHS? If you do not provide adequate care services, there will be bed blocking, which will have an impact further down the line. Are you not just making a new problem?

Stephen Boyle: You are absolutely right. It is a reflection of an interconnected system with changing demographics and growing demand for adult social care. The impact of that does not reside solely within the IJB; it will affect the NHS in due course. Again, I note for the committee's interest that, alongside the IJB output that we will publish in early January, we will also publish our joint report on delayed discharges and how the system is operating in Scotland. We will bring that report to the committee in due course.

Colin Beattie: Where is the responsibility for addressing the overspends? Wherever I hear about them, they are significant—we are talking about millions of pounds. Somebody must be in charge of that, in control of that and managing that. Who is it?

Stephen Boyle: That must happen between the three entities—the IJB, the health board and the council. As you rightly pointed out, the IJB is an arrangement between the council and the health board, so there must be a consensus about preparing realistic budgets—Alison Cumming mentioned that and I support the Accounts Commission's view, which is quite right. It sounds as if NHS Grampian has set a realistic figure for 2025-26, which I am sure it hopes is sufficient to meet its risk-sharing obligations.

There is a wider point about the sustainability of the model for adult social care. There has been much discussion about and parliamentary consideration of how to move from the model that we have in Scotland. That is where we are at. A huge societal issue is presenting to be tackled in how we can deliver a sustainable model of adult social care provision in Scotland.

Colin Beattie: Is any tangible action being taken at the moment?

Stephen Boyle: We will set out more detail in the delayed discharge report. On adult social care, there has been parliamentary consideration of legislation around social care models. Inevitably, it will take time to assess what is making a difference, together with the preventative model ambitions of keeping people healthier and out of hospital for longer, which we have mentioned a couple of times today. Those are the fundamental next steps to move from the challenges of today into a more sustainable model in the future.

Colin Beattie: In your report, you say that the IJBs are a "significant barrier" to NHS Grampian achieving a balanced budget. Would you say that that is the primary reason?

Stephen Boyle: Not to contradict you, but I am not sure that saying "barrier" is a fair representation. I think that it is a factor in the model. In reality, the NHS, and NHS Grampian specifically, cannot step out of the IJB arrangement. It must have ownership of the issues that affect health and social care in its locality, so it is about the reality of what that will cost.

Alison Cumming might want to say more about this, but I echo the Accounts Commission's judgment about realistic budgeting and NHS Grampian working with its partners in the council to understand its population and their needs, to signpost them to the right level of support and care, to have interventions at a far earlier stage to keep people healthier for longer and out of hospital, and to provide the right level of tailored support for individuals. That is all part of a very complex system. Working with the councils and the Scottish Government, with the support that the Government provides, will be the key to getting out of what is a very challenging situation and avoiding the reactive arrangements that might be characterised by some of the financial problems.

Colin Beattie: I do not disagree with what you say, but it seems to me that if we look at this very crudely, the IJBs in this case—and, for all I know, in other cases across other NHS boards—are having a very significant impact on the budgets and possibly, although I am speculating a little bit here, they could be the core factor in driving NHS boards into deficit. If so, should there be some concerted effort to manage that? The issue is not going to go away.

Alison Cumming: On that point, NHS Grampian published a medium-term financial framework earlier this year, and it projects that, for services that the board has not delegated to IJBs, it would return to financial balance in 2028-29. It is the continued pressures through the services that are delegated to the IJBs and the financial obligations that the board has through the IJBs that will result in the board being in deficit for a longer time, so that remains, and will remain, a significant factor.

We acknowledge that the Accounts Commission recognises that more needs to be done in that partnership space at local level—although it is not all IJBs or all parts of the country—to better learn from where this is working well what needs to be done to get more robust, realistic and transparent budgets in place for the start of the year and to have agreements in place about managing the in-year risk and minimising the exposure to the other bodies.

It is an area of increased and continuing interest for the Accounts Commission in relation to the sustainability implications. From the Accounts Commission point of view, it is about the IJBs and

the councils, but it is undoubtedly a system issue for health and social care in Scotland. From the way in which the accountabilities work, and with IJBs being local government bodies, we certainly know that the financial delivery unit in the Scottish Government is focused on the NHS services and does not have any locus in the social care dimensions. Therefore, for the services that are delegated to IJBs, we do not see the same concerted national effort to generate the potential savings schemes and gain learning as we do for what we might describe as core NHS delivery.

Colin Beattie: If we are talking about the need to redesign IJBs, surely there must be a joined-up effort in taking that forward. You cannot look away from that. Local councils and the NHS must get together and either come up with a new formula or accept that additional funding will be needed to meet those needs.

Stephen Boyle: It is very clear that the need for sustainability does not confine itself to the boundaries of budget setting—it is not the case that this is the health budget and that is the local government component; there will have to be a system-wide consideration of sustainability.

To echo Alison Cumming's point, it is not the same everywhere. Not all IJBs or all health boards are experiencing a level of financial challenge, but it is important to know whether the insight and analysis that exist to make that contrasting assessment could be improved.

Audit Scotland hopes to contribute to that understanding when we publish in early January the report that we have referred to on IJB finances, for which we will prepare a data tool to allow people to interrogate how services compare and contrast across different IJBs, which we hope will be a helpful contribution to offering some insight into the different performances across the country.

The Convener: Thank you very much. Of course, the IJB structure was set by legislation passed by this Parliament, so it is very much of interest to us that you are doing further work in this area to see whether the intention has been carried out in the implementation.

I will invite Joe FitzPatrick to put some questions to you.

Joe FitzPatrick: I will start off with some questions about the NHS Scotland's support and intervention framework escalation. We know that NHS Grampian was escalated to stage 3 in January 2025 and then, just four months later, it was escalated to stage 4. Was that too late? That seems like a rapid escalation. What went wrong that required it to move so quickly from stage 3 to stage 4?

Stephen Boyle: We touched on aspects of that in the report. Effectively, we say that the differential between stages 3 and 4 reflected the Scottish Government's lack of confidence in the financial trajectories set out in financial plans that were submitted by the board to the Scottish Government.

On timing, that is probably a matter of consideration and judgment by the Scottish Government. We talked in the earlier session about how stage 3 for NHS Ayrshire and Arran lasted seven years. For NHS Grampian to escalate from stage 3 to stage 4 within a matter of months is significant and probably reflects the level of confidence that the Scottish Government either had or did not have in the financial plan.

11:30

It feels like there was a marked difference in what the Scottish Government sought to do regarding assurance board arrangements, along with commissioning the external reports that we mentioned from KPMG. I do not underestimate the significant difference between stage 3 and stage 4. From our perspective, what matters is what will happen next. What consideration will be given to address the finding in the report that the auditor referenced about what combination of reform or change to the financial position is required to move to a sustainable model?

Joe FitzPatrick: Will you say a bit more about the difference between stage 3 and stage 4 and what that meant for NHS Grampian in dealing with the challenge?

Stephen Boyle: I am happy to start. As set out in paragraph 16 of the section 22 report, as a result of being at stage 4, an additional layer of governance, as well as the reporting, was brought in. First, an assurance board, chaired by the Scottish Government, is created to report to the chief operating officer of NHS Scotland and the chief executive of NHS Scotland and director general health and social care. It is not about intervention or special measures in the sense that you would get to a further layer; the responsibility for delivering healthcare and making governance decisions still rests with NHS Grampian. Clearly, the KPMG report that was commissioned by the Scottish Government, together with the assurance board arrangements that are in place, are a step change.

What matters is not just adding a layer but that it results in change and a move to a different model. I will pause in case colleagues want to come in with any more detail on the distinctions.

Leigh Johnston: This is not really about the distinction, but when you compare NHS Grampian going to stage 4 and NHS Ayrshire and Arran

going to stage 4, a key factor was the concerns around the quality of services that were raised by Healthcare Improvement Scotland. I guess that Healthcare Improvement Scotland then revisited that and felt that the board had not responded in the way that Healthcare Improvement Scotland had hoped to some of its concerns. That raised concerns about leadership of the board, which I think also contributed to NHS Grampian being—

Joe FitzPatrick: So this was about more than just money.

Leigh Johnston: It was about the quality of the services and service performance.

Joe FitzPatrick: You mentioned leadership. I will ask similar questions to those that I asked about leadership at NHS Ayrshire and Arran. I think that KPMG suggested that, in some meetings, the board provided a good level of challenge to the leadership team. However, given the answer that we received in relation to NHS Ayrshire and Arran, I am guessing that board members sometimes did not have all the information that they needed in order to provide effective challenge. Is that problem common to both boards, or is the situation at NHS Grampian entirely different?

Stephen Boyle: Broadly, that is a fair assessment. The complexity of dealing with an on-going financial challenge will undoubtedly consume board attention, but there are a couple of differences. Alison Cumming might want to talk about the detail of the judgments that the auditors have made about NHS Grampian's governance arrangements.

As we discussed in relation to NHS Ayrshire and Arran, there has also been a change of executive leadership at NHS Grampian. When a new chief executive comes in, they have the opportunity, along with the board and the Scottish Government, to take stock and to come up with a path to sustainability.

Alison Cumming: The appointed auditor found that there was regular reporting to committees on the financial position and did not flag any specific concerns about the operation of governance arrangements within the board. However, although the auditor found that NHS Grampian has arrangements for securing best value, they recommended that the board should undertake its own assessment against the best value framework to assure itself that it has the necessary arrangements in place to deliver continuous improvement.

Joe FitzPatrick: The KPMG report suggested that meetings, especially of board sub-groups, were still being undertaken online. Do you have any thoughts on whether, in that context, online meetings are as effective as in-person meetings?

Stephen Boyle: I have not given a great deal of consideration to that. In my personal view, governance is best discharged in person, but it can vary. I have seen appropriate challenge and scrutiny being undertaken in both an online and a hybrid format.

To go back to KPMG's wider points, if the board is doing an assessment of its best-value arrangements—whether in an online meeting or otherwise—governance is a factor that it should give proper consideration to.

Joe FitzPatrick: I just feel that, if things are escalating, maybe it is time for people to get in a room together and spend a bit of time—

Stephen Boyle: My natural instinct would be to say yes, in-person meetings provide a better understanding of the context, by enabling people not only to see and hear the speaker, but to take a view of body language, dynamic culture and all the factors that it is perhaps not possible to have full insight of when it is a remote meeting.

The Convener: That is a moot point and a question for our times, is it not?

I now invite the deputy convener to ask some questions.

Jamie Greene: I draw your attention to paragraph 14 of the report, which I read with interest. We have spent a lot of time talking about the finances of the board, but it seems that that is not the only issue here. There are concerns about performance, services, quality and the existence of "significant operational pressures". Could you talk us through the concerns that you identified, other than those to do with the financial problems at NHS Grampian?

Stephen Boyle: I am happy to do so. I will bring in Leigh Johnston, who can set out for the committee some of the detail in relation to NHS Grampian and the views of regulatory bodies about what I referred to in my opening statement, which was the identification by the board of the "intolerable" strategic risks that it felt that it faced. The committee may recall that that took place about 12 months ago, when it was reported that the board considered that its ability to deliver services safely in the way that it wanted to was threatened. That, together with the views of regulatory bodies on NHS Grampian's ability to respond to some of the pressures, was fed into the Government's consideration of what that meant for its support and intervention framework.

Leigh Johnston, are you happy to start on that?

Leigh Johnston: Yes, I can give a bit more detail. Healthcare Improvement Scotland inspected both Dr Gray's hospital and Aberdeen royal infirmary. There were significant concerns about Dr Gray's hospital, which related to

cleanliness standards not being consistently met and issues with patient privacy and dignity. We have talked about the low numbers of beds, which resulted in beds being in corridors and areas other than wards. That presents challenges for patient privacy and dignity.

There was also non-compliance in relation to the safe management of drugs, with, for example, medicine cabinets being left open, and there were issues around staff hand hygiene and ensuring that clinical leaders had enough leadership time.

As I said earlier, Healthcare Improvement Scotland made a number of requirements in its first inspection. When it went back for a follow-up inspection, it found that a range of those had still not been addressed. That gave rise to further concern, which led to the chief executives of Healthcare Improvement Scotland and NHS Education for Scotland coming together—unusually—to write a joint letter to the board about their concerns. NHS Education for Scotland had a range of concerns about medical education and the leadership of medical education within NHS Grampian—for example, it felt that some of the training programmes and the support for trainees were not at the level that it would expect.

Of course, there was also the critical incident that was declared at Aberdeen royal infirmary, which was in the news. That related to unscheduled care, ambulance turnaround times and the significant pressure on the acute system, which meant that the board had to declare a critical incident. That led to ambulances queueing outside the hospital and people being turned away and having to go to other hospitals further away. That lasted for only three days, and the board did its best. It got a lot of help from surrounding boards to address the situation. Those are the other quality and performance issues that led to concerns.

Jamie Greene: Thank you for that comprehensive answer, which was very helpful but also very concerning. You mentioned beds in corridors, cleanliness issues, safety issues and staffing at dangerous levels. It is hard to believe that we are talking about the health service of a first-world country; the conditions that you have described make it sound like the health service of a third-world country.

However, I am keen not to scapegoat the staff in the hospitals, who, I am sure, are working in difficult conditions. Is there any evidence that none of this is the fault of the hard-working nursing and caring staff, the cleaners and the caterers—the people who deliver the services in such tough conditions? Is the problem higher up the chain?

Stephen Boyle: I do not think that we can escape the capacity context that NHS Grampian is operating in. We touched on its bed base and how that compares with the bed capacity in other parts of mainland Scotland. More detail is provided in paragraphs 26 and 27 of the section 22 report. Paragraph 26 says:

> "NHS Grampian has the lowest bed base in Scotland, approximately 1.4 beds per 1,000 population. The next closest mainland board has approximately 2.0 beds per 1,000 population, while the Scotland median is 2.4 beds per 1,000 population."

That shows that NHS Grampian faces markedly different capacity issues relative to other parts of the country.

The board is alert to the issue. In September of last year, a review was produced that highlighted that the provision of additional bed capacity would be critical in enabling Aberdeen royal infirmary to respond to in-patient demand levels. There are indications of sustainability and service pressures with the current level of capacity, but it is quite reasonable to note—while I do not want financial issues to dominate the discussion—that, for the board to move from where it is now as regards bed capacity, significant additional investment, whether in relation to resource, how people are used or estate provision, will be required, and that is in the context of a health board that is receiving considerable brokerage and loan funds to deliver financial balance. All of that needs to be squared if the board is to be able to move to a sustainable model in which, ultimately, staff and patients receive the experience that they ought to receive in NHS Grampian.

Jamie Greene: Thank you, Auditor General. How can a hospital run out of beds? Is it that suddenly and very quickly there is an unexpected wave of people who are very unwell or is it because of poor planning and forecasting capacity?

Stephen Boyle: I am not sure that I would characterise it as one or the other. I go back to the critical incident—and Leigh Johnston might want to say more on this—which was about unscheduled care, with people arriving for services from the health board that led to it not having capacity, the result of ambulances then queueing outside and not having the throughput through the hospital. What happens at the other end of the hospital system is also relevant in the context of the availability of care packages. We refer to that as delayed discharge.

It will be the result of a combination of events that take place and the known structural issues that affect how a health and social care system operates. It is both. It is not just about what happens in the hospital, but—to go back to Mr Beattie's questions—is about how all of this system operates. It is clear that the system is facing real capacity and pressure issues.

11:45

Jamie Greene: Is any of that a surprise to anyone? We know that there is an ageing population, particularly in this health board area. Demographic analysis has been done—using data, presumably. It would not have been a new problem, but would have been known to the board and, indeed, to ministers for some time.

The idea that it is a surprise that lots of people who are elderly and unwell might present at A and E—setting aside the issue of Covid or an unexpected health issue, which clearly people were not prepared for—seems surprising; I am surprised that this is a surprise to people.

Stephen Boyle: In terms of our interest, what triggered the section 22 report is the fairly quick escalation of the board to level 4 of the support and intervention framework. As Mr FitzPatrick points out, in a number of months this health system moved, initially, to level 3 and then to level 4 .

It would probably be unhelpful for me to speculate on this, and it may be more for the health board and for the Scottish Government to express a view, but things seem to be happening at pace in recognition of the scale of the issues being experienced within NHS Grampian. Contrast that with the example of NHS Ayrshire and Arran, which we spoke about earlier, which spent many years—seven years—at a certain level of support. That does not seem to be the position with NHS Grampian.

None of it means that there are not issues that really need attention. I support the view that the auditor took, that reform or recasting of the funding—or a combination of both, I suspect—will be needed to move to a sustainable model.

Jamie Greene: That leads nicely into what the solution is. Is it just throwing more cash at the problem? Is it the end-to-end fixing of all the problems that response times for A and E, bed-blocking and delayed discharge present? Do we need more staff? How do we solve these issues? You can either write cheques endlessly to health boards or have a systemic root-and-branch review of the entire journey from being ill to getting home again.

Stephen Boyle: The response is more in the latter than the former. I do not think that public finances will allow for on-going financial support without a wider look at how the money is being spent. As we have touched on, the KPMG report was beginning to explore some of the detail of that, including considering increased staffing levels—whether it is the transfer in from agency workers or there is an issue of capacity not being able to be deployed in the way that the board would like because of bed levels—how the arrangements with the IJBs are working and whether the estate within the health board is suitable to deliver the service model, and then the board playing its part, as I am sure that it is, in considering moving to a more preventative-based model of healthcare.

The challenges presenting within NHS Grampian are pressing. Therefore, while I am sure that full consideration is necessary, it is clear that there is urgency in the financial position and some of the service performance indicators, which I am sure that the board, together with the Government, will need to address.

Jamie Greene: Thank you. That is a very succinct analysis of the wider problem. Is the solution to the bed issue a new hospital or a new site? You state that there are physical issues in the estate, so the answer to that clearly is a new building, more beds and more people.

Stephen Boyle: That is a question for the board, together with the Scottish Government, as part of capital planning and service planning arrangements.

Going back to the director general's letter to the committee, the Government's consideration of how and where services are being provided—whether they are local or national centres—will undoubtedly be part of that. We know that the board is also undertaking service capacity growth and new health provision is also being built.

That is a wider question for NHS Grampian, which needs to reassure its own board, the Government and the committee, about how it is planning to address those challenges.

Jamie Greene: The assurance board has a role to play in all this and will be there for the foreseeable future until things have turned around.

Is the improvement plan forthcoming? Where are we at with that? Has it been signed off? Has it been ratified? Are people happy with it?

Leigh Johnston: We have not yet seen the improvement plan. I did look at the assurance board minutes. The last assurance board was in October and it talked about different improvement actions that were taking place, particularly around planned and unscheduled care, driving efficiencies and savings, and looking at productivity. Of course, the appointed auditor will be looking for that improvement plan as they plan for the coming audit.

The Convener: Okay. I will finish where we started. As I understand it, this is the first time in 20 years—two decades—that a section 22 report has been presented to Parliament on NHS Grampian. The final question from me is: what has led us to this point? In the report, you start off by talking about the financial position: the £65.2

million brokerage in the financial year that the audit is from, the loans outstanding being £90 million and so on. If it was just the financial position alone, would that warrant a section 22 report, or is it warranted by a combination of the financial position together with those performance issues, the Healthcare Improvement Scotland inspection of Dr Gray's in Elgin and the traffic-light performance review attached to the report, which shows there are some major areas of concern in delivery of key treatments? Is it around the bed capacity issue? If it was just performance issues, would there be a section 22 report? If it was just financial issues, would there be a section 22 report? Is it because there are both sets of issues that it warrants, in your view, a section 22 report presented to Parliament to outline your concerns?

Stephen Boyle: Convener, there is no precise model for a section 22 report. It is a matter of judgment for me, based on the findings presented by the external auditor across the piece for public bodies in Scotland. In isolation, the receipt of £65 million of additional year-end funding is significant. There is the opportunity cost of public spending for that amount of money. All the other factors are, of course, relevant but a financial position is indicative of something else.

All the issues that the committee has considered this morning that are set out in the section 22 report and the annual audit report are indicative of a system that is under pressure within NHS Grampian, and of issues with its capacity and ability to respond. The Scottish Government is recognising that with its escalation, and by commissioning external views to support the board.

I go back to the conclusion in our report: either the financial position needs to be addressed or there needs to be a reform of the system. I think that the latter will give a sustainable model of health and social care working across partners, and especially a sense of how the local authority and the health board, together with the Scottish Government, can move to a clear, sustainable, end-to-end health and social care model in NHS Grampian and surrounding areas.

The Convener: Okay, thank you. On that key message, we will draw this morning's evidence session to a close.

Thank you again for the very useful evidence that you have provided for the committee this morning in our consideration of the audit report into NHS Grampian. I thank Alison Cumming, Leigh Johnston and the Auditor General for providing us with lots of food for thought.

I will now, as previously agreed, move the committee into private session. Thank you.

11:54

Meeting continued in private until 12:10.

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