OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit Committee

Thursday 20 June 2024

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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CONTENTS

PUBLIC AUDIT COMMITTEE
20th Meeting 2024, Session 6

CONVENER

*Richard Leonard (Central Scotland) (Lab)

DEPUTY CONVENER

*Jamie Greene (West Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Fulton MacGregor (Coatbridge and Chryston) (SNP)
*Graham Simpson (Central Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

John Burns (NHS Scotland)
Caroline Lamb (Scottish Government)
Richard McCallum (Scottish Government)

CLERK TO THE COMMITTEE

Lynn Russell

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit Committee

Thursday 20 June 2024

[The Convener opened the meeting at 09:00]

Interests

The Convener (Richard Leonard): Good morning. I welcome everyone to the 20th meeting in 2024 of the Public Audit Committee.

The first item on our agenda is for Fulton MacGregor to declare any relevant interests to the committee. Fulton joins us online. Over to you, Fulton.

Fulton MacGregor (Coatbridge and Chryston) (SNP): Thank you, convener. I apologise to everyone for being online today, but it is fortunate that I am able to use this facility.

I am looking forward to being part of the committee. In answer to the convener's question, I have no relevant interests to declare.

The Convener: Thank you very much, Fulton MacGregor.

I take this opportunity to put on record my thanks to Willie Coffey, who has made an outstanding contribution to the committee not only in this session of Parliament, but in previous sessions. He will be greatly missed. Thank you, Willie, for the work that you have done with the committee.

Decision on Taking Business in Private

09:01

The Convener: The second item is for members to decide whether to take agenda items 4, 5 and 6 in private. Are we content to take those items in private?

Members *indicated agreement.*

Section 23 Report: “NHS in Scotland 2023”

09:01

The Convener: The principal item on our agenda is further consideration of the Auditor General for Scotland’s section 23 report “NHS in Scotland 2023”. In the interest of transparency, I refer members to my membership of two trade unions that organise workers who are employed in the national health service.

I welcome our witnesses this morning. We are joined by Caroline Lamb, who is the chief executive of NHS Scotland and the director general of health and social care for the Scottish Government; Richard McCallum, who is the director of health and social care finance, digital and governance for the Scottish Government; and John Burns, who is the chief operating officer of NHS Scotland.

The committee has got quite a number of questions to put to you, but, before we get to those, I invite Caroline Lamb to make a short opening statement.

Caroline Lamb (Scottish Government): Thank you very much, convener. The Audit Scotland report calls for a long-term vision for health and social care to address the pressures that services face. The Cabinet Secretary for Health and Social Care outlined that, given persisting health inequalities and the growing demands that health services face, the NHS requires a programme of reform to ensure that we have a sustainable health service that is able to deliver the best quality care for patients.

That desire to reform is driven by an overarching vision that will guide our work, which is for a Scotland where people live longer, healthier and fulfilling lives. The vision is underpinned by work to improve population health, to prevent ill health, to provide quality services and to maximise access, with due consideration for people always at the heart of the services that we offer.

We also continue to implement a range of immediate actions to support performance and sustainability against an incredibly challenging backdrop. I am sure that the committee will want to ask us questions about that today. We have published “Delivering Value Based Health & Care: A Vision For Scotland” and the “Value Based Health and Care: Action Plan”, which set out what we must do to deliver better value care.

I welcome Audit Scotland’s report, and I see close engagement between Audit Scotland and my team as incredibly important. We are carefully considering the actions that we need to put in place to respond to Audit Scotland’s recommendations. I am happy to answer questions.

The Convener: I will ask you at the outset whether you accept the recommendations that are made in the Audit Scotland report.

Caroline Lamb: Yes, we accept the recommendations, and our work is now to look at the actions that we need to take to implement those recommendations. Some of that work is already in train.

The Convener: Okay. I will look at the recommendations that were made in the report from last year, which are covered in appendix 3 of the report from this year. It is a summation of progress that has been made against the recommendations from the 2022 report, which are grouped into nine broad areas. The Auditor General’s assessment describes that some progress against the recommendations has been made in some areas, but that there has been only limited progress in others and some where no progress was made. How do you respond to that summation in appendix 3 of this year’s report?

Caroline Lamb: There is one area where the Auditor General has described that no progress has been made, which is in relation to revisiting and updating the NHS recovery plan commitments. The Auditor General acknowledges that we published an NHS recovery plan update in December 2023 but finds that the update did not report progress sufficiently clearly and recommends further action. We will absolutely pick up that recommendation. We acknowledge those findings and we will look at what we need to do to revisit those commitments in light of the circumstances in which we find ourselves now and the reform work, and to respond to that recommendation. We will roll that into the things that we are considering alongside this year’s recommendations.

The Convener: Why are you so resistant to doing that? Over a year ago, you were sat there and you and I had an exchange about the Auditor General’s recommendation to produce annual reports that would give greater transparency and clarity about whether progress was being made. You said—rather dismissively, I think—that you were not really interested in what you described as “a dry annual report.” Why do you have such resistance to the idea of openly publishing an annual summary of progress being made or not?

Caroline Lamb: We need to recognise that we did publish an annual report. What we tried to do in that annual report was not only to recognise areas where, in fact, actions had already been completed—for example, in relation to

international recruitment—but to give a broader update on some of the other areas that set that in context.

We first published the NHS recovery plan at a point when we thought—maybe slightly optimistically—that the pandemic was over. It was not, so we have had to adjust. However, as I said, we published an annual report. Obviously, the Auditor General found that it did not fully satisfy all the things that Audit Scotland would wish to see in an annual report, and we will take that into account when we look at our next publication.

The Convener: You understand why, to us as the Public Audit Committee, it is unsatisfactory that, in this year's report, the Auditor General had to repeat a recommendation. On the recommendation to

"Publish annual progress updates on the reform of services",

under the heading "Limited progress", he said:

"We repeat the recommendation in this report."

Reform is the watchword of the new Cabinet Secretary for Health and Social Care, so why have you not come up with the standard of reporting that the Auditor General thinks is required?

Caroline Lamb: You are absolutely right that reform is a large focus of the new cabinet secretary, and we would want to be clear as we further develop that reform programme. That aligns with the recommendations that the Auditor General made about our vision and our reform plan, which need to be integrated. In the past, we have reported on some areas of reform, but we have not made that as consistent and coherent as we would want to.

You will be aware that we have been working with Public Health Scotland to publish a dashboard to support our care and wellbeing programme, which is our main vehicle for reform. We will want to look at that. I would also say that we need to be clear that we are able to capture the right information to support that reporting. We still have further work to do and will continue to work on that. We also need to ensure that we are giving enough time to provide a true measure of the impact that innovation is having, for example on diabetes and other areas.

The Convener: On the 2023 report, the Auditor General, in a fairly stark summary, said that there was

"no single overall vision for how health services will look in future."—[*Official Report*, *Public Audit Committee*, 21 March 2024; c 36.]

When I raised that with the then First Minister at a meeting of the Conveners Group in the Parliament, he said:

"I respectfully disagree with the Auditor General on that point".

Where do you stand on that?

Caroline Lamb: The cabinet secretary set out a clear vision for health and social care services in Parliament a couple of weeks ago. He has also been clear that that is not about having a radically new or different strategy but is about pulling together a number of strategies, some of which are referred to in the Audit Scotland report.

We have a number of strategies. If you look at them, you will see that they are all very much aligned and are moving in the same direction. We have absolutely clarified that and pulled it together by articulating the overarching vision that was implicit in many of those strategies.

The Convener: You are discussing "strategies" plural, but the concern expressed by the Auditor General was that there was "no single overall vision". I know that, during the debate on his vision, the cabinet secretary told Parliament:

"I am not looking to publish a new strategy."—[*Official Report*, 4 June 2024; c 91.]

Are we just going to keep going along with several "strategies" plural?

Caroline Lamb: What the cabinet secretary has done—this is what I think that the Auditor General indicated was required—is to set out a single overarching and coherent vision. The cabinet secretary has articulated that vision and it is underpinned by a far more holistic approach to the reform that we need to make.

The vision looks at the requirement to improve population health, which is an area in which many of the required actions lie outwith the health and social care portfolio. That is about having a strong economy, good jobs, fair work, healthy environments and good housing.

The second element of the vision involves prevention and early intervention, so that we can address health issues at the earliest possible opportunity. It also focuses on the need to deliver quality and safe services and to improve access to services.

Those four domains sit underneath the vision and pull together all the activities that we must take forward. The Auditor General recognises the interdependencies across the system. We must be mindful of how we are taking those together, looking not just at acute health services but at the impact on community, primary and social care services.

The Convener: One of the phrases that is used is about treating people as close to home as possible, is it not?

Caroline Lamb: That is correct.

The Convener: The downgrading of neonatal services at University hospital Wishaw means that people there are being told that they might have to travel to Aberdeen. How do you reconcile that with that goal?

Caroline Lamb: That is a characterisation of the position in Wishaw. We have been working through the neonatal plans, driven by clinical colleagues and by evidence, to look at how to achieve the best outcomes for the sickest babies. We are still in a process of working through the detail of all that, but the overriding concern is to get the clinical model right so that the very sickest babies have the best possible chance of a good outcome.

The Convener: Okay. Finally, I will take you back to the cabinet secretary's vision and therefore, I presume, to the Government's vision. The cabinet secretary told Parliament that he had outlined his vision to Cabinet colleagues before he made his statement. He also spoke about the establishment of ministerial task forces, expert reference groups and stakeholder advisory groups. What are they going to do?

Caroline Lamb: The cabinet secretary is concerned to ensure that he is listening to all voices and is getting advice not only from within Scotland but from systems outwith Scotland. That is the genesis of the expert advisory group. We must challenge ourselves as to whether there are ways to think differently in order to provide the sustainable, high-quality health services that we all want to provide.

The cabinet secretary is also keen to engage with staff and to hear the views of front-line staff. We have already done quite a lot of that through the work of the nursing and midwifery task force. He also wants to ensure that there is a conversation with the public. We have not yet published plans for that, because we are in a pre-election period, but we will be putting a bit more detail around some of that.

The Convener: I do not expect you to give me a comprehensive reply to this this morning, but who will be on the ministerial task force, the expert reference group and the stakeholder advisory group?

09:15

Caroline Lamb: In relation to the expert reference group, we will be looking to identify people with expertise of systems outwith Scotland who can be critical friends. Some of that work has already been done, but you will understand that I do not want to name names right now.

As we came out of the pandemic, we had the mobilisation recovery group—or the MRG, if I am getting my acronyms right—which brought together a range of stakeholders, including system leaders, trade unions and groups such as Community Pharmacy Scotland. A number of those stakeholders have said how useful they found that group, as it kept them informed and they felt engaged and were able to offer their views. The stakeholder reference group will not exactly replicate that group, but it will build on what we learned through that experience.

The Convener: Is there a patient voice in and among all that?

Caroline Lamb: Absolutely. We have been working with Healthcare Improvement Scotland, as part of its community engagement work, and with the Health and Social Care Alliance Scotland. We have been taking advice from them on how we engage with people. One piece of advice that we have had is that we should not ask people the same questions that they have been asked before. We are working to understand the work that those groups have already done, and we will absolutely be engaging with patients. We have had great experience of engaging service users through our work on the national care service, and some of that is relevant to this work, too.

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

Graham Simpson (Central Scotland) (Con): Good morning. If you were to issue a health report on the health service, what would it say?

Caroline Lamb: Audit Scotland has issued a health report on the service. It is fair to say that the system faces considerable challenges and pressures as a result of the impact of the pandemic. As I have said, Covid has not gone away—we are still managing it. In common with other areas of society, the health service has been hit by inflation and by the impact of Brexit. There is no getting away from the fact that the system is managing very significant pressures—it is under the highest level of pressure that we have ever seen. I have talked about the unprecedented challenges.

At the same time, it is important that we remember that the vast majority of people get a great service and still report really good experiences of interacting with health services. Our staff across health services work incredibly hard, day in, day out, to provide those services.

There are still lots of opportunities, such as those relating to new technologies and innovation. We have been working on continual improvement across our health and social care services for a number of years, and there are still opportunities in that regard, too.

Graham Simpson: Okay, but you would not give the health service a clean bill of health, would you? If the health service was a person and it tried to get an appointment with a general practitioner, what would the GP say? Would they say, "Go away—you're okay," or would they say, "You need to rush to an accident and emergency department"?

Caroline Lamb: We need to be clear that some of our health services continue to be under significant pressure and that some are under less pressure. There is not a homogeneous picture across the piece.

Graham Simpson: I have mentioned GPs, so I will ask about them first. General practice is where people enter the system—they might end up in hospital, but GPs are their first port of call, so it is really important that the GP system, if I can call it that, works effectively. However, we often hear reports that people cannot get to see their GP because of the booking systems that some—not all—GPs operate.

I have done a mini survey of GPs in my area, Lanarkshire, and there are different models. For example, if you want a same-day appointment with my GP, you have to phone up at 8 am, and it is really difficult if you want to book for, say, the next week. Having to phone at 8 am puts people off. It certainly puts me off—because I am working, I wonder whether I will ever get to see my GP again. It is really difficult.

Do you have any data that shows what is happening out there with GPs?

Caroline Lamb: As you will be aware, GPs are independent contractors, but we support general practice through the employment of a range of multidisciplinary team members in order to try to take pressure off general practitioners. You said that GPs are people's first port of call, but NHS 24 is increasingly a first port of call for people, too. Given the nature of our relationship with general practitioners, it is still the case that our data on general practice is not as good or as consistent as we would like it to be, although we are working to improve that data.

Graham Simpson: Why are we in a situation in which the NHS does not know what is happening in general practice?

Caroline Lamb: There is a long-standing issue relating to the different relationships between bits of the NHS. The Scottish Government has access to all data on acute boards, and Public Health Scotland has been working hard to improve the quality of data on general practice, but some of that is down to the willingness of individual practices to engage with such programmes. We are getting better at that, and we continue to look at that area.

Graham Simpson: Surely that situation needs to be sorted out, because you cannot plan if you do not know what is happening out there. If you do not have information on what patients are suffering with or whether people are struggling to see their GP—which, in some cases, they are—how can you plan ahead?

Caroline Lamb: I do not have the information in front of me, but I would be very happy to provide you with further information about the work that we are doing to improve the flow of information.

Graham Simpson: That would be useful.

When I was preparing for this meeting, I was curious about whether more people are going private, probably as a result of being completely fed up with trying to see their GP. It appears that more people are going private, and the number of private GP clinics in Scotland has more than trebled since 2019. Is that not an indication of failure somewhere? People should not have to pay to see a GP, should they?

Caroline Lamb: I agree with the cabinet secretary, who has said that he is committed to the principle of NHS Scotland, which is that healthcare should be free at the point of need. I do not have access to the figures that you have looked at on private GPs, but I would be very happy to respond to you once I have had a look at them.

Graham Simpson: I urge you to look at them—I think that I saw them on the BBC, so they should not be too difficult to find. You should have that sort of data.

You have mentioned technology. NHS England has an app that people can use to book an appointment with a GP, get repeat prescriptions and do other things. Why do we not have a similar app here?

Caroline Lamb: You are right that NHS England has an app. People cannot book appointments with every GP on the app, but NHS England has been very successful in engaging with that technology.

In Scotland, we have our digital front door programme, which is absolutely about giving people better access not just to their own health information but to information that will support them in looking after their health. The ambition is to move towards increasingly enabling people to interact with appointments, not just in general practices but in the acute sector, too.

We also have a digital prescribing programme under way. I do not know whether Richard McCallum wants to say anything about either of those.

Richard McCallum (Scottish Government): I would just make the point that there is a commitment in the programme for government for the digital front door to be in place by the end of this parliamentary session as a first stage of the digital link-up across the system. I think that that speaks to some of your wider points about data sharing, too, Mr. Simpson, because it is a critical component of that. Alongside the digital front door, we need to ensure that the right infrastructure is in place for a data platform to support that work and that there are appropriate safeguards to enable us to share data across the system safely but effectively.

Graham Simpson: I suppose that my question is: are we going to get a similar app here?

Caroline Lamb: I do not think that it will be exactly the same, but yes, we are absolutely looking to provide the same functionality.

Graham Simpson: It will never be exactly the same, but, from a patient point of view, will there be an app that enables you to book an appointment, get repeat prescriptions and do other things? I mean, the app that we have been talking about does other stuff, too. Will we get something similar, and, if the answer to that is yes, when will we get it?

Caroline Lamb: As Richard McCallum has indicated, the commitment is to provide the first version of the digital front door by the end of this parliamentary session.

Graham Simpson: The end of this parliamentary session.

Caroline Lamb: Yep.

Graham Simpson: Okay. I will very much be looking forward to that.

The issue of private finance initiative contracts came up in a previous evidence session, so you will be expecting to be asked about it and will, I hope, be prepared for these questions. We know that a number of PFI contracts in the health service are due to expire. I will just run through them. The contract for Tippethill hospital in Bathgate expires next year; the contract for New Craigs hospital in NHS Highland expires in 2026; the contracts for the Carseview centre in NHS Tayside and Larkfield in NHS Greater Glasgow and Clyde expire in 2027; the contract for the Royal infirmary of Edinburgh expires in 2028; and the contracts for Ellen's Glen house in NHS Lothian and—in my patch, and the convener's patch—Wishaw general in NHS Lanarkshire expire in 2029. What happens when the contracts expire? Do you have to pay a sum of money in all those cases to retain the facilities?

Caroline Lamb: When the contracts expire, we will need to go through various things to look at what state the facility has been left in. That can be challenging with some of the providers and less challenging with others. Richard, do you want to talk through the detail?

Richard McCallum: This question came up, I think, with regard to the infrastructure pipeline, and we are working closely with the Scottish Futures Trust to prepare boards appropriately for the end of the contracts. As Caroline Lamb has hinted at, there are different options for the next steps that we will take with the hospitals or facilities as the contracts come to an end. Some of that will be about the arrangements or negotiations that we will have with the PFI provider, which we are working through, and some of it will, as Caroline has also said, be about the remedial work that will need to happen as the contract comes to an end. We are very much alive to the reality that those contracts will come to an end, and we are ensuring, too, that we have provision in place beyond the contract end dates.

Graham Simpson: But do you have to pay lump sums in all cases?

Richard McCallum: That will depend on the individual contracts, and we are working through that. It would not necessarily be a lump sum in that sense, but there are different models for the different PFI contracts, and we are working on these matters case by case with the Scottish Futures Trust to ensure that things are properly planned. We are actively working with the health boards and the Scottish Futures Trust on all the contracts that you have mentioned.

09:30

Graham Simpson: Let me take just one of them—Wishaw general, the contract for which ends in 2029. What happens when it ends?

Richard McCallum: As I have said, all the contracts are set up slightly differently, so rather than give you—

Graham Simpson: I am just asking about that contract.

Richard McCallum: In giving you an answer on that individual case, I would want to be clear on the arrangement that is in place. I am happy to come back to the committee on that rather than give an answer that might not be exactly right, if that is okay.

Graham Simpson: Is that because you do not know the answer in this case?

Richard McCallum: No—well, in this instance, I think that, to give you a full and detailed position on the action that we are taking, I would rather take that step.

Graham Simpson: All I am asking is whether, in that case, the NHS would have to pay a sum to retain the use of Wishaw general.

Richard McCallum: It is not necessarily as straightforward as that, because we are at the moment paying significant revenue charges each month. There is a balance with regard to what happens at the end of the contract and the option for it to come into public ownership—the ending of those revenue costs will have an impact, too. I think that it is not as clear-cut as making a lump sum payment. As I have said, I am happy either on a specific case or on the general issue to give more detail to the committee.

Graham Simpson: I would rather have some kind of answer today. You can write to us, but, if you know the answer, I would rather have it now.

Caroline Lamb: The point is that the contracts are very complex and all quite different, and we would not want to be in the position of giving the committee incorrect detail when we can have much more certainty by going and looking at the individual aspects of the particular arrangement and coming back to you on that.

Graham Simpson: Right. I am not very satisfied with those answers, to be perfectly frank. If you want to write to us, I expect those answers in writing to be pretty detailed. I have not really asked you any detailed questions, but you are prevaricating and not answering what is quite a straightforward question.

I can try another one if you want—Tippethill hospital in Bathgate, which is ending quite soon, in 2025. I do not know that facility. What is the situation there?

Richard McCallum: I think that it would be helpful to come back with the approach that we are taking for each of those contracts, Mr Simpson.

Graham Simpson: That really is unsatisfactory. You must have known that these questions were going to come up, and I would have expected you to have been better prepared for them. However, I will move on, as I am not getting an answer.

I am going to ask about something else, you will be relieved to know. A number of health boards have struggled to make ends meet, with about a third not managing to hit targets and some having to be bailed out. That is not a sustainable model for the health service, is it?

Caroline Lamb: As Audit Scotland identified, not all NHS boards managed to break even during the year that it reported on, and, as a result, the Scottish Government provided brokerage to a number of them. I think that that reflects the overall financial position, the pressures that boards are under and the costs that they need to meet.

Richard McCallum's team continues to work very closely with NHS boards to support them to deliver the level of savings that we need them to deliver in order to achieve balance. We have a programme of work that supports that. We agreed a 15-box grid with chief executives that identifies areas of opportunity for NHS boards to look for savings, but there is no doubt that the financial position is challenged.

Graham Simpson: Do you agree that it is not sustainable? We cannot be in the situation every single year of boards saying, "We can't make ends meet. You will have to give us more money," can we?

Caroline Lamb: One of the reasons why the cabinet secretary has been clear about the need for reform is the fact that the demographic change in our population means that we need to be very mindful of how we provide more sustainable services. That is why there is such a focus, as part of the overall vision and the domains that I described earlier, on having a healthier population and on more preventative and early intervention measures. We need to be intervening when, frankly, it is cheaper to do so than when people get more unwell.

While we do that, we also need to manage the current position, which is that we are dealing with significant demand with limited resources.

Graham Simpson: This is my final question, convener. Are there too many health boards?

Caroline Lamb: I refer again to what the cabinet secretary has said. At the moment, our focus needs to be on maximising our performance and our delivery, based on our systems and the structures. We need to focus not on how many organisations we have in the landscape but on how we best provide services for patients.

That might mean that we need reform in future, which would absolutely mean that we would need to look at that, but, at the moment, it is about trying to design services in the best possible way for people, and then looking at what that means for the number of organisations that we have.

The Convener: Just to emphasise Graham Simpson's point, he is asking questions about PFI contracts of varying value, one of which is coming to an end at the end of 2025, which is not that far away. We would expect you to have a bit more detail to furnish us with this morning.

The question that he asked about Wishaw general is pertinent because of the value of the contract, which is £100 million in capital value terms. I recognise that some of the other ones are quite small: one is due to expire at the end of 2029

and is valued at £2.7 million, which is probably small fry in the overall scheme of things. However, we would expect you to have a bit more detail to give us about a larger one such as a significant general hospital that is coming up to the end of its PFI term.

I will follow up another point that Graham Simpson made, which is about savings. Perhaps you can help me, because I do not quite understand why, when we see real-terms increases in the NHS Scotland budget year on year, territorial NHS boards are asked to come up with savings. Will you explain that to me?

Caroline Lamb: I think that the explanation is fairly straightforward, in that, although we have provided year-on-year increases to NHS budgets, the vast majority of spend in the NHS is on staffing costs and the medicines bill. There have been increases in staffing in order to meet demand. We have managed to achieve pay deals with the unions that have meant that there has been no industrial action, but a cost is associated with that. Prescription costs consistently run higher than the normal rate of inflation, taking into account new medicines, new therapeutics and everything else that the public rightly expect to be able to get from the NHS.

The Convener: But does a territorial health board not have a budget for staffing?

Caroline Lamb: We allocate the budget to territorial health boards. Within that, they need to try to meet all the pressures on their budget, which relate to increased demand, increased medicine costs and increased staffing costs, which is a factor of the increased demand and pay awards.

The Convener: Okay. I am not sure that I entirely understand that, but that is probably a reflection on me and not you, director general.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I want to touch on governance. Over a fairly long period across the whole public sector, basically, governance and the actions, or inactions, of non-executive directors have always been a contributory factor where there have been difficulties and deficiencies in organisations. Are you satisfied that the recruitment process for board members is working effectively and that you are getting people with the right skills? It is okay to say that training is provided on the job, so to speak, but an incoming non-executive director would be expected to have certain key skills that might be needed on the board. How satisfied are you with that process?

Caroline Lamb: Recruitment of non-executive directors goes through the public appointments process. It is a rigorous process in which we are very clear about the capabilities that we are looking for. That is driven partly by what we would look for in a non-executive director, but it is also driven by the particular requirements of the board.

We expect boards to do their own analyses of where there are gaps in expertise around the board table. For example, we have in recent years seen boards going out to recruit people who have specific experience of running big capital projects. Another such example is people with finance experience. The recruitment process is robust.

It is clear that we need to ensure that the best possible pool of people apply for the posts. We have done a lot of work on looking at ways in which we can cast our net a bit wider and get a more diverse group of applicants for NHS boards. We try to attract the best possible people, and to ensure that our recruitment processes appoint the best possible people and that they get support and training once they are in the post.

One thing that proved to be a little bit challenging was boards meeting remotely during the pandemic. It was much more difficult then for new non-executives in particular to get on-the-ground experience—to walk around hospital facilities, for example, and to really understand matters and get a feel for what they might want to ask more probing questions about. However, there is always work to be done on the calibre of the non-executives whom we recruit and on how we support them.

Colin Beattie: How do you monitor the effectiveness of the non-executives?

Caroline Lamb: "The Blueprint for Good Governance in NHS Scotland" has a number of aspects, one of which relates to assessment of the performance of non-executives. That is a role for the chair of the board. I do an annual appraisal interview with board chairs in which I pick up with them how comfortable they are and how they review the performance of their own non-executive members.

Colin Beattie: Where are you with implementation of the revised edition of "The Blueprint for Good Governance in NHS Scotland"?

Caroline Lamb: I will look to Richard McCallum to ensure that I get this right. All boards have completed their self-assessments against "The Blueprint for Good Governance in NHS Scotland" and I believe that all of them—if not all, then nearly all—have developed action plans and responses. There have been conversations in the chairs group about sharing themes from the action plans so that boards can learn from one another's experiences.

Am I being accurate, Richard?

Richard McCallum: Yes. The revised blueprint was published in November 2022, and boards

were expected to take that work forward and use it as the basis for their governance arrangements.

As the Audit Scotland report references, a self-assessment process, which started in March this year, has taken place. All boards have undertaken self-assessments. From our perspective, the review of those self-assessments and the verification that will be done around them will be critical.

09:45

We have started to roll out a process to review and scrutinise the returns. As Caroline Lamb said, that is drawing out some of the key governance themes that boards need to consider.

Colin Beattie: If the revised blueprint was published in November 2022, why was it March 2024 before any action was taken?

Richard McCallum: To be clear, I note that it is not the case that no action was taken after publication of the blueprint. As I have said, boards were expected to work within the framework of that blueprint and, indeed, the previous version of it. The self-assessments that were undertaken this year were supplementary to the work that we would have expected boards to be doing anyway as part of implementation of the blueprint from November 2022.

Colin Beattie: Have the boards come up with significant areas for improvement?

Richard McCallum: As Caroline Lamb said, there are a number of areas in which things are operating well, but there are also areas that boards have recognised need to be strengthened. One example is review and understanding of financial reports. They have identified a range of things. Boards will undertake self-assessment next year: we expect that significant work will have been undertaken over the course of this year to embed the points that have been identified for improvement.

Colin Beattie: I will touch on your point about ability to read financial reports. I would have expected that a non-executive would have certain basic skills, including being able to read a balance sheet, for example. What are the base skills that you would expect a non-executive director to have? I realise that when someone comes to the NHS as a non-exec there are certain peculiarities that they would have to get their heads around, which is why they need training and development in order to be most effective in that environment. However, there must be base skills that you would look for that would ensure that they are able to cope with the role.

Caroline Lamb: Absolutely. For non-executive roles, we would look for candidates who understand good governance and—especially in the NHS—the criticality of financial balance. They would also need an understanding of risk and the board's role in overseeing and managing risk across the domains of financial balance, performance, staff governance and clinical governance. They should have some experience of engaging with partners, given that the relationships between boards and their local authority partners are pivotal to how integration joint boards and social care services function.

As I have said, sometimes we will look for particular skills and expertise, such as public engagement skills, communication skills or experience with big capital projects. The boards will assess where they need to be strengthened. However, experience in basic governance processes for large and complex organisations will be at the core of our requirements.

You mentioned that we should be able to expect someone to read a balance sheet. Understanding the complexity of the NHS and the links between financial balance, performance, clinical governance and staff governance is very important, because the board plays an important role in ensuring that we balance those domains.

Colin Beattie: The support that the Scottish Government should be giving to address the challenges in recruitment at executive and board levels is key. What is being done to ensure that effective leadership development is taking place, and that succession planning, which is key, is in place across the sector?

Caroline Lamb: You are absolutely right about the importance of succession planning for non-executive roles and chairs, in particular, but also for executive posts.

Through NHS Education for Scotland, we have been running two programmes, in particular. One is the programme for aspiring chief executives, which identifies people from the health and social care systems who not only aspire to be chief executives but, through their performance, demonstrate that they have the qualities that make them able to aspire to be chief executives.

In the same way, we have been looking at our existing cohort of non-executives. Individual boards have been identifying those who have the potential to become chairs of boards, and we have been running a programme for aspiring chairs alongside that. That sits on top of our other development opportunities.

Colin Beattie: I will move to something a bit different, boards are being asked to find recurring savings of 3 per cent. How is the Scottish Government supporting boards to achieve that? At this point, it must be incredibly difficult to achieve

that; I cannot remember the last time that boards were not asked to find recurring savings.

Caroline Lamb: You are right about the challenge and, if you look back at what boards have delivered over the past few years, it is clear that the easy savings options have already been taken. Therefore, it is really important that we provide boards with support. Earlier, I referenced the 15-box grid, which is a series of measures that was agreed with chief executives, but we also have, within the Scottish Government, a finance support unit that provides tailored or more general support to NHS boards.

Richard—do you want to say more about that?

Richard McCallum: During the pandemic years, given the boards' focus on immediate service pressures, it was a challenge to make the same levels of recurring savings as they had made in past years. Three per cent is a challenging target; it is also challenging to achieve it on a recurring basis.

Two things are absolutely key. One is support, which Caroline has already referenced, including support around data. Boards have identified a lot of opportunities by comparing, between boards, data on prescribing spend and agency spend.

The other key thing is the need for space and time for boards to work through the options. Although we come up with national ideas, there will also be stuff that is relevant to local health boards, so close dialogue with all 14 territorial boards and eight national boards about the challenges that are specific to local systems is really key.

From well in advance of this financial year, we have been clear that the expectation is that they will make 3 per cent savings, so boards have had a run into that. They are not being landed with something at the start of the financial year and told, "Go away and do that". It is key not just to take that national approach, but to recognise the local challenges.

Colin Beattie: The committee has seen lots of reports on individual boards; most frequently, there is a problem with the board making recurring savings. Most of the savings seem to be one-offs that might not be repeated in a subsequent year, which is not a very comfortable situation. Sometimes, boards manage to make the savings through vacancies, which has its own issues.

How can you be sure that that 3 per cent is possible, given the experience that we have seen, board by board, and the fact that such savings do not seem to happen?

Caroline Lamb: As you have identified, that is really challenging. At the beginning of the year, we start by asking boards to submit their revenue plans, which identify the schemes that they are looking at for savings, then Richard McCallum and his team work closely with the boards to understand what is under the schemes and how confident we are of delivery.

It is fair to say that we are confident that boards will be able to deliver in some areas, but we do not have the same level of confidence about other areas. We will work with boards on things that are going on nationally that they might not have focused on locally, but which might provide opportunities, and we will look at data that shows boards where they are positioned relative to others, so that they can consider where the opportunities might be, given their local circumstances.

Richard McCallum might want to add to that by talking about the detailed work.

Richard McCallum: The point that Audit Scotland has made about financial pressure is absolutely right. We certainly accept and recognise that.

Although five territorial boards did not meet their financial targets last year, nine did and were able to make the required savings. You are right that all boards have challenges in making recurring savings. There are huge challenges, and the financial pressure that all boards face is significant, but there has been variation in financial performance. The 3 per cent target for recurring savings is tough and challenging, but if some boards can achieve it, we want all boards to achieve it. That is what our team is focused on.

Colin Beattie: The issue of vacancies is frequently discussed. Do you have a target for vacancies? Are there guidelines on what is an acceptable level or the recommended level? Is it 5 per cent? Is it 7 per cent? What are the expected savings from vacancies?

Caroline Lamb: We do not set targets on vacancies. Vacancies are for boards to manage locally, being mindful of their particular services and the areas that they need to staff. When boards have vacancies, there is clearly a risk that they will start to overspend on agency staff, so we have been doing a lot of work relating to spend on agency and locum staff. A board that is able to manage its vacancies within its establishment, perhaps through use of its bank staff, is clearly in a different position from a board with vacancies that spends additional funds at premium rates for agency and locum staff.

Colin Beattie: I am thinking of expensive vacancies, such as consultant vacancies, because greater savings could be made by sliding the marker a bit further into the future.

Caroline Lamb: That goes back to what I said about the need to balance financial performance with delivery of services to patients, because we must ensure that we have the staffing levels that we need in order to deliver services without having to resort to expensive locum staff.

Colin Beattie: My final question is about the three-horizons reform planning hierarchy. What progress has been made on the wider programme of reform that aims to improve sustainability and prioritise outcomes?

Caroline Lamb: I think that you are referring to what Audit Scotland said about horizon 1 being about sustainability and value in the immediate term, horizon 2 being about what we call choices—the things that we need to look at nationally—and horizon 3 being about reform and change. The work that the Cabinet Secretary for Health and Social Care signalled about the overall reform programme is an important element of that, as we start to look at how we can deliver services differently, because—as everybody has identified—health services spend a lot of money but are still under significant pressure from rising demand. In the reform and change programme, we need to look at measures to reduce demand through improving population health and through earlier intervention.

There is a lot of short-term action in that regard, particularly the measures that we have taken using NHS 24 and flow navigation centres to try to reduce demand at the front door—accident and emergency departments in hospitals. The longer-term reform involves our looking at how we can best provide services in a way that fully implements our national clinical strategy.

Colin Beattie: Thank you.

The Convener: The deputy convener has questions on a number of areas.

10:00

Jamie Greene (West Scotland) (Con): A very good morning to you. I will see if my voice lasts; I will try my best. As you can probably hear, I am recovering from illness, including Covid.

I thought that I would share a little story with you, because it is probably indicative of a situation that many people in Scotland have found themselves in. When I was unwell, I made the decision to call 111 for assistance, in line with the advice. I picked up the phone at 8 pm, and—I know this because I have just checked the data on my mobile phone—I spent two hours and 24 minutes trying to speak to somebody. The call was not answered for an hour and 12 minutes and I was in a waiting queue along, I presume, with many other people. I expect that many of those people simply hung up, but I hung in there as best I could.

When the call was answered, it was dealt with by a operator who was not medically trained, but who did their best to assist. The outcome of that two-and-a-half-hour phone call was simply this: “If you feel really bad, go to the hospital, or we’ll get an out-of-hours GP to call you back.” I said, “Yes, please.” The out-of-hours general practitioner eventually called me back at 2 o’clock in the morning—some six and a half hours after I first called. The outcome of that conversation was to be told, “If you feel really bad, phone an ambulance or get yourself to hospital; otherwise, call your GP in the morning.” I duly did that.

The third and final part of my story is that I called the GP at 3 minutes past 8 that same morning and was told that there were no appointments left, because it was 3 minutes past 8. I was told—guess where this is going—to call 111 or, if I felt really unwell, to get myself to hospital.

I suspect that that is an experience that is shared by many people. Does that really sound like an NHS that is working for people?

Caroline Lamb: The first thing that I will say is that I am really sorry that you had that experience. It is not an experience that we want anyone to have. As I said earlier, we have been investing in NHS 24 in a number of ways. Were you offered a call back at any point?

Jamie Greene: Yes—I was called back at 2 in the morning. I have to say that all the people whom I spoke to were lovely. I am really grateful to every one of them: it was clear that they were all really overworked and were doing their best.

However, I think that you get the gist of my point. People end up in a vicious circle in which the only option is to present to A and E, and we all know the problems that A and E departments are facing.

Caroline Lamb: Absolutely. Again, I am really sorry to hear about the experience that you had, because we absolutely do not want people to go down multiple routes only to end up back at the same place.

Obviously, we monitor the performance of NHS 24 and are aware that, at particular peak times, people have to wait longer than necessary. We continue to work with NHS 24 to do more. That includes looking at how it can put in place mechanisms that mean that people do not have to wait on the phone and can be called back.

We have also been working with NHS 24 on its online information, so that people can work through something that is not quite an app, but which is like an app in that it offers decision points.

However, I appreciate that that is not for everybody, and that it does not cover every health concern.

John—do you want to say anything about NHS 24 and the work that we are doing with it around access?

John Burns (NHS Scotland): Yes—thank you, Caroline.

The points that you have made cause me to reflect on how we are developing our flow navigation centres and the link from NHS 24 to local systems. We want NHS 24 to be able to refer people, through a flow navigation centre, to a local system—if it feels that that is appropriate—where clinicians can engage with the caller and determine what care would be best for them.

We have much more work to do in developing our flow navigation. There are some very good examples across Scotland, and we want to build on those good examples. We will not, because of scale and size, be able to replicate everything in every locality, but we want to make sure that we have a strong core of flow navigation. I am continuing to work with my team on how we might go beyond the current redesign of urgent care and develop it further over the coming months, as we look forward to next winter.

A ring-back system has been introduced so that people do not have to wait, and the data shows that more and more people are using that option.

Jamie Greene: Here is the problem: the situation that I found myself in was not an accident or, indeed, an emergency. Many people will present at hospital simply because there is no other option available to them, and that is adding a huge amount of pressure to our accident and emergency departments.

There is a situation, when someone has taken unwell, that falls outside a regular GP visit or appointment but in relation to which, between 3 minutes past 8 in the morning and 8 o'clock the following morning, there is simply no option other than to spend three hours on the phone to 111 and not achieve anything, or to turn up at hospital. That is my point. The system feels broken, and there are thousands of people out there who feel the same way.

Are we looking at this in the right way? Is there any fresh or blue-sky thinking about how we deal with people who want to speak to a clinician as quickly as possible but do not want to burden the hospital system and absolutely cannot get an appointment with their GP, sometimes for weeks on end? There has to be a middle ground somewhere, and it does not sound as though there is one.

Caroline Lamb: I agree with you. Our intention is that NHS 24 on 111 should be that middle ground. We have ambitions for that. As John Burns said, we need to enhance the way in which our flow navigation centres work so that NHS 24 is able to link someone who just needs to speak to a clinician quickly to those systems.

The results from the flow navigation system in Glasgow have been really impressive in terms of the proportion of calls that it is able to deal with through somebody being able to speak to a clinician. It is still necessary to advise some people to physically attend the emergency department, but at least that is a considered judgment.

Again, I am sorry that you had the experience that you had. We continue to work with every bit of the system to try to improve the situation. Our overriding ambition is for only those people who really need to present at A and E to do so. There are other options around minor injuries departments, but we also need to ensure that the provision and signposting for that are better than they are at the moment.

Jamie Greene: Where are we at with A and E at the moment? There has been a lot of discussion recently about how long people have to wait once they get to A and E. There is a four-hour waiting time target, which I believe means that 95 per cent of people should be admitted, discharged or transferred for treatment within four hours of presenting. What is the current statistic?

Caroline Lamb: I am going to get confused with management information here, but, in terms of published information, we have been consistently running—

John Burns: It has been mid-60s to high-60s.

Jamie Greene: So the current performance rate is about 65 to 70 per cent.

John Burns: Yes.

Jamie Greene: It has dropped since September 2023, when it was sitting at above 70 per cent, and it has dropped considerably since September 2018, when it was 92 per cent—in fact, you almost made the target. However, we are now saying that two in three people will not be seen within four hours. Is that right?

Caroline Lamb: Those are the figures. Our performance is well below where we would want it to be. When we compare the current figures with September's figures, we need to be a bit careful, because we are still coming out of the winter. I know that it is June, even though the weather does not feel like it.

If we compare our position at the moment with where we were pre-pandemic, there are a number

of challenges. One is the impact of the pandemic and the fact that we have Covid in our system, which is still having an impact in terms of staff absence and having to close wards and deal with the infection prevention and control issues. The second element is that our hospitals are much fuller than they were pre-pandemic. The factors that drive that are around length of stay and the number of delayed discharges—

Jamie Greene: Do not worry—I am coming to that.

Caroline Lamb: Okay—I will look forward to that. John, do you want to say anything about any of those factors—maybe length of stay, in particular?

John Burns: Yes, I can do that. The Public Health Scotland published figure for March 2024 was 67.6 per cent. That is for EDs only—

Jamie Greene: Just before you go on, that is way off target.

John Burns: Yes, it is.

Jamie Greene: That is so way off target. You are 30 percentage points off the target. What is going wrong?

Caroline Lamb: That is in common with every other part of the UK, I should add. We are not an outlier—

Jamie Greene: Yes, but I am not interested in every other part of the UK. This is the Scottish Parliament, and you are the chief executive of NHS Scotland. I mean this respectfully: I simply want to know what is going wrong in Scotland's A and Es.

John Burns: There are a number of factors that are impacting on that measure. The first is that, since the pandemic, there has been a considerable increase in the average length of stay for an emergency admission. Pre-pandemic, that was around 6.6 days, and, since the pandemic, although it varies, that averages at above seven days and sits between 7.1 and 7.5 days.

When it comes to hospital admissions, we are seeing a change in the age profile. This will come as no surprise, but, increasingly, the age profile of those who are being admitted with complex acute needs is older—we are talking about the over-80s and the over-90s. Of course, that will impact on their length of stay, as they require intensive acute care. Those are some of the factors that we are seeing. Within that, the total number of emergency admissions has fallen slightly, so it is the length of stay that is driving the occupied bed day demand.

We are working with the centre for sustainable delivery and with every health board in Scotland to look at an analysis that we have done of length of stay to see whether there are any improvements that we can work on with clinical teams across the country—we are working closely with clinical teams—to determine whether there is an ability to reduce that length of stay, which would reduce the number of bed days and improve the flow into hospital.

Therefore, we are doing two bits of work. One involves looking at long lengths of stay in hospital—stays of more than 14 days. The other involves looking at short lengths of stay—short-term assessments, which are usually up to 72 hours. We have some examples of good practice that we are looking to share across Scotland with regard to how shorter-stay admissions can be a positive outcome for patients, as a long in-patient stay is avoided.

Jamie Greene: Can I stop you there for a second? I am still trying to get my head around this. According to what you have just said, there are two reasons why we are so far under the target. Overall, you said that there were three points, but the first one is a positive—the number of emergency admissions is going down, which is good news. However, the other two points are not positives. You are saying that the age profile of people and the fact that they stay in hospital a little bit longer than they used to are the reasons why so many people are sitting in accident and emergency for eight or nine hours. I do not see the link. Please explain it to me.

John Burns: The link is that the higher number of occupied bed days—that applies across all ages, but there is a predominantly older age profile—means that our emergency beds are running at very high occupancy, as you will see in the published data. That has an impact on the ability to admit patients from A and E into an acute in-patient bed. We describe that issue as the admitted flow into hospital. We are looking to ensure that, in addition to the work that I have outlined to you, our discharge processes in hospital are effective, efficient and follow good practice. That is part of the improvements that we are making in the work that we are doing. The most straightforward way to describe it is that our focus is on reducing the occupancy of our hospitals, through a number of interventions.

Caroline Lamb: I will add to that. The performance of our A and E departments is not just about people who are waiting for beds—people who are there because a bed is not yet available for them. That situation also increases the congestion in A and E, which has an impact on the time that it takes to treat others.

Jamie Greene: Yes, but not everyone who presents at A and E will need to stay overnight or will need a bed. They simply need to be seen by somebody. Are you looking at that?

10:15

John Burns: The majority of patients who attend A and E are discharged from A and E. Around a quarter of people who attend A and E need to be admitted. That varies across the board but, on average, around a quarter need to be admitted. The majority of people who come in through the minor injuries flow, as well as an assessment flow, are managed, treated and discharged. A small but nonetheless important number—I do not want to diminish it by saying that it is small—go into our admitted pathway. That is where the issue arises that results in the A and E figure that you see. The A and E figure—I am sure that this has been discussed before—is a symptom of the system and how the system is working.

Jamie Greene: That goes back to my first question. If no other options are available, it is no surprise that people present at hospital. Therefore, the rest of the system needs to be working in order to take the pressure off. However, that is not a new problem. We have been talking about that problem in the Parliament for more than a decade—it has definitely been talked about in the Parliament for longer than I have been an MSP. Why have we not got to the bottom of that? Is it simply the case that people are getting sicker? Are there more sick people or not enough doctors? What on earth is going on? Why do we still face endless missed targets and waiting times that are going up and up?

Caroline Lamb: I think that there is an impact from the ageing demographic, people presenting with more complex needs and people being a bit sicker than they used to be. There is no doubt that there is an impact from that.

One of the things that we are looking at in order to manage demand away from A and E is a programme around frailty. There are frail elderly people for whom A and E is, frankly, not the best place for them to be. How can they be better managed back in the community?

You are right. That is a factor of pressure across the whole of our system, from primary care through our acute sector and into social care as well.

Jamie Greene: I will move on, because there is a lot to cover.

We have to talk about delayed discharge. I know that this is not a political setting, but ministers have promised to eradicate delayed discharge. That is ambitious and probably not achievable. There are targets—official and unofficial—but the statistics do not seem to bear out that progress is being made on that.

That can be analysed in a number of ways, such as by using the average number of people per month who are waiting to be discharged or the number of days that are spent in hospital by people who are ready to be discharged. I will not go into all the numbers, but where are we at with delayed discharge in Scotland at the moment? Are we making any progress at all, or are things getting worse?

Caroline Lamb: I suppose that, if you look at only the most recent public statistics, you will see that they do not paint a very pretty picture. The Public Health Scotland statistics from April 2024 had delays that added up to 57,433 days. That was up 12 per cent compared with the figure in April 2023, and it is around 40 per cent more than what we sat at pre-pandemic. That is an indication of what John Burns and I were saying about how full our hospitals are. The median length of delay has also gone up. That is a very uncomfortable statistic, not least because there are people behind that. People are being cared for in the wrong place—a place that will not be the best place for them to be.

We continue to work incredibly hard with our partners in local government and through integration joint boards to see what more can be done to improve delayed discharges. A couple of bits of work are currently under way. One involves looking at what further improvements can be made to discharge processes in the acute sector, and social care staff knowing when somebody is due to be discharged and therefore being in a position to be ready to accommodate them. That builds on work that has been on-going for some time.

We have made huge strides on data in that area. In the autumn, we launched a data dashboard that gives local systems—health and social care partnerships, health boards and local government—access to data on social care provision and the number of delays in their area. Being able to make comparisons with other areas means that we are able to identify areas with similar demographics that might be doing better.

We are focused on continual improvement, given that we recognise that there is not a heap of extra money to invest in the system.

Jamie Greene: There is not continual improvement; it is continually getting worse.

Caroline Lamb: It may well be. We have to balance the increasing pressures on the system against increasing efforts and finding new ways to improve things. All of that is incremental.

The second area that we are looking at is particular types of delays, especially in relation to adults with incapacity, who tend to be delayed for longer because of some of the legal processes that need to be gone through. Those people are

among the most vulnerable in society. If anything, we need to be able to expedite their discharge into more appropriate settings.

There is a broader consultation, but work is going on under the existing legislation on what can be done to expedite getting more consistency from lawyers across local authorities in how they deal with that, and to be able to work closely with families to get those people into a place that is much more suitable for them, which releases capacity.

Jamie Greene: I appreciate that update.

The problem with delayed discharge, or bed blocking, as it is commonly called, is that it is exactly that—it is bed blocking. I presume that that is bad for two reasons. The person who is languishing in hospital, who should not or does not need to be there, would rather be, and should be, somewhere else, wherever that is. Equally, there is someone at the other end of the spectrum who could be occupying that bed but is on a waiting list—and we all know what waiting lists look like at the moment.

It seems to me that half of the job is yours, and you are doing your best, but the other half of the solution is not working, because you cannot discharge people if you have nowhere to put them and there is no plan in place to look after them. You have a duty of care to look after your patients, and you would not want to send them out to their homes with no care package and with nobody to look after them, so you keep them—I understand that.

Is that your mitigation? Are you saying, "We've done as much as we can, but local authorities haven't got the money to look after folks, so we have to keep them."?

Caroline Lamb: We literally cannot afford to be in that position, because keeping people in acute beds is more expensive. That is not only not right for them; it is more expensive. That is part of the overall financial challenge.

We are not in a world of saying, "We've done all we can do," and throwing up our hands and saying, "It is over to you." There is always more that we can do to break down the barriers between health professionals and social care professionals. It will commonly be found that health professionals are a bit more risk averse when it comes to discharging people and that, typically, if they assess somebody in a hospital environment, they will assess them as needing more care and support than if they were to assess them in their home environment, which is more comfortable and familiar. There are things that we need to do on that.

The cabinet secretary and Councillor Kelly, who is the Convention of Scottish Local Authorities spokesman, jointly convene a weekly meeting with system leaders to look at the data and what progress is being made, and to identify any other areas in which we can take more action.

Jamie Greene: Mr McCallum, this must make for very uncomfortable listening. You are director of health and social care. We have heard from health professionals what the issue is. They cannot get people out of hospital because the social care system is not delivering, but people in the social care system will say, "There are simply far too many people being put into our system and we haven't got the money to deliver the care." From a holistic point of view, have you got this all wrong?

Richard McCallum: No, I do not think that we have got this all wrong. I should say that Caroline is also the director general for health and social care.

Jamie Greene: I was trying to let you off the hook a little bit there, but okay.

Richard McCallum: I recognise that this is not just an NHS challenge; it is a whole-system challenge. It is about ensuring that the right funding flows are in place. Actually, the key role of integration authorities is to ensure that the funding that is available, whether in the NHS or social care, is allocated in the right way and in the best way possible. Yes, it is a huge challenge. We have talked about the NHS being under pressure, as the Audit Scotland report sets out, but we have to see the issue absolutely in the round, as you say.

Jamie Greene: Anybody who speaks to local authorities will know that they are really struggling. For example, there are simply not enough places in care homes and there are not enough staff to treat people in their own homes. Frankly, when someone is in a hospital environment, that is not seen as the local authorities' problem; it is the NHS's problem. There does not seem to be any joined-up thinking. I appreciate what you say about integration boards but, for far too many people, the system is simply not working. If it was working, we would not have so many people in delayed discharge or struggling to get a place in a care home, and we would not have so many people having to pay to go private.

Do you admit that there is an issue? Given the numbers that we have just spoken about and that things are getting worse, not better, it sounds a bit like an emergency that we need to deal with.

Caroline Lamb: I would not say that any of us is comfortable with the current position. The Scottish Government provided funding to support the increase in social care wages up to £12 an hour to try to help with some of the challenges

around the workforce, which we understand exist in many areas of Scotland. We have also provided support to employers to look to become visa sponsors to try to attract more workers from overseas, although there have been changes to the visa arrangements of late that have not been helpful in that respect.

The other thing that I would say is that it is not a universally bleak picture across Scotland. If you look at the delays per 100,000 of population, you find that some systems perform incredibly well and others are much more challenged. The work that the cabinet secretary is doing with Councillor Kelly, and the leadership that they have provided, is about trying to challenge in relation to what makes some systems perform well and in a way that is really good for people, while other systems are much more challenged. The data has been absolutely critical to all of that.

Jamie Greene: I can tell you that, anecdotally, when I speak to care homes, workforce is the issue, and getting staff is part of the problem.

On people, which is my final topic, where are we at with head count? Let us look at three statistics. First, let us look at the total head count in the NHS now in comparison with the number in the past couple of years. Just to give you a heads up, secondly, I will ask about the sickness absence rates in the workforce and, thirdly, I will look at turnover rates. What statistics do you have to share with us on those three issues?

Caroline Lamb: Let me just—

Jamie Greene: I ask because the data that I have is from the Audit Scotland report, which is from September 2023, so you may have something more up to date.

Caroline Lamb: The most recent data that we have, which is up to March 2024, is that we are at a head count of 187,157 in NHS staffing.

I am sorry, but I am just trying to pull out the data.

In the past quarter, vacancies in nursing and midwifery have dropped to 3,382. Medical and dental consultant vacancies are up slightly, by 11, to 447, and allied health professional vacancies have come down by 14 per cent, to 664. Am I reading the right stuff, Richard?

Richard McCallum: Yes.

Caroline Lamb: Do you want me to move on to staff absences, Mr Greene?

Jamie Greene: Yes, please.

Caroline Lamb: I think that the latest figures that we have for staff absences are for 2022-23, so that—

Jamie Greene: It is 6.2 per cent.

Caroline Lamb: Yes, it is 6.2 per cent, so that is the same as the Audit Scotland figure.

Turnover has risen. The overall turnover rate that I have is 9.4 per cent, which is the 2022-23 figure.

10:30

Jamie Greene: If and when you discover that newer data is available, please share it with us. We are looking for trends, as we often do, and we want to interrogate that information.

It looks as though the overall head count is on the rise. The figure of 187,000 is up from 183,000 last September. People will say that there are far more people in the NHS than there were before, yet everything that we have discussed—such as waiting times, delayed discharges and staff shortages—is still happening. There are more people in the system, and the Government is spending more money on it, but outcomes are poor. My question is: why is that the case?

Caroline Lamb: We need to examine the workforce statistics. We have been doing work to interrogate those and to understand the areas in which we have seen increases. For example, following the Covid pandemic, there has been a considerable increase in the vaccination workforce, which would not have had any impact on waiting times. We are also doing work on productivity to understand the factors that influence that. You are right to say that, on the face of it, it looks as though we should be able to do more.

Our earlier discussion about delayed discharges is also relevant here, because many of our boards open up surge capacity during the winter in order to deal with increased occupancy levels. The shutting down of surge aspects all has to be staffed as well, which boards find difficult.

Jamie Greene: On sickness, anyone who speaks to people who work in the NHS will tell you that they are super stressed. In the past couple of weeks, campaigning members of the Parliament have had the luxury of chapping on people's doors, probably much to their annoyance. Frequently, we have heard that many NHS staff are considering leaving the profession altogether. Absence due to stress and long-term health issues seems to be a problem. I appreciate that people get acutely sick—we all get sick, including NHS staff—and some people get Covid. However, I want to understand the underlying absence levels due to long-term illness. What is the trajectory on those? What are you doing to support people who work in our NHS?

Caroline Lamb: I absolutely appreciate that, in some of our services—we have talked about A and E, for example—the pressures are intense. However, they are not absolutely the same across all services. The results from our iMatter staff survey are pretty positive, and I would be very happy to provide the committee with a read-out of those. That is not to diminish the fact that we know that we need to work with our boards to tackle sickness absence levels.

Following the pre-election period, we will publish our improving wellbeing and workforce culture framework, which will set out actions for the Scottish Government and boards to implement on improving cultures in the workforce and supporting people to stay at work.

We have also been working with human resources directors across NHS boards to agree the further measures that we need to put into managing sickness absences and supporting people to come back to work, not least because of the pressure that high absence levels place on additional staff in the system.

Jamie Greene: I have a final question. How much is being spent on agency staff?

Caroline Lamb: I am sorry; I am searching for that figure among my papers.

Jamie Greene: I have some numbers. That is in the hundreds of millions of pounds. It is a lot of money, and having agency staff is way more expensive than having full-time equivalent staff. There is all this talk about privatising the health service. You are already privatising it if you are outsourcing work to agencies that charge hundreds of pounds per hour.

Caroline Lamb: I absolutely agree that some of the surcharges and premium-rate agency charges are completely unacceptable. We have moved away from boards using any off-framework contracts, and that is starting to cut down on the absolutely premium rates that we have seen.

We have also been working closely with boards on the extent to which they can use their own staff banks. That has the benefit of using people who already work in board areas and who understand what is happening there. We know that that is much safer for patients than bringing in staff from elsewhere.

We have an on-going programme of work with boards to bring down such spend on nursing agency staff and medical and dental locums.

Jamie Greene: Do not even start me on dentistry—otherwise, we will be here all day.

I will park my question on digital records, in case others want to come in.

The Convener: Thank you. We are coming towards the end of our session, but we want to ask a few questions about estate management and where we are on capital expenditure.

There is a pause on capital investment, is there not? Will you describe what that means for the overall state of the NHS estate? Secondly, will you answer with particular reference to where we are with the national treatment centres, which were proffered as part of the solution to some of the things that we have spoken about this morning?

Caroline Lamb: I will start with the national treatment centres and then Richard McCallum can tell you a bit more about the work that we are doing on an infrastructure plan.

As you have referenced, given the overall constraints on the capital budget in the Scottish Government, we have had to pause development on a number of the national treatment centres. We expect that the Forth Valley treatment centre and the Golden Jubilee phase 2 will come into operation this year. Alongside the national treatment centres that we have already opened, they will provide additional procedures.

However, even had we been able to continue with the national treatment centres, they would not have been open particularly quickly, so we have been looking at what we can do within the existing estate to tackle some of the waiting list issues. We have already committed the first £30 million out of a planned £100 million investment; that has been targeted at some of our longer waits. John Burns can talk more about the detail of how we are spending that money but, basically, it has been spent on increasing capacity through such things as extra sessions within our existing estate, making use of theatre capacity that is already available to us, and using mobile units.

On the broader question of where we want to go and how we are planning for that NHS infrastructure, I ask Richard McCallum to say something about the work that he has been doing with boards.

Richard McCallum: There are two points on that. First, I think that Alyson Stafford has written to the committee in the past week or so about the overall infrastructure investment plan. It is key to look at capital—more so than with revenue—on a whole-Scottish-Government basis, because there are key capital projects outside health that need to be looked at in the round. We recognise that point, and the importance of the capital investment plan in health being part of the wider infrastructure investment pipeline.

Rather than NHS boards seeing capital and infrastructure as a single thing, we have asked them to look at that as part of their wider whole-system plan and to plan on a population health

basis. We know that there are movements in the population, so we have asked them to look ahead 30 or 50 years and consider what infrastructure they will need to support those population changes, taking into account all the digital points that we have discussed this morning. We expect those plans to come back from boards over the course of this year.

On the wider point about the existing estate, we typically spend in the region of £300 million to £400 million on investment in the portfolio. About half of that tends to be new investments. We have talked about the treatment centres and one or two other projects. The other half tends to be on the maintenance of the existing estate, such as equipment replacement and some of the upgrades that we need. That is based on and targeted specifically at the maintenance backlog in the system.

The Convener: There is a considerable backlog of maintenance, as highlighted in the Audit Scotland report. What are the Scottish Government's plans to address that?

Richard McCallum: As I said, our key endeavour in the portfolio envelope that we have is to target as much as possible towards equipment replacement and backlog maintenance. Backlog maintenance is categorised as low, moderate, significant or high. Clearly, we focus attention on the areas that we consider significant or high.

The building of new facilities—for example, the work that is under way in Grampian on the Baird family hospital and ANCHOR, which is the Aberdeen and north centre for haematology, oncology and radiotherapy—helps as well, in addressing the backlog in the system because, clearly, those new facilities will supersede what is there.

There is an on-going focus on backlog maintenance. We use our existing envelope to target those areas—that is where the focus is.

The Convener: Does that include consideration of RAAC, or reinforced autoclaved aerated concrete?

Richard McCallum: Yes, it absolutely does. We recognise the impact of the discussions and the risks that lay elsewhere in the wider estate, so we commissioned NHS Scotland Assure—our technical experts not just on infrastructure and the estate but on looking at things from the point of view of clinical infection prevention and control—to look at more than 500 of our properties. It has carried out that work and we will go back to 20 to 30 areas to give those further attention and do further work.

In the returns that we have had from NHS Scotland Assure, we do not see any immediate patient safety risk. A number of the areas that it has addressed are in facilities that do not directly impact on patients, but we are working closely with it and the health boards to make sure that that work is taken to completion.

It has been a full process. All of that is published on the NHS Scotland Assure website, where the committee can see the work that has been done and the facilities that NHS Scotland Assure has looked at.

The Convener: Thanks for that. We would be interested in being sent the link, so that we can look at that work.

One other thing of interest is the asset management and capital investment strategy, which I think is due for publication. Has it been published? Is there a date for its publication?

Richard McCallum: That capital plan was the subject of a recommendation from Audit Scotland. Caroline Lamb has raised points about needing to see that infrastructure and asset plan within the context of the wider Scottish Government position. Given that the UK-wide capital spending review ran only until the current financial year, the plan from our colleagues in the Scottish exchequer is to publish the infrastructure investment plan later in the year. Given the criticality of understanding that position, as I have said, we will look to align our publication with that IIP.

The Convener: Okay. I will ask one final question. Last year, we had a discussion about the national treatment centres, their costs, why they had gone over time—why they were being delayed—and so on. You wrote back, director general, on 22 July last year, explaining that the "original plan" was to open up six centres by 2021, at a cost of £200 million of public money. You also appended a table setting out details of seven centres that were yet to be completed, which had an estimated cost of £827 million. Why was there such a huge increase in the costs that were budgeted for the building of those treatment centres?

Caroline Lamb: I am sure that Richard McCallum can give you more detail but, in principle, the areas that have led to a very significant increase in costs for capital build in healthcare are things such as changing standards in relation to space, infection control and ventilation, plus net zero and inflation. Building construction inflation has run way ahead of what we anticipated. Have I missed anything, Richard?

10:45

Richard McCallum: No, those are the key points.

Even in the relatively recent past—the past four or five years—infrastructure inflation has significantly outstripped wider inflation. In addition, largely, and rightly, the importance of infection prevention and control measures has significantly increased the footprint of hospitals and planned treatment centres. That has been a big driver of that significant increase in cost.

The Convener: You mentioned general levels of inflation, which have been high in the past couple of years, although they have come down a bit more recently. However, we are talking about an increase of 400 per cent, and more, in the expected cost of the construction of seven of those national treatment centres, are we not?

Caroline Lamb: As Richard McCallum said, construction inflation is a big element of that, but there is also an increase in the size of hospitals. The facilities are much bigger than those that we would have built 10 years ago for the same sort of activity.

The Convener: So what is the current estimate of costs for those seven treatment centres?

Richard McCallum: For the two that are due for completion, which Caroline Lamb mentioned, we have previously shared figures. For Forth Valley, it was £11.1 million. There may be a slight increase in that because of the inflationary pressures that we mentioned. For the Golden Jubilee phase 2, the figure of £82.5 million was previously shared with the committee.

How you break down the additional national treatment centres depends a bit, because I think that those two were included in the seven. Given the pause that there has been with the remaining five, we still think that those will be in excess of £700 million; however, the plan needs to take into account the fact that, because we have paused those programmes at the moment, those full business cases are not developed. Once they are, we can give you an update on the relevant cost estimates.

The Convener: But is your cost estimate likely to break the £1 billion barrier?

Caroline Lamb: We would need to wait until we saw the final business cases.

The Convener: But that would not be impossible, would it? Given that it has gone from £200 million to £827 million, we can easily see how it could continue to rise.

Caroline Lamb: It would not be impossible.

The Convener: On that note, I will draw this morning's session to a close. Caroline Lamb, I thank you for answering the questions that we have put to you. John Burns and Richard McCallum, I thank you, too, for your input.

There were a couple of areas that we did not quite get to, so we might write to you with some follow-up questions. You have also committed to giving us some information that you were not able to provide in oral evidence this morning.

I thank you very much indeed, and I draw the public part of this morning's committee session to a close.

10:48

Meeting continued in private until 11:25.

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