OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

Public Audit Committee

Wednesday 18 February 2026

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 18 February 2026

CONTENTS

PUBLIC AUDIT COMMITTEE
7th Meeting 2026, 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)
Derek Grieve (Scottish Government)
Caroline Lamb (Scottish Government)
Stuart Nugent (Audit Scotland)
Michael Oliphant (Audit Scotland)

CLERK TO THE COMMITTEE

Claire Menzies

LOCATION

The Alexander Fleming Room (CR3)

Scottish Parliament

Public Audit Committee

Wednesday 18 February 2026

[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 seventh meeting in 2026 of the Public Audit Committee. Our first agenda item is for the committee to consider whether to take items 4 to 8 in private. Do members agree to take those items in private?

Members *indicated agreement*.

"Delayed discharges: A symptom of the challenges facing health and social care" and "Community health and social care: Performance 2025"

The Convener: The first item of public business for us is consideration of two reports: primarily the Accounts Commission and Audit Scotland report entitled "Delayed discharges: A symptom of the challenges facing health and social care", along with a briefing note, which is also a joint production by the Accounts Commission and Audit Scotland, entitled "Community health and social care: Performance 2025".

I am very pleased that we are joined this morning by Caroline Lamb, who is director general for health and social care and chief executive of NHS Scotland, and Derek Grieve, who is director of health and social care performance and delivery for the Scottish Government.

We have some questions to put to you on the report and the briefing note, but before we get to those questions I invite the director general to give an opening statement.

Caroline Lamb (Scottish Government): Thank you, convener. I welcome Audit Scotland's report on delayed discharge and the briefing note on community health and social care performance. My team and I have carefully reviewed the reports and the recommendations that have been made.

The Scottish Government shares the view that, despite the hard work that we have undertaken with the Convention of Scottish Local Authorities, health boards, and health and social care partnerships, more must be done to ensure that people receive the care that they need, in the right place and at the right time. We agree with Audit Scotland that delayed discharges have a detrimental impact, most importantly on the people who are affected by those delays, but also on the wider health system. We also agree that delays are a symptom of the many challenges that the health and social care system faces.

As the committee will be aware, the delivery of social care support is the statutory responsibility of local government, and we have been working with COSLA and local systems through the collaborative response and assurance group to explore the challenges in that area; to ensure that there is common understanding of the impact; and to look at good practice and improvement.

The recommendations in the delayed discharge report are complex, in particular those around performance, cost modelling and evaluation. Addressing them will require careful, whole-

system thinking, especially given the different approaches to the integration of service delivery across Scotland and the different systems and processes in play across the country. Ministers have asked the collaborative response and assurance group, which they co-chair with COSLA, to consider all those recommendations and to develop a partnership approach to addressing them.

Alongside that work, local systems continue to work hard to share best practice, to reduce delays and to deliver on the commitments in the "NHS Scotland Operational Improvement Plan". Despite the challenges that the report sets out, some areas have delivered improvements through a whole-system approach.

The community health and social care performance briefing reinforces the need for stronger, more consistent performance information as an essential foundation to improving outcomes across health, community health and social care. Once again, we agree with that, and we will continue to work with partners across the system, building on the work that we have already taken forward, to provide the whole-system pressure dashboard. That work recognises how important it is that every part of the system can see how their performance compares with that of others in order to identify areas for improvement. It also enables different services to see their performance as part of the whole system, helping to drive shared accountability and a common understanding of risk.

We will be very happy to answer the committee's questions.

The Convener: Thank you very much indeed. I begin by asking you whether you accept in full the key messages, findings and recommendations of these reports.

Caroline Lamb: Yes, we accept the key messages and the recommendations. We also accept that some of those recommendations will be complex to implement, given that they require a whole-system approach. That is why ministers have taken the approach of asking the collaborative response and assurance group—I will call it CRAG from now on, if that is okay—to work to ensure that a whole-system approach is taken to implementing those recommendations.

The Convener: As I mentioned at the start, you are the chief executive of NHS Scotland, so you must be concerned—must you not?—when you see figures such as

"11.7 per cent of hospital beds being unnecessarily occupied"

by people because of delayed discharge. That is 720,000 days that are lost because of delayed discharge, and two thirds of those delays involve people over the age of 75. What is your response to that?

Caroline Lamb: First of all, yes—I am very concerned by those figures. I am concerned because of the impact that delayed discharge has on individuals; we know how bad it is for people to be in hospital in an acute bed, in particular when they are there for longer than they need to be. We know that that leads to deconditioning, and that the longer people spend in hospital, the more care and support they are likely to need when they get home. I am concerned, from the perspective of those individuals, about wanting to ensure that they can get back into a homely environment as soon as possible.

However, there is also no doubt that the levels of our hospital beds that are occupied by people who do not have a clinical need to be in them has an impact on how the whole system operates. That is why we have focused not only on a whole-system approach, bringing all the partners to the table through CRAG to examine where things are working well and how systems can learn from each other, but on things we can do within the national health service. For example, we look at what we can do within the NHS to ensure that people are not admitted to our hospitals unless they absolutely need to be and that, if they are admitted, their stay is as short as possible. We aim to do everything that we can, working with partners, to ensure that, from the moment someone arrives in hospital, we are planning for the time when they can be discharged.

It is important to remember that 97 per cent of discharges happen without delay, but also to acknowledge the impact that delayed discharge has on those people who are delayed, as individuals, and on the way in which the whole system works.

The Convener: You have mentioned a whole-system approach a couple of times. In the report, exhibit 3 sets out the areas where there are contributory factors to this systematic failure. It talks about "financial pressures" but also makes the observation—it is the Accounts Commission and Audit Scotland making this observation—that "governance is complicated", and that, while we have "an ageing population", there

"is a lack of planning for the future housing needs of an ageing population".

The report also highlights something that we have discussed repeatedly over the past few years, which is our workforce shortages, not just in the national health service but in social care in particular. Could you explain to us how you are addressing each of those challenge areas that are identified in the report?

Caroline Lamb: I am happy to do that. If we take the first area, which is the financial challenge, there is absolutely no doubt that there is a financial challenge across both health and social care services, and that we need to redesign systems and make sure that we are working, and using every penny that is provided to us from the public purse, as effectively as possible.

In our "Health & Social Care Service Renewal Framework 2025-2035" and "Scotland's Population Health Framework 2025-2035" documents, which were both published in June last year, we very much set out the progress that we need to make around moving the focus of our systems towards prevention and early intervention, which is when those interventions are cheaper, and—in the service renewal framework in particular—needing to look at how we work differently across the system. That means looking at delivering more activity in primary care and in the community—again, away from the most expensive sectors, such as acute hospitals—along with a focus on digital and on how boards work better together on a collaborative basis. The committee will be aware that we have recently published ministerial directions around subnational planning. All of that is about tackling the financial pressures, in particular—understandably—from a health perspective.

With regard to governance, we accept that organisations play many different roles. The national health service has its role to play; local government still has statutory responsibility and has a role to play; and there are the integration authorities that seek to join those areas up. In addition, Audit Scotland referred to the important role of the third sector and the independent sector—that is important, too.

That is complex, and those relationships work best when they work really well locally. Certainly, from my perspective as chief executive of the NHS, having our chief officers sitting at the executive tables in our NHS boards and, therefore, being part of understanding the totality of system pressures and their contribution towards meeting those, and where they can make a larger contribution, has been key to that.

We have an ageing population—that is not going to change. It is important, therefore, for us to look at how we can deal with the demands of that ageing population in the way that is most appropriate to it and which helps the functioning of the system. I would point to areas such as frailty units at the front door and the success that some of those initiatives are having in reducing the length of stay. Our primary objective is to prevent that elderly population from needing to be admitted to hospital in the first place, but, where they are admitted, we are trying to ensure that they can get home as early as possible.

With regard to the workforce, there are challenges around international recruitment in particular. We were making good progress on international recruitment; that has obviously been made more difficult by decisions at a United Kingdom Government level. That said, the most recent Scottish Social Services Council workforce report, which looked at the workforce as at 2024, shows an increase of around 6.36 per cent, I think, in the care home and care-at-home workforce from 2015, and a smaller increase—but still an increase—of 1.4 per cent between 2023 and 2024.

We have more recent statistics available to us on the NHS workforce. The latest quarterly report, as at December, shows a small increase in that workforce now. There will continue to be pressures and we need to focus on not only how we continue to attract and retain people in our workforce, but how we look to design our services and look to use digital so that we are focusing our workforce on the jobs that only people can do.

I think that your final point was on housing. We absolutely recognise that pressure, and the committee will be aware of the moves that the Scottish Government is currently making to try to address some of the housing issues. That includes in remote and island communities, where it is particularly difficult to attract and retain staff because of the challenges that they have in accessing housing.

Sorry—it has been a bit of a canter through all that. I am happy to pick up on any of it in a bit more detail.

The Convener: No—I recognise that it was a wide-ranging question, and well done for remembering all of those different headings that I put to you.

I have just a couple of other questions that I want to raise with you. I suppose that one of my overall points is that we have integration authorities and integration joint boards, and you are the director general of health and social care, but we are still having all these issues with delayed discharge. That is about whether we have a joined-up social care and health system, is it not? Does this report not suggest that that is not working? The integration is not working, and the plan that we have had for the past 10 years has not delivered what it was supposed to deliver.

Caroline Lamb: I think that the report acknowledges that delayed discharges are a symptom of the pressures across the system. We have just run through a number of those pressures, which are multifaceted. I do not think, therefore, that it is fair to say that integration is not

working. I think that integration has actually delivered a lot of improvements on the ground. Whether those are enough to address the challenges that we face is another question, but I think that it is still really important that we focus on what is right for the person in the middle of it all, and that is done better by looking across systems than by focusing on a single siloed system.

The Convener: Okay. I have just one particular area that I want to ask you about, which is mentioned in the report: the whole issue of power of attorney. That gets us almost into a legal area, does it not? It is about whether people have access to established power-of-attorney arrangements with their relatives or with whoever. That is seen to be one of the reasons why we have delayed discharge: because those arrangements are not in place. Could you shed a bit more light on that and perhaps explain what the Government is doing to tackle it? That seems to be one of the driving forces behind delayed discharge and people getting caught up in the system.

09:45

Caroline Lamb: That is absolutely the case with regard to the issues relating to adults with incapacity, which is how they are described in the system. Those are people who do not have the capacity to make their own decisions and for whom there is no power of attorney in place. You are absolutely right that that creates a difficult position, because local authorities then have to apply for guardianship arrangements in order to enable those decisions to be made on behalf of people. That is a complex legal process, and there are some different approaches to it and different appetites for risk around that across the country.

First, as a Government, we have recognised that we have to promote the need for people to have power of attorney in place—all of us, across the whole population—to ensure that we are prepared to deal with the eventualities that arrive in life. We have done some publicity campaigns around that; our current approach is to try to identify the impact of those, and also to identify barriers to people being able to put a power of attorney in place, particularly when it is seen as just an additional expense on top of everything else that people are dealing with.

We also need to look at the legislative route. The relevant legislation is the Adults with Incapacity (Scotland) Act 2000; the Government has been out to consultation on that and published the results of that consultation. We are now working on what the policy response would be, bearing in mind that there are some quite complex interplays with the European convention on human rights. We need to ensure that we are protecting the rights and dignity of the individual at the same time as recognising that, for most people who fall into this category, hospital is absolutely the wrong place for them to be, and we need to find a way in which we can address that.

With regard to numbers, this group of people is significant as a proportion of those who are delayed, and they tend to be delayed the longest.

Derek Grieve (Scottish Government): I will add something here if I can, convener.

Caroline Lamb is exactly right: the Scottish Government has a role in promoting the importance of power of attorney, but it would be fair to say that it is not just the Scottish Government's job. We know that the social care workforce, and also the social worker workforce, play an important role in this space because they are often the interface between the family and patients, in particular before someone reaches crisis point.

As Caroline alluded to, having families go through some of the process when there is a wider crisis in play and somebody is in hospital is really challenging, so the ability to have power of attorney in place and to support those difficult conversations with families is important. However, as Caroline rightly said, having power of attorney when one does not need it is probably the place where we want us all to be.

The Convener: As a very quick question, are people eligible for legal aid to help them to pay for that? The documents for establishment of power of attorney are not inexpensive, are they?

Caroline Lamb: No, that is right—they are not inexpensive. I will confirm this to you, convener, but my understanding is that people are eligible for that, although whether the Scottish Legal Aid Board is able to wholly meet the demand in that area is another challenge.

The Convener: It might be a Scottish Government issue as well, of course.

Caroline Lamb: Yes.

The Convener: Okay. Colin Beattie has some questions for you.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I am looking at what needs to happen with regard to delayed discharge. The Auditor General told the committee that the delayed discharge reflects a wider long-standing failure to shift the balance of care from hospitals to community settings. Since I have been on the committee, that has been the headline. Nothing has changed, and I have been sitting here for 15 years.

Malcolm Bell from the Accounts Commission told the committee:

"IJB reserves are being continually depleted, often to shore up day-to-day work"—[*Official Report, Public Audit Committee*, 21 January 2026; c 29.]

instead of doing what they should be doing, which is transforming the whole-service offering. Witnesses were clear that progress depends on clear leadership, stronger governance and firm accountability at both national and local levels, but none of that seems to have happened.

I say again: this is a repeat. The issue comes up every time that a report comes before the committee, but there is no movement. Why?

Caroline Lamb: It is fair to say that a lot of us recognise that our strategic intent has, for some time, as I said in answer to the convener's question, been to move the activity in our systems away from our acute hospitals and towards the community—towards social care and community services.

When we published the service renewal framework in June, we were clear that, although that was not a new approach, we needed to look at the concrete actions that are required to ensure that we can implement that approach. One of the first concrete actions that we have taken in that regard concerns the additional funding that is being made available to general practice in the draft budget for 2026-27, which will enable us to increase the capacity in general practice and to place an enhanced focus on the preventative role that general practice can play.

It is also important that we are able to look at the spend in its totality across both the acute sector and primary and community care. One of the most successful areas where we have seen that progress is being made, not only in reducing delayed discharges but in all the other measures that contribute towards that, such as reducing admissions and length of stay and accelerating the processes for discharge, has been NHS Lothian. That progress was achieved by some of the funding that was made available by the Scottish Government being directed by the health board towards the social care partnership. That has achieved results, so it is clear that we are starting to understand the interventions that make a difference and to see some progress, but I absolutely accept that that has not been as fast as we would want it to be.

There is only a finite pot of money, so part of what we need to do is ensure that our acute sector is functioning as productively as it can, in order that we are able to identify ways in which we can provide more support to community and social care.

Derek, do you want to come in?

Derek Grieve: I will add a couple of points.

The Audit Scotland report outlines that the operational improvement plan gives strong signals that we are seeking to shift the balance of care. That comes with additional funding, but it is being used as a means to leverage existing funding rather than being the only funding available.

Caroline Lamb gave some examples earlier, such as the development of frailty units, having hospital-at-home programmes in place and looking at a wider range of community-based interventions in order to shift the balance elsewhere from the acute system. If I can give the committee a little bit of hope in this space, I will highlight another example in addition to the example of NHS Lothian, which Caroline outlined. We have taken this to CRAG as an exemplar. We know that in NHS Forth Valley there has been an explicit decision taken to reinvest a quantum of funding from the acute services and redirect it into community care services.

We are now seeing practical examples of systems doing exactly what we are looking for, which is shifting the balance of care.

Colin Beattie: I am pleased to hear that. I understand that, from the beginning, the concept was that there would not necessarily be additional funds going into the IJBs—rather, there would be a movement of funds from secondary to primary care. That was a sticking point, of course, because nobody wants to lose any part of their budget, and it never really happened.

You have described a situation where it has happened, but it is certainly not happening in general. How are you going to stimulate progress on that and push people to actually deliver what was originally intended? It seems almost a moot point after 20 years.

Caroline Lamb: We stimulate that progress partly through sharing good practice, such as Derek Grieve described in NHS Forth Valley. There is good practice to be shared from NHS Lothian, too.

The approach through the whole-system pressure dashboard has been to give all those people who are involved in different elements of the system an overview of what is happening as a whole, so that they see their responsibility in relation to the overall performance of the system. Everybody who is working in these systems wants to do the best thing for people, and that requires having a system that is working at its optimum.

Another shift has been around leadership. Leadership is important with regard to not only focusing on the acute sector but seeing how primary care, community care and social care impact on the acute sector. In that context, I note that a significant number of our recent

appointments to chief executive posts in NHS boards have experience of working in social care, some as chief officers.

We have been developing a leadership cadre who absolutely understand the interdependencies and are interested in doing the best thing for the population and ensuring that the health board is doing its bit by doing whatever it can to keep people out of hospital in the first place. That can be through hospital at home or frailty units, or even through the work of the Scottish Ambulance Service, which is now conveying only around 50 per cent of its call-outs to hospital.

There is a whole healthcare system approach in order to ensure that people stay out of hospital and then, through work in multidisciplinary teams, to ensure that people are being discharged. There is an increasing recognition that—as Derek Grieve said—where there is money to be spent, it is better directed at the areas that can provide support to those more expensive aspects of the system. It is increasingly recognised that that is what we need to do with the money as a whole, rather than being able to do it only when additional bits of money are being made available.

Colin Beattie: You touched on leadership, which is obviously mentioned in the Auditor General's report. There are concerns about the quality of leadership and the governance and accountability. Those themes come forward again and again, but we do not seem to see any movement on them—certainly nothing that would give us confidence. How are you going to strengthen leadership, both nationally and locally, as well as the important areas of governance and accountability?

Caroline Lamb: I think that we are making progress in all of that. We have brought the whole system together to work together, starting with CRAG, which is co-chaired by ministers and Councillor Kelly, who represents COSLA. We are working with all our local systems to ensure that they have the data to understand how they are performing relative to others and, therefore, to identify the areas where they can improve. It is also about enabling them within their own systems, through our systems and the health board working closely with the IJB and health and social care partnerships. All of that is critical to each system starting to appreciate where its focus needs to be in order to improve the performance across the whole system, and to understand which areas it needs to prioritise.

Sometimes that is complex with regard to governance and people being prepared to give things up in order to achieve a better outcome for the whole. However, we are seeing areas where it has happened. Derek Grieve pointed to the example of NHS Forth Valley, where money has been shifted from the acute sector into social and community care, and we have seen a similar approach in NHS Lothian. Our health boards are certainly moving to a position where the thing to do in response to pressures is not simply to try to open more acute beds, but to look carefully at what they can do to support their social care, community care and primary care sectors. That is absolutely understood across the system.

There is more for us to do, and it remains work in progress. However, I believe that, in the face of all the pressures around demographics and around funding, the work that we are doing, although it is not yet enabling us to see a big reduction in delayed discharge, is enabling us to see a stable position, which might not otherwise have been the case.

Colin Beattie: We have had 20 years—in my case, 15 years—of reassurances from you and your predecessors. Why should we believe that it is going to work this time? You paint a very rosy picture, but the report does not paint quite such a rosy picture. How can we get the reassurance that things are actually happening and we are moving in the correct direction?

10:00

Caroline Lamb: I am not sure that I would describe what I am painting as a rosy picture; there are very significant challenges across the piece. However, I think that we have set out conditions that make it possible for systems to start to change. I have already referenced the money to support enhanced capacity in primary care, and that is accompanied by data reporting requirements. I know that the quality of the data that we have on primary care has been an issue of interest to the committee, and we will be able to assess that.

I would also point to the actions that we have set out in the population health framework, and probably even more to those in the service renewal framework regarding how we will work differently across our NHS boards. We are introducing the concept of the west subnational and east subnational regions, and we are looking at all the opportunities to work differently and more collaboratively not just in and between boards, but, just as important, with partners in social care, too.

Colin Beattie: We have talked about money, but what is actually needed? IJBs need sustainable financial security to take forward what they are supposed to be delivering, and clearly that is very patchy. What can be done to ensure that that financial stability—that funding—is in place, so that they can deliver timely discharge services?

Caroline Lamb: First of all, as a Government, we need to do our best to make as much money as we can available within quite a constrained financial envelope. The local government settlement is at a record level this year, and it will be up to local government to make decisions about how it chooses to deploy that money and what it prioritises. As I have said, and as the committee will be well aware, social care is the statutory responsibility of local government, and I am sure that the committee will want to speak to COSLA about its role and the role of local government in managing delays, too.

We are spending a very significant amount of money and we need to focus not just on trying to quantify what more money we might need, in the knowledge that that funding is not readily available, but on making use of the money in absolutely the best possible way. That will involve ensuring that we are not reworking or duplicating things. In that context, I would point to all our work on getting it right for everyone, which focuses on the person and what they need and ensures that the multidisciplinary teams that need to do so can come together, share information about that person and make decisions on the best support that can be provided to them without all of that needing to be repeated multiple times across the system.

There are also opportunities for us to use digital in a different way, not only to support people but to free up time and capacity in our staff teams, so that they can focus more on the face-to-face work that absolutely needs to be done with people. There are some great examples of that, such as our virtual wards and the use of virtual monitoring to keep people out of hospital and in an environment that provides better value for money.

I do not think there is any silver bullet here; if there were, we probably would have found it by now. We need to look at the multiple opportunities that we have across the system to make small gains and to bring everything together.

Derek, do you want to add anything?

Derek Grieve: I am sure that the committee will be aware of this, but, as the Audit Scotland report has identified, there is, as well as the real human cost, a financial cost to high levels of delayed discharge. That money could be used elsewhere in a different way, and we are focusing on trying to support those local systems and those with the authority to make such decisions to shift the investment from, say, acute hospital care, which is probably the most expensive care that is provided, to an alternative and—more important—more appropriate form of care, which will often involve community-based care.

Colin Beattie: Is it correct, then—this is my interpretation of what you are saying to me—that you have moved away from the original concept of transferring resources from the secondary to the primary sector and are now looking to find other funds to go into the IJBs?

Caroline Lamb: The IJBs have always been funded partly by health boards and partly by local government.

We are still considering where the opportunities are in our secondary care sector. As Derek Grieve pointed out, if we can reduce delayed discharges, we have a huge opportunity in our secondary care sector to free up resource, beds and staff time that is unnecessarily spent looking after people who do not need that level of care.

That is only one example of the work that we are doing. We are also using the service renewal framework to consider ways in which we can increase productivity and to identify ways in which we can shift resource from the secondary care sector into primary and community care. The process is not about winners and losers; it is about providing resource to the areas where it makes the most difference to people and where it can result in the best outcomes for people.

It is also much more difficult to identify resource to release while under a lot of pressure. We have been trying to seed initiatives such as the frailty units, hospital at home and virtual wards, and some of the money has gone into social care, to demonstrate the difference that that can make to the systems.

Ultimately, we can provide some of the enablers, but we rely on individual systems to identify where the opportunities are. It is about trying to shift our focus away from the secondary acute sector and putting more focus on primary, community and social care, and on prevention.

The Convener: In response to one of Colin Beattie's questions, you said that the answer is not more acute beds, but what about when health boards such as NHS Forth Valley close wards? It closed ward A11 of the Forth Valley royal hospital and has reduced the bed capacity. Do you have to sanction that, or is that a decision for the health board to take on its own? Do you have a general view about the contraction of capacity? Looking at the report, the lack of available beds is clearly highlighted as an issue.

Derek Grieve: The closing of the ward in Forth Valley royal hospital is exactly the kind of thing that I meant in the example that I gave.

There was a ward with a high level of delayed discharge and that was equating to the high proportion of delayed discharge, so NHS Forth Valley took the decision to close that ward. It

transferred the resources and staff from the ward and reinvested them in community activity. That is an exemplar rather than something to frown upon. The care is delivered in a different way, and people are being supported in a different way rather than being required to stay in hospital when they do not need to be there.

The Convener: I am afraid that the families whose relatives were in that ward would not see that as an exemplar. I will not go into any more detail, but let me assure you that that is not how they saw it—and, frankly, it is not how the staff at the hospital saw it either.

Graham Simpson (Central Scotland) (Reform): I completely agree with what the convener has just said.

I will now go back to the issue of power of attorney, which the convener explored earlier. It is important for people to have that in place. I was reflecting on experiences that I have had, and there are cases where people's health goes downhill very quickly, so there is not time to put a power of attorney in place. Do you think, therefore, that maybe we need to put in place a system that deals with such situations so that families can act quickly?

Caroline Lamb: The ideal would be for all of us to put in place a power of attorney at the point at which we assume that it will be a long time before we need it. I accept the convener's point about the associated expense, but the ideal is that we all do it when we are fully able to. You are right that people's health can decline incredibly quickly, so it would be good to get to a point at which people are more focused on thinking about the what-ifs and making those arrangements.

We also need a better solution to deal with the situation when people are unable to make a power of attorney so that their dignity can be maintained and the power of guardianship, or whatever it is called in the future, can be put in place in a way that means that they can be accommodated in the place that is right for them.

The Audit Scotland report highlights the work that East Ayrshire health and social care partnership has been doing with Alzheimer Scotland to identify people who are coming to the point at which they might no longer have capacity. There are things that we can do to encourage people who are not close to that point yet, but we can also target those people who still have some capacity but might not have it for very much longer. It is important that we also look at those folk.

Graham Simpson: We have received a letter from Carers Scotland. I do not know whether you have seen it.

Caroline Lamb: No.

Graham Simpson: You have not, so I will quote from it, if that is okay. The letter came last month and it refers to a Carers Scotland report called "State of Caring", which was published in November 2025 and which found that

"just 34% of unpaid carers said they were involved in decisions about discharge and what care and treatment was needed. Only 13% had been asked about their ability and willingness to provide care, down from 19% in 2024 and just 12% felt they had been provided with sufficient support on discharge to protect their health and wellbeing and that of the person they care for."

If those figures are to be believed, and I have no reason to disbelieve them, they are pretty shocking, are they not?

Caroline Lamb: Yes. The Carers (Scotland) Act 2016 provides that carers should be involved in the arrangements for discharging the person they care for. That is hugely important to the carer's understanding of what some of the requirements might be and to their confidence that they can manage them.

Those statistics are extremely disappointing. We have been working to provide more educational resources for staff across health and social care to ensure that they understand the requirement to involve carers. There are some good examples, but carer link workers being put in place in some systems specifically to support carers is probably not consistent across the piece. Carers do a valuable job and it is important that local systems are able to provide them with support so that they continue to perform that role for their loved ones.

Graham Simpson: I will quote another bit of this very good letter. It says:

"This poor involvement and lack of support for unpaid carers risks unplanned readmission of individuals, poorer outcomes and increases the cost of caring to carers' own health. Carers are already experiencing high levels of poor health, with 30% living with poor physical health and 36% with poor mental health.

A lack of involvement in decisions around care … has long term consequences."

The letter goes on to talk about the 2016 act, which you have referred to, saying that Carers Scotland welcomes the call in the report—its report, not the Auditor General's report—for

"integration authorities with their partner NHS boards and councils to ensure they fully implement their duties and responsibilities for including unpaid carers as set out in the Carers (Scotland) Act 2016."

Given the figures that I have just quoted, it appears that the duties in the act are not being met—why not?

10:15

Caroline Lamb: Part of the reason why the duties are not being consistently met is the complexity of some of our discharge arrangements. That is why having carer link workers has made such a positive impact, and that is certainly an initiative that we would look to spread elsewhere.

There is something about that general awareness of the educational materials and making sure that health and social care staff across the piece understand that requirement. There is also something about how we make it as easy as possible for staff to ensure that carers are being involved and engaged. That is why the link model is appropriate.

I also note the comments about the pressure on carers. The move towards having short breaks for carers is important in addressing some of that pressure.

Graham Simpson: It seems to me that we have an act that was brought in 10 years ago but the requirements in that act are not being fulfilled. You accept that they should be fulfilled, but we really need to do better, do we not?

Caroline Lamb: Yes.

Graham Simpson: You agree—okay. How are we going to do better? If we come back here in a year's time, will the figures be better?

Caroline Lamb: As I said already, the example of having carer link workers in local systems has demonstrated that that is a route through which we can do this better. We would want to look at encouraging other areas to take up that approach.

Graham Simpson: The term "rosy picture" was used earlier, and you said that it is not quite a rosy picture, which it is not, is it? The figures in the Auditor General's report—there is a graph, which is exhibit 1—shows that there was, as you would expect, a huge dip in delayed discharges during Covid, then it rocketed, and now it is basically a straight line. It is stubbornly high and is not coming down. There is the occasional blip, but, in essence, it is high. It is probably higher than it has ever been, and we do not seem to be getting any improvement. Why is that, given that we have known about the issue for years?

Caroline Lamb: The Audit Scotland report usefully identifies the pressures that are out there around money, workforce and other issues. A huge amount of work is going on across the system, which is overseen by CRAG. There is regular reporting through that group, so we know which partnership areas are doing better than the Scottish national average, and we know which are struggling against the Scottish national average. We know which partnerships are improving and which are not, so we will have conversations with those partnerships about the challenges that they are dealing with that are impacting on their performance.

A huge amount of work is going on across the piece, and as I have already described, I do not think that there is only one measure that we can take here that would change things. It is about making many small gains in the system, and the delayed discharge is the symptom, if you like. That is the headline figure that we see, but behind that, the things that we need to focus on are preventing people from being admitted to hospital in the first place and, once they are admitted, making sure that their stay in the acute sector is as short as possible. If they are then moved on to any step-down facility, we also need to make sure that that stay is also as short as possible, and that they are being discharged.

Initiatives such as discharge to assess have demonstrated real success in that when somebody is assessed for their care needs in their familiar home environment, they are generally assessed as needing less care and support than they would be if they were assessed in an unfamiliar environment in a hospital. All of those factors are really important in ensuring that we are able to maximise the contribution of our workforce and the money that we have to tackle this.

I would absolutely accept that the level of delayed discharges is higher than we would want it to be. We have seen dips—we have seen it coming down. We would regard it as having been stubborn, certainly since we came out of the pandemic. We could also have continued to see an increase. The position is stable, but not as stable as we would want it to be. We would like it to be stable at a much lower level.

Derek Grieve: The Audit Scotland report usefully highlights some of the wider challenges, not least the fiscal challenge. On the demographic challenge, the report clearly illustrates that the proportion of people who are over 65 has been increasing significantly—it is now more than 20 per cent. Caroline Lamb is absolutely right: the level of delayed discharges is stubbornly static at too high a level, but that is almost despite an increase in the demands that are being placed on the system.

Graham Simpson: There is a knock-on impact on ambulance waiting times, for example. There are people in hospital who do not need to be there. Ambulances turn up, bring people to accident and emergency, and there is nowhere for those people to go. There is a whole-system impact.

Mr Greive mentioned costs, but, according to the report,

"There has been no published information on the costs of delayed discharges since 2019/20."

Why not? If we managed to do it then, why have we not managed to do it since?

Caroline Lamb: The straightforward answer to that question is that Public Health Scotland believes that there is not sufficient rigour around the financial data that it has available to it to assess the cost. It is complex assessing the cost, because costs will vary depending on exactly where somebody is being accommodated. Also, I think that the Audit Scotland report quotes the gross cost, so you would have to offset the cost of care packages, care homes or whatever accommodation is provided.

I think that we would all agree that that is a metric that we would like to see. We have our own internal assessment of what the cost to the healthcare system is, but we would like to be in a position in which that information could be published.

Graham Simpson: Will you do that?

Caroline Lamb: We will work with Public Health Scotland to do that, yes.

Graham Simpson: The Auditor General had to resort to coming up with figures of his own. In paragraph 26, he tells us that it is cheaper to have someone in a care home than in hospital. If that is the case, why are we not properly funding care places in order partly to fix the problem?

Caroline Lamb: The Auditor General's figures are not out of line with the figures that we would use for our internal assessment. You are right: we need to work with Public Health Scotland to get to the point of publishing those figures.

Your question takes us back to the tension throughout the system, which is how we release resource from one bit of the system to invest in another bit. That is really difficult when the bit of the system from which we need to release money is running as hot and under as much pressure as it is at the moment. As we said, the initiatives that we are taking are around trying to demonstrate what is possible—what is possible by reducing admissions and the length of stay. However, without significant additional resources to invest, it is hard to create that headroom. We need to continue to demonstrate what can be achieved, but we also need to implement the reforms that we set out in the service renewal framework, which are about the things that we need to look at across our hospital sector.

Graham Simpson: Okay.

I have one last question. I have noticed that there are a number of working groups and strategies around. You have mentioned the collaborative response and assurance group, or CRAG. There is also the national care service advisory board, whose remit is

"to provide advice and suggest where improvements could be made",

and the health and social care delayed discharge and hospital occupancy action plan—I am not sure how that is coming along. We also have the rapid peer response and support team, which provides

"targeted support to IAs struggling with persistent delayed discharge pressures".

How effective do you think all these committees and plans are?

Caroline Lamb: I will talk about just some of those things—I will try not to go through all of them.

We have talked quite a lot about the role of CRAG already. It is chaired at a very senior level by ministers and by Councillor Kelly, and, essentially, it looks at the data across all systems on, I think, a fortnightly basis at the moment.

The difference with the NCS advisory board is that the board includes people with lived experience. It has established a number of priorities, and its focus is on providing advice, particularly through that lived experience lens. That is really important, because one of the things that we have to tackle in accelerating discharge processes is the perception that hospital is the best place for somebody to be. Sometimes, people still have it in their heads that if they are in hospital, that is the best place for them to be, even though all the evidence demonstrates that a hospital is, in fact, not the best place. That is one of the challenges that we face in thinking about the moves that we need to make.

The delayed discharge and hospital occupancy action plan set out three key areas of activity, one of which focused on data. I think that we have largely addressed that through the whole-system pressure dashboard, which has now moved on. The plan also set out the things that we would expect every system to have in place, and a lot of that work has now been picked up by the discharge without delay collaborative, which is focusing on that small number of measures that I keep referring to—that is, reducing admissions, reducing length of stay, and improving discharge processes.

I have slightly run out of steam. Have I missed anything, Derek?

The Convener: Before you go on, I want to go back to one point. You gave a fairly clear commitment that you would be working with Public Health Scotland to produce total cost data, and the recommendation was that that should be done within the next 12 months. Will you meet that timetable?

Caroline Lamb: We would just need to confirm that. As the statistics authority, Public Health Scotland needs to be assured that it can access data of the appropriate quality to do that work, but I am very happy to come back to the committee on that point.

The Convener: Okay—that is fine. I invite Joe FitzPatrick to put some questions to you.

Joe FitzPatrick (Dundee City West) (SNP): I want to cover some areas in which I think some really good practice is happening across Scotland. You have talked about some of this already, but I want to give you the opportunity to say a little bit more about how things are working in practice and how we are measuring the effects.

The first area that I want to focus on is the work that we are doing to prevent people going to hospital in the first place; after all, if they are not in hospital, they are not going to cause delayed discharge. You touched on the frailty teams and hospital at home—two areas on which there is a real focus and that are, in fact, being expanded. How are you doing with getting more beds at home? I have had personal experience of the hospital-at-home system, and I have to say that, until you have been there, you cannot appreciate how amazing it is in preventing somebody having to go into hospital in the first place. How are you getting on with those things?

Caroline Lamb: I will ask Derek Grieve to come in with some detail, but it is important that we recognise the differences here. Hospital at home, as a development, is at the high end. Essentially, it provides acute clinical services, including the equipment, the staff and whatever else is needed, in people's homes. We also have the virtual bed service, which is much more about the virtual monitoring that I mentioned and does not involve as much face-to-face contact or people going into homes. However, people are still being monitored to ensure that, if there is a deterioration in their condition, things can be triggered. Those two areas, along with the frailty teams, have been key focuses for us through the operational performance improvement plan.

Derek Grieve will give you some more detail.

10:30

Derek Grieve: I will start by talking about the hospital at home programme. As you are aware, there is a commitment in the operational improvement plan to have up to 2,000 beds by December. We are working with Public Health Scotland on the collection of exact data and there are some challenges with that, but we know that every system is now in the process of developing hospital at home pathways where those do not exist and expanding them where they do. That work includes recruiting new staff.

Two things are happening with hospital at home: the overall volume is increasing and so is the range of specialities. The older people pathway is well developed, and you may have had some experience of that. We are now expanding into paediatrics and other specialties, which has the potential to be a real game changer.

There have been some challenges with the programme because it requires a different model, but, as you alluded to, there is really strong evidence of highly effective patient outcomes from hospital at home. Those outcomes happen for all the reasons that we have spoken about. There is less deconditioning and less risk of infection. There is a quicker response and there are the wider social benefits that come from being at home, surrounded by friends and family.

We are tracking progress, and, although we do not have any published data, we have management information that gives us strong confidence that we are on target.

Regarding frailty units, there is a commitment in the operational improvement plan, and every A and E unit now has access to frailty services. All boards are working towards an enhanced frailty service, and we are highly confident that every mainland board will have access to such a service by the end of March. Caroline Lamb alluded to the really strong evidence of impact. There are reduced hospital admission rates for frail patients and reduced lengths of stay for those who are admitted. For all the reasons that we have indicated, that delivers better patient outcomes.

Joe FitzPatrick: The next area that I will ask about is delayed discharge and the variations in that across the country. There is some really good practice, and I highlight NHS Tayside, in my local area, where elected members get regular briefings and have been told off for calling it "delayed discharge" when we should turn that idea on its head and talk about "planned" discharge without delay. We can see all three integrated authorities in Tayside doing better than those in other parts of the country because of that ethos and way of working. There are variations within Tayside: there has been an amazing improvement in Angus; Dundee consistently does well, and Perth is not as good but is still better than the national average.

How do we ensure consistency when good practice appears to be happening in some areas, including those that you mentioned? How can that be picked up by integration authorities and NHS boards across the country?

Caroline Lamb: You are right to highlight Tayside, and it is no accident that Tayside also has

the best performing A and E in the country as a result of all those factors.

Taking good practice and spreading it gives us both an opportunity and a challenge. We must accept that there can be quite different conditions in different areas and that the systems and processes that they dock into can also be quite different. It is not as straightforward as lifting a bit of good practice and dropping it in a different area. That said, there is a lot of learning to take from the areas that are doing really well, and one way that we try to do that is through CRAG and by having a regular show and tell of where systems are shifting and making a difference.

The discharge without delay collaborative is important because it brings clinicians and multidisciplinary teams together to focus on the areas that we know make a difference, such as avoiding admissions, reducing length of stay and having really good discharge processes. I think that that has been operating for about a year.

Derek Grieve: It has been slightly longer.

Caroline Lamb: Right. That collaborative approach, which has been used in dealing with other challenges in health and social care, is an opportunity for people to come together, share experience and translate that into their local environment and conditions.

Derek Grieve: That is exactly right. The collaborative is engaging with the vast majority of partnerships, and the issue is a regular topic of discussion at CRAG. As Caroline Lamb said, there are ingredients that have a really strong evidence base, but the work needs to be tailored to local circumstances. Importantly, local systems, clinicians and teams on the front line need to feel that they can shape and own the work in a way that operates in their individual context, because each system will be slightly different from others.

Joe FitzPatrick: Are we managing to resource that collaboration work? Time is one of the most challenging issues, so is there funding to ensure that there is time to collaborate?

Caroline Lamb: You are right that time is one of the most challenging things. That is very much for local partnerships to look at, but we have some real champions of that approach across the system who are inspirational in what they bring to it.

Joe FitzPatrick: Thank you.

The Convener: Finally, I turn to the deputy convener, Jamie Greene, who has some questions for you.

Jamie Greene (West Scotland) (LD): They are hot off the press, I should add.

Caroline Lamb: Oh, gosh.

Jamie Greene: Good morning. I want to take a step back. I have listened carefully to the lines of questioning and I thank you for your answers thus far. In fairness, the report identifies that a lot of work is going on across the country to tackle the problem. However, we must be realistic and honest with ourselves about the scale of the challenge.

My main problem is that we do not really seem to be budging on the issue at all. Back in 2015, there were 550,000 delayed discharge days. The then health secretary, Shona Robison, said:

"I want, over the course of this year, to eradicate delayed discharge out of the system".

She said that on 25 February 2015, which will be 11 years ago next week. What has happened since then? The year after that, the figure rose to 660,000 delayed discharge days. Last year, there were 720,000. The figure is going up and up and up. There is eradication and there is multiplication. Do we know what the figure will be this year?

Caroline Lamb: I absolutely recognise that this is one of the most wicked problems across not just our system but health systems across the United Kingdom. Every health system across the UK is challenged by the number of people who are in our hospitals when that is not the best place for them to be. We would all like the number to come down substantially.

Our understanding of what is impacting on the numbers has improved. As we have discussed already, we recognise that there is a particular set of issues around adults with incapacity, which means that they form quite a large chunk of our delays. Unfortunately for those individuals, they tend to be the people who are delayed the longest. We referred earlier to the fact that a huge amount of work is going on. I said in my opening statement that an enormous amount of work is going on across systems, but that is not yet delivering the impact that we need to make a step change.

We are retaining a bumpy but stubbornly high level. It is higher than we want, but we are not seeing that multiplication factor. In fact, since about 2021, the figure has remained relatively stable, albeit at a much higher position than we would like. That is a factor of all the work that has gone into the issue, but it is set against the challenges around demographics, workforce and financial resource to support that workforce.

I am not saying that I think that the level that we are at is a good level to be at—it absolutely is not. It not only impacts the people who are delayed but has an impact on the way in which the system operates. We need to continue to do all the things that we are doing. As I have already said in this

session, if there was a silver bullet, we would have found it by now. We need to look at multiple factors across the system and harness the creativity and innovation of the people in the system to understand what we can do to make a difference and focus on those factors. I suspect that we will need to continue to work hard to maintain our position at the same time as looking at our options in digital, what we are learning from virtual wards, hospital at home and the frailty units, and how we can scale up that sort of activity to start to see a reduction.

Jamie Greene: Forgive me, but that sounds a bit like you are saying that it is not getting any worse but it is not getting any better, so that is fine. I am not talking about a blip. The report is not about one year out of the ordinary but a pattern that has been repeated over the decades since a promise was made to eradicate delayed discharge. I question whether it is possible to eradicate delayed discharge at all. It has been sitting at around 3 per cent of all discharges and consistently affecting around 18,000 people, year on year, for the past 10 years. Is that just the base level that we have to accept now?

Caroline Lamb: I would hate to think that it is the base level that we have to accept. We need to find ways of getting those figures down. Some of that will involve looking at how we manage adults with incapacity and making sure that they are not being delayed in the place that is least suited to their needs, and work that involves legislation is being done around that.

I agree with your analysis that it will be impossible to eradicate delayed discharge completely, because things will always happen that mean that arrangements are not quite ready or people will have complex packages that take a bit longer to put in place. We need to eradicate long delays and do everything that we can to make sure that our processes work as effectively as they can to get people out of hospital. Part of that will also be about the broader understanding that hospital might not be the best place for people to be.

Jamie Greene: During the most recent session that we had with the Auditor General, we talked about dealing with this long-term stubborn issue, which Mr Beattie picked up on earlier. In the week or so since that session, I have tried to do some analysis of Audit Scotland's previous reports. The 2005 report was called "Moving on? An overview of delayed discharges in Scotland" and there was a report in 2016 called "Changing models of health and social care".

There have been repeated Audit Scotland reports over the years. One of things that has never really been clear from all those reports is what lessons were learned. I feel like I have a bit of déjà vu. If I could go back to the audit committee of 10 years ago, I would probably find that it was having the same conversation and getting similar answers from the director general for health at the time. I feel as though we are going round in circles. There is a lot of jargon and rhetoric, but the statistics prove that virtually no progress has been made since those reports came out. My biggest fear is that, during the next parliamentary session, we will be having exactly the same conversation in two, three, four or five years' time. Fill me with some confidence that the next public audit committee and whoever sits on it will not need to have this conversation again.

Caroline Lamb: I would like to think that they will not need to have this conversation again, but we do face some challenging issues. It is not just about the Scottish Government and local systems, because local government still has a statutory responsibility for social care, and it would be interesting to hear what COSLA would say to the committee in response to some of these questions. It is about our working together and recognising the critical importance of social care to the health and social care system and to enabling people to live good and productive lives and enjoy being with their families and in their communities.

10:45

More work can be done to set out where the priorities lie in social care and where they sit in respect of other parts of the service. I have already spoken about the work that we have kicked off under the service renewal framework to look at how we can be more efficient in the acute sector. We have done that with the intention of shifting resources that we never managed to shift in the past. However, it is incumbent on every bit of this system to ensure that we are as effective and efficient as we possibly can be, because the demographics will not change. At the moment, we are running very fast just to keep up with those demographics, so we need collectively to find ways in which we can make an absolute step change.

Digital and technology will be part of that change. Back in 2005, there was not the ability to carry out the remote monitoring and have the virtual wards that we have since set up. We did not have the investment in paramedics and peer-to-peer contact that has enabled the Ambulance Service to convey only around 50 per cent of calls. We also did not have a focus on flow navigation centres, which again involves peer-to-peer contact and enables people to stay further away from hospitals. We also did not have the same focus on multidisciplinary teams, particularly in the case of frail elderly people. Over the past few months, I

have been in a number of the frailty units, and the thing that has struck me is the importance of hospital staff getting an understanding from community staff of an individual's baseline—what we would normally expect of their abilities—and what that means for when they are ready to be discharged home rather than being kept in hospital. It is a multifaceted problem, which everybody needs to come together to resolve.

Jamie Greene: I do not doubt that there is the will, desire and good intention to come together to fix the problem. However, although it is not for me to put words in the mouth of COSLA, I am pretty sure that if you asked it whether social care is adequately funded, the answer would be a big fat no. We know that because that is what it said in the briefing document that it sent us a couple of weeks ago, after the budget. If the answer to the question, "Is social care properly funded?" is no, you will never resolve the issue of bed blocking, will you?

Caroline Lamb: Every bit of the public sector could make an argument about funding adequacy or otherwise, and we work within a constrained financial envelope. I would turn that question around to ask whether we are confident that we use all our money in the best way possible across the totality of the services that we offer. Even the likely costs around delayed discharges demonstrate that there are opportunities to shift resource and activity out of the acute sector towards funding support in social care and primary care.

I am sure that there are opportunities to find efficiencies and enable different ways of working across all our public services, and the public service reform strategy sets out that ambition and requirement, along with our collective responsibility to ensure that money that is spent on behalf of the public purse is used in the best way possible. There are opportunities, and we need to be careful that we focus not only on the adequacy of funding or otherwise, but on how well we use existing funding, which is quite considerable.

Jamie Greene: Let me rephrase my question: who is not spending their money wisely? Which bit of the system is not as productive as it could be?

Caroline Lamb: In every bit of the system, you can identify opportunities for people to work differently together in a way that provides better—

Jamie Greene: Can you give me an example?

Caroline Lamb: One example is the work that we are doing across NHS Scotland to develop single approaches to business systems that provide us with better intelligence and information and take manual labour out of some of those processes.

Another example is the subnational arrangements, in which we are looking at a single plan for orthopaedics across Scotland and how we best use capacity across Scotland to manage demand. There are examples out there. We need to focus on how we deliver against those and implement some of those plans.

Jamie Greene: You are director general for health and social care, so I appreciate that you are not in charge of local government or its budget. However, I presume that you have some influence over the working of integration joint boards, the role that they play in delivering social care and how that links into the wider health and social care budget, which is essentially a unified budget. What would you like to happen? I appreciate that it is difficult to give an analysis when you are the person in charge, but you must know why people are stuck in hospital. You must know the main reasons why you cannot get people out of hospital beds and into another setting. There must be analysis of the main reasons for that. You will know what the sticking points are. What are they, and how will you go about fixing them?

Caroline Lamb: Part of the reason for people getting stuck in hospital beds—for the longest delays that we see—are issues around adults with incapacity. It will require legislation to fix some of those, but if we started to see improvements, that could bring down not just the absolute number of people delayed but the cost in total bed days to the system, because so many of our long delays fall into that category.

A lot of our other delays can be relatively short term, but, looking at the demographics and the increasing elderly population, we also need to continue to focus on the things that will prevent people from needing to go into hospital in the first place. At the moment, our focus is very much on additional investment in general practice to do that preventative work. Our focus is also on the initiatives that we talked about—the frailty units, hospital at home and virtual beds are all important in shifting the balance and are all about caring for people in the community, rather than in the acute base. We need to continue to make progress in all of those areas, while looking at the things that we can do through digital and technology to improve our overall efficiency.

Jamie Greene: That is helpful.

On the issue of adults with incapacity, are those people who are medically fit to leave hospital, but do not have the capacity to look after themselves once discharged? If they were sent home, they would not be able to look after themselves, therefore they are safer in hospital.

Caroline Lamb: The issue there is people who are in hospital at the moment who, because they

have Alzheimer's or learning difficulties—whatever it is—do not have the capacity to make a decision either to go back home, potentially with care packages, or go into another form of care that would be more suitable for them. Unless there is already a power of attorney in place that enables their families to make that decision, there is quite a complex legal process, in which local authorities have to get guardianship orders.

Jamie Greene: And all the while, those people are stuck.

Caroline Lamb: Yes.

Jamie Greene: That is clearly an issue. That is a cohort of people who are stuck for quite a long time—sometimes months. We have heard some horrible anecdotes.

Caroline Lamb: Yes.

Jamie Greene: That is one area in which there could be improvement.

We have talked a bit about data. Mr Simpson talked about the £440 million mentioned in the report. That was just one year. I presume that that was a primitive calculation based on the number of bed days and the cost per day per bed, which I think is around £618. It is a very simple way of looking at it. There must be a better way of measuring the cost. Do you have a number?

Caroline Lamb: The Auditor General is sitting behind me, so I am not sure that I would describe that as a simple calculation. What I have said to the committee is that we make our own internal assessment and it is pretty much in line with that assessment. The Auditor General has drawn on the same data that we have in order to produce that. I have accepted that we need to work with Public Health Scotland on getting that information to a quality standard at which it can be published and made available. That would be really helpful for the whole system.

Jamie Greene: How many staff hours are lost to managing patients who are medically fit to leave hospital but are still having to be cared for in a hospital environment?

Caroline Lamb: I do not have that figure. Boards will be able to give you, at any one time, the numbers for beds and wards, but we just need to be careful about assuming that, if those beds were not being occupied by people who did not have a clinical need to be in them, we would not need to staff them any longer. After all, there are other pressures to deal with. There are, for example, the pressures that come through the front door in A and E, with people needing to be admitted, and one of the challenges that we face with ambulance drop-offs and the long waits in our A and E departments is not having beds available. Therefore, the first call on those beds would be to improve flow through A and E.

There are also occasions when there are limitations on the number of beds, particularly when the hospitals are very busy, and that has an impact on planned care, too. Therefore, I do not think that our first move would be not to staff those beds; instead, we would look at how we might be able to use them differently to improve performance across the whole system.

Jamie Greene: I am not suggesting that you do not staff those beds. My point is that the beds are being occupied by people who do not need to be in them.

Is there any analysis of how many clinical or non-clinical hours are taken up with looking after those patients? After all, once someone has gone out the hospital door, they are someone else's problem—the duty of care lies with someone else—and that member of clinical staff will be automatically and immediately freed up to look after someone else either in that bed or otherwise. Has that piece of work, or analysis, ever been done?

Caroline Lamb: I will come back to the committee on that, but I am not aware of anything. There has been work done on cost, which obviously will include a staffing element. We can look at whether that previous work contains that sort of breakdown of the staffing element.

Jamie Greene: Finally, has the Scottish Government or the NHS done any holistic analysis of increased mortality rates as a result of delayed discharge, or indeed, additional harm caused to patients as a result of delayed discharge? If not, why not?

Caroline Lamb: My statements about hospital not being the best place for people to be in draw on evidence from research not just from the NHS but from a number of different sources. I can come back to the committee with details of some of the research reports indicating the impact on people who are delayed.

Jamie Greene: Statistical data would be helpful. Thank you.

The Convener: Picking up on that final question, one of the striking things in the briefing on community health and social care performance is exhibit 4 at the end, which talks about the impact of inequalities and the importance of reducing them. It points out clearly the huge gap in life expectancy, both male and female, between the most deprived and least deprived areas in Scotland, and it talks about the relationship between deprivation and the frequency in the use of day beds, premature mortality in areas of dense population and—this takes us back to the letter

that Mr Simpson read out—the higher rates of unpaid care in some of the most deprived communities.

There are some fundamental social and economic structural issues out there, are there not? I acknowledge that it is perhaps not your sole responsibility to challenge and remedy them, but do you, in your position, take a view on those things? What is the Government doing to try to address the huge inequalities that exist?

Caroline Lamb: I am acutely aware that the drivers of poor health or good health are, as I think that Michael Marmot would argue, 80 per cent influenced by factors that have nothing to do with what the health and social care system is doing. The population health framework very much takes a cross-sector, cross-society approach to tackling some of those issues.

As for what the Government is doing, the single thing that I would probably point to as being the most important is the child poverty action plan. As we know, poverty and other adverse events in early childhood are things that have the longest-lasting impact on your life chances, your educational and health prospects, and whether you are involved with the justice system—all of that. Therefore, we are talking about root cause prevention and tackling some of the things that result in some of our children being so very disadvantaged and, as a result, more likely to experience health inequalities throughout their lives.

11:00

The Convener: Thank you. Before we finish, Graham Simpson has a quick follow-up question.

Graham Simpson: It is not quite a follow-up, convener.

Ms Lamb, last time that you were in front of the committee, you had been criticised for not visiting hospitals, and I asked you about that. However, you have told us today that, in the past few months, you have visited a number of frailty units. Now that you have been out and about and seen at first hand the problems on the ground, has that new approach of getting out of the office been useful to you in your job?

Caroline Lamb: Thank you for that question. Getting out and about has always been a key element of my job and something that I enjoy more than anything else that I do in that job, because it is inspirational to talk to staff. Seeing what is going on in the frailty units gives a flavour to some of the things that I read. It is the same for everything; I have also been in several hospitals to look at what they are doing to improve productivity and planned care.

You asked me that question before and I thought that you might ask again. In my record of being out and about, there was a step change in the number of my engagements that were out of the office, as you put it, between July 2024 and July 2025. I am on record as saying to the committee that that was partly due to the fact that, during that period, I gave evidence four times to the UK Covid inquiry. Anybody who has been involved in that will appreciate just how time intensive the preparation is.

However, the reason why I was wondering whether you would ask me the question is because it also gives me the opportunity to put on record another factor that influenced what I was doing during that time. In June 2024, my father became very unwell and it became clear that he and my mother, by whom he was supported but who had Alzheimer's, would no longer be able to carry on living independently in Yorkshire. In July 2024, therefore, we moved them up to Edinburgh to be close to me, because my brother lives in France. Unfortunately, my father died in early September of that year, and my mother passed away in June 2025. During that period, I took the decision that I needed to spend as much time as possible visiting my parents in the evening. That was one of the things that impacted on my ability to get out and about. I probably would have found it hard to talk about that the last time that we met, but I am grateful to have the opportunity now to put that on the record.

Graham Simpson: I am glad that you felt able to share that. You do not have to share such very personal things, but you have put it on the record. You spoke very well about your experience of visiting the frailty units and you have told us how useful that has been. We will leave the personal stuff, but at least you have had the chance to put it on the record.

Caroline Lamb: Thank you very much for that. I appreciate it.

The Convener: Thank you for that and for the evidence that you have given us this morning. Caroline Lamb and Derek Grieve, I thank you very much indeed for your time. I do not know about your diary, director general, but the committee has you booked to come back and see us in a couple of weeks' time, in our final meeting of the parliamentary session. We look forward to that. If you want to follow up anything in writing, following this morning's session, please do that. We would welcome anything that you wished to share with us.

I now suspend the meeting for a changeover in witnesses.

11:04

Meeting suspended.

11:09

On resuming—

Section 22 Report: "The 2024/25 audit of the Scottish Public Pensions Agency"

The Convener: I welcome everyone back. We have had a changeover of witnesses, and I am now very pleased to welcome to the committee the Auditor General, Stephen Boyle, to aid us in our consideration of the section 22 report that was recently published on the audit of the Scottish Public Pensions Agency for the financial year 2024-25. Alongside the Auditor General are Michael Oliphant, who is an audit director at Audit Scotland, and Stuart Nugent, who is a senior audit manager at Audit Scotland. Auditor General, I invite you to begin the evidence session with a short opening statement, after which we will put questions to you, Michael and Stuart.

Stephen Boyle (Auditor General for Scotland): Many thanks, convener, and good morning. As you mentioned, I am presenting a report on the 2024-25 audit of the Scottish Public Pensions Agency under section 22 of the Public Finance and Accountability (Scotland) Act 2000. My report brings to the committee's attention issues relating to the SPPA's performance in discharging its responsibilities in relation to the 2015 pensions remedy, as well as wider concerns about the agency's governance and transparency.

Following what is known as the 2018 McCloud judgment on age discrimination in the UK's 2015 pension reforms, the SPPA, as a public pensions administrator, has a legal responsibility for delivering pensions remedy calculations to members of the four public pension schemes that it administers, which are the schemes for the NHS in Scotland, police, the fire service and Scottish teachers. That work includes presenting all eligible scheme members with a choice about the different options for benefits that they will receive. There was a statutory deadline of 1 April 2025 for the SPPA, along with other UK pension authorities, to do that, but the SPPA did not meet the deadline.

In the auditor's view, the SPPA underestimated the scale and complexity of the work that is involved in calculating the options across each of its four schemes. It is now working towards revised deadlines through to 31 July 2028—more than three years late—to fulfil its obligations. The legislation allows for some flexibility in timescales, but progress remains slow. As of November 2025, the SPPA had issued choices to 55 per cent of scheme members out of a total eligible population of just under 200,000. That includes active and deferred members, as well as those in retirement. Delays mean that some retired scheme members might not be receiving their full pension entitlement.

It is our view that, overall, the SPPA has not yet demonstrated sufficient transparency regarding its progress on remedy. As I mentioned, the auditor has also reported concerns about the governance of and transparency in the agency. During their annual audit, Michael and Stuart will continue to monitor developments and progress, especially progress with remedy. I will take a view on whether there should be further public reporting to the committee on receipt of their next annual audit report.

As you mentioned, convener, between the three of us, we will be happy to answer any questions that the committee has on the report.

The Convener: Thank you for outlining a little bit of the history of the situation. At the start of your statement, you mentioned transparency, and it strikes me as being of interest that there is such a variation in the level of assessments made for the different occupational pension schemes in the public sector. For example, in your report, you highlight the fact that 85 per cent of retired police scheme members have received their assessment, but zero per cent of retired firefighters have received their assessment. Why is there such a big variation between two groups of workers in that way?

Stephen Boyle: You are right, convener. I refer the committee to exhibit 1 in the section 22 report, which sets out the different categories of pension scheme members and progress towards remedy calculations across the different schemes.

11:15

I will bring in Michael Oliphant to set out some of the specific detail about why the police and fire service pensions are so different. Towards the end of last year, the SPPA's accountable officer and chief executive gave evidence, along with his colleagues, to the Parliament's Finance and Public Administration Committee and some of that is really relevant. There is now only one employer for the police in Scotland and the situation is the same for the fire service. That is an important point to come back to, but if we look at other schemes, such as the scheme for teachers, we see not only local authority employers but others, too, and there are more than 800 employers in the NHS scheme.

Although there is a difference of scale between the NHS and the police, that does not tell the whole story. Having 800 NHS employers was not a new development for the pension scheme, but it highlights some of the historical issues within the SPPA. This is not the first section 22 report that has been produced: it is the first in this session of Parliament, but my predecessor prepared section

22 reports on the progress of the implementation of information technology systems in the agency and some of that is still relevant today. In his evidence to the Finance and Public Administration Committee, the chief executive recognised that there has been underinvestment in both IT and effective data management arrangements within the agency. Those data management arrangements are fundamental to why the agency has not been able to make consistent progress.

To address your second point, transparency really matters, because people who are retired might not be receiving their full pension entitlement. The agency has been dealing with a great deal of complexity and is not the only pension provider in the UK that is struggling to meet the deadlines, but we think that there has been an optimism bias in its communication to members and that it should be far clearer about what members can expect to receive, and when.

My final point is that there is considerable work to do. As I said in my opening statement, 2028 is the revised deadline. There is scale and complexity in going through the individual calculations for all the remaining members and there is a need for the agency to take stock, as it is doing, of the technology and data management arrangements that it needs to put in place, alongside addressing remedy.

I will hand over to Michael to address the differentials in relation to the police and the fire service.

Michael Oliphant (Audit Scotland): As the Auditor General said, the agency is dealing with one employer for police data and one employer for fire service data, but approximately 800 employers for NHS data. The agency can point to having better and cleaner data for the police, which means that less time is spent getting it into the right format for the system. All the police data is held within the pension administration system, which is not quite the case with other employers.

The difference between the police and fire service pension schemes is that some work was required on fire service data relating to pay differentials, acting-up allowances and so on before that data could be used.

In the year to October 2024, 87 per cent of all the freedom of information requests that the agency received in relation to remedy came from police scheme members, so the weight of voices in the police scheme may have been a factor.

The Convener: That is interesting. I think we are going to get the accountable officer from the agency in to see us in a couple of weeks' time and can put some of these things to him.

You said in your opening statement that the Scottish Public Pensions Agency has a legal responsibility, which begs a question. Are there any financial consequences for the agency if the remedy is not addressed properly and on time?

Stephen Boyle: I will bring in colleagues on some of the specifics. However, if a member of the scheme has been underpaid, they will receive the differential plus interest. The interest rate is 8 per cent; it is set by the UK Government in recognition of the recourse that a member should have received.

Unlike the local government pension scheme, these pension schemes are not asset backed. They are, in jargon terms, pay-as-you-go pension schemes, the cost of which will be met annually through funding provided in the Scottish budget to meet the pension schemes' obligations. Michael can supplement that answer.

Michael Oliphant: The accrued interest rate that is applied is 8 per cent. That is funded by the UK Government. The recent estimate is that remedy payments for Scotland will cost the UK Government £1.7 billion; in the UK context, the cost is £19 billion. There are administration costs for the SPPA. It has estimated that administration for the remedy period—so over three or four years or so—will cost the agency about £20 million.

Stephen Boyle: I wonder whether it is worth touching on some of the financial implications for the agency. Michael Oliphant is quite right in what he said, but maybe he can say a bit more about the additional resources that the agency has had to request from the Scottish Government to continue business-as-usual activity as well as make remedy calculations. The chief executive, Dr Stephen Pathirana, set out some of the detail on that to the Finance and Public Administration Committee.

As the chief executive noted, part of the issue is that it can take up to a year to train a member of staff so that they can go through the most complex calculations. As I mentioned a moment ago, individual calculations need to be made for each member. There has therefore been a significant injection of additional resource into the agency to allow it to work through those calculations.

Alongside that is what all of that that means for future provision and the work on digital and data management, which will be key to the quality of provision in future to those affected by remedy and the schemes' other members.

Michael Oliphant: The agency has a core establishment of about 300 staff, and it has had to recruit an additional 100 on temporary contracts to help with the remedy process and issue remedial service statements.

As the Auditor General said, it takes about a year to recruit staff and train them up. Usually, the new recruits deliver the business-as-usual stuff, which allows capacity to be freed up for staff who are more experienced and have greater technical knowledge to be involved in more complex remedy cases.

The Convener: That makes sense.

I go back to my original question. All of this stems from the McCloud judgment, which was a court case in which the UK Government was challenged under age discrimination laws. My question was whether the Scottish Public Pensions Agency could be sued by people in the small claims court or another arena because it has failed to meet its legal responsibilities to make those assessments and then to give people any back pension pay that they are due.

Stephen Boyle: I do not know whether the Scottish Government or the agency has adopted a definitive legal position on that. Our understanding is that the provision of accrued interest, which Michael Oliphant mentioned, is the position around remedy—that is on offer.

However, it might be that individual members or groups of members wish to take such a course of action. I am not fully sighted on that, so it might be for the agency to share with the committee whether it has any insight or experience in that regard. I will pause there, in case my colleagues have further information.

Michael Oliphant: In relation to the timescales that were set, the agency will point to the section of the Public Services Pensions and Judicial Offices Act 2022 that is discussed in paragraph 10 of our report. The "relevant date" that it has to meet can be

"such later day as the scheme manager considers reasonable in all the circumstances in the case of a particular member or a particular class of member."

So although the agency did not meet the original timescales, its view is that that provision in the legislation allows it to move the timescales. However, the act is silent on whether the agency can do that repeatedly, and we have queried that with the agency and the Pensions Regulator. We have not yet had a conclusive answer from the regulator, but we are not aware of anything that would suggest that it is not content with the action that the agency has taken. The agency was in discussions with the regulator before taking this action, but we have not had direct confirmation from the regulator as to its view.

The Convener: Does it not then become a test of whether or not the agency's action is "reasonable"?

Stephen Boyle: I think that that is right. Michael has rightly mentioned the role of the Pensions Regulator. As a regulated entity, the SPPA is subject to engagement and communication with the regulator, so it will be instructive to hear whether its view on the reasonableness of the SPPA's action leads to any individual issues or concerns, or potential legal action. It is clear that the SPPA's regulatory engagement is not out of the ordinary among the steps that other pensions agencies across the UK are taking, but our view is that, given the complexity of the process, it would be better for the ability of the SPPA to carry out that process if there was more transparency.

The Convener: Thank you. I am going to move us on and invite Colin Beattie to put some questions to you.

Colin Beattie: Auditor General, in your opening remarks you briefly touched on the impact on individuals. Although the bulk of your report is about process and so on, it is important to remember that there are people behind this who are suffering because of it.

I have had a few complaints, as you might expect, a couple of which I will highlight. One involves a constituent with cancer who is taking early retirement, for obvious reasons. They needed to adjust their mortgage deal, which could only happen once they received an updated pension projection. They were advised that it would take quite a few months to achieve that, and they were extremely concerned that they were at risk of losing their home. That is hardly a good position to be in when you are suffering from cancer. That case has been resolved.

Another one concerns someone who is retiring after 36 years of service. Since July 2025, they have been waiting for what they refer to as a quote from Capita. They have received no pension payments. They are suffering financial hardship, stress and anxiety. They, too, are fearful that their lack of financial resources might make them homeless because they will not be able to keep up the payments on their house. That case is still outstanding.

There are serious issues behind this matter that are affecting individuals. It is not just about people who already have pensions waiting to see whether they are going to get the option of an adjustment—people are being affected by this every day. I am concerned about whether there is anything in place for them, other than turning to an MSP or whatever, because a lot of people just will not do that.

Stephen Boyle: The examples that you give are clearly very serious, Mr Beattie. May I ask, for clarification, whether those are cases that are

being directly administered by the Scottish Public Pensions Agency?

The committee might be familiar with the UK civil service pension scheme, which is administered by the UK Government along with its provider. I asked because you mentioned Capita, which is the partner of the UK civil service pension scheme, and there are live and documented concerns about the issues with that pension scheme, to the extent that there was a joint statement from the UK Government and Capita in the past fortnight or so that acknowledged the scale of the issues and set out that the UK Government will provide hardship payments to scheme members who have not been receiving pensions.

11:30

I do not dispute the examples that you gave, particularly the first one, on the Scottish Public Pensions Agency, but I do not want to leave the committee with the impression that the SPPA is not making pension payments. It is making payments. However, the example in our report is that the right pension amount might not be being paid. Forgive me for asking for clarification.

Colin Beattie: Case 1 certainly involved the SPPA, because we got a response from it and, as I said, that issue was resolved. The second case referred to the SPPA, but I do not have the full letter in front of me—just a few brief highlights. The constituent certainly believes that the SPPA is involved. That will come out in the response, which I have not received yet.

Stephen Boyle: Thank you.

I might ask colleagues to come in. There are two parts to the issue of performance, opportunities and risks around the SPPA. One is about addressing remedy, and the other is the impact that that is having on business as usual, such as providing annual benefit statements. I turn to Michael Oliphant to give more detail on what that means for the organisation's performance in the round. Many people who are approaching retirement—some of whom will be affected by the remedy while others will not—will need information for life events, whether that is remortgaging or the sort of unfortunate example that you gave in which people are ill. The SPPA is best placed to come back on the detail on that, but we can perhaps say a little more about how that is affecting business as usual, as we understand it.

Michael Oliphant: With the SPPA, scheme members are continuing to receive payments, although they might not be on the most beneficial payments. The agency has estimated that 70 per cent of affected members are on the correct pension, although they might not know that until they get their calculations and make their choice. However, that means that 30 per cent are not on the correct pension. Obviously, as Mr Beattie highlights, that creates a lot of uncertainty for financial planning. There is potential stress associated with that, and there could be historical tax implications that need to be addressed. That is part of the reason why the issue is so complex.

On the impact on business as usual, the agency has poor performance on issuing annual benefits statements, which is part of the issue with the remedial service statements that need to be given out in relation to the remedy. The agency also has to correct historical errors that have been identified. The Government Actuary's Department has looked at some of the remedy calculations to provide assurance, and it has revealed some historical errors, albeit minor ones. Nevertheless, the agency has a responsibility to correct them.

On the agency overall, we mentioned some of the data problems, but it also relies heavily on manual processing. Its pensions administration system is now, I think, more than 20 years old. It relies heavily on manual processing, which can obviously introduce errors. Part of the agency's longer-term ambition is to move to what it terms digitising the retirement journey, but it is unable to make sufficient progress on that while it has to deal with the remedy. It has to sort that out and correct the backlog before it can move forward to something that is more automated and digital.

The agency hopes to procure a new system by 2028, which will, we hope, reduce and potentially eliminate manual processing. I guess that, with that, the agency would be looking at reducing the staff numbers that it needs back down to the core levels that it would normally expect.

Colin Beattie: I will move on to the timescales involved. Paragraph 9 of the report states:

> "The SPPA did not meet its 1 April 2025 legislative deadline for providing affected members … with Remedy calculations and options".

Paragraph 10 states:

> "Following guidance from TPR, the agency provided 'breach of law' reports for the affected cohorts in May and June 2025".

Will you give us a bit of background as to what a breach of law report is and explain what sort of consequences, if any, it has?

Stephen Boyle: I ask Michael Oliphant to take that one.

Michael Oliphant: A breach of law report is a standard report that the Pensions Regulator requests of scheme administrators if they are in breach of any part of legislation that regulates pensions. The agency issued those reports on 22 May and 22 June in order to move the timescales

for the police, NHS and teachers schemes out to 31 August 2025.

As part of issuing a breach of law report, the agency is supposed to outline a realistic timescale. The Pensions Regulator expects there to be a clear and realistic plan to ensure that, in this case, accurate remedial service statements are issued as soon as possible. It also expects engagement with the pension board and it expects affected members to be informed of the new date. If the Pensions Regulator's expectations are not met, it might investigate further or consider using its statutory powers, which would be a form of special measures. However, it has not done so in this case.

Colin Beattie: At this point, there have been no consequences for the SPPA, other than the formal issuing of the breach of law reports.

Michael Oliphant: No penalties have been applied, and the Pensions Regulator has not implemented any action that we are aware of.

Colin Beattie: The report states:

"In correspondence with TPR, the SPPA acknowledged that the previous extended dates were 'ambitious'."

Did the SPPA explain why those ambitious dates had been set?

Stephen Boyle: That speaks to one of the overall conclusions of the report, which is that the original expectation of delivery by 2025 was overly ambitious. With the appointment of a new chief executive, we have seen a better understanding of the scale and complexity of the issues that the agency faces in relation to delivering remedy statements.

That also speaks to some of the evidence that was given to the Finance and Public Administration Committee in December last year, which better set out why the process has been so much harder and more difficult than the agency expected. The agency has had to go through line-by-line calculations for individual cases. Exhibit 1 sets out some of the progress that has been made, especially for former police officers who are members of the police pension scheme.

That realistic projection needs to continue, especially now that the agency has gone through some of the—arguably—cleaner data in relation to police members who are now retired. The agency still has to go through data in relation to the NHS and teachers schemes, which will, inevitably, be complicated.

The timescales need to be transparent and avoid optimism bias, and there needs to be clear, transparent and consistent communication, whether in relation to meeting the deadlines at the end of 2027 or, as we mention in paragraph 13 of the report, potentially into 2028 for some of the NHS calculations. There is a lot of work still to do, and it matters that that is communicated clearly to individual members and to scheme members across the piece.

Colin Beattie: Have you had an opportunity to see the assumptions behind the original estimates about time? Did they seem reasonable?

Michael Oliphant: We have not looked at that. As the Auditor General mentioned, when the new chief executive was appointed in June 2024, he made some changes to governance. However, by his own admission in his evidence to the Finance and Public Administration Committee in December, it was a while before he realised the scale and complexity of the challenges.

During that time, the agency employed contractors to oversee the project, but it also sought assurance from the Scottish Government in the form of the digital assurance office providing it with health checks. That office provided an amber assessment of the project in September 2023, and an amber assessment was also reported to the audit committee in January 2024. The assessment moved to amber-green in March 2024, when the office said that it had found an improving position with strong project leadership being in place.

Tied to that were the agency's risk registers, which scored the remedy project at 100 out of a maximum of 250. Our review of the governance papers showed that it was not until the latter part of 2024 that the remedy risks really came to light in what was being provided to the governance groups. The risk register then put the score at 250, which is the highest that it can be. It was not until the turn of 2024 into 2025 that the risks to the original timescale became apparent.

Stephen Boyle: It is fair to say that some of the legislation and the guidance to pension schemes to support the remedy calculations were not provided on time. The agency found data quality issues as it progressed, as well as issues with the complexity of the calculations that it was working towards. As it noted in its evidence to the FPAC, it embarked on the ill-health retirement assessments with the UK Government-set deadline of 2025, but they were delayed. The SPPA was not the only provider that was unable to meet that deadline.

The agency now has a much better understanding of the complexity of the issues, and it is working through them. What matters now is that the revised deadlines that are set are realistic, for all the reasons that you mentioned in your original question, Mr Beattie. Individual pensioners may or may not be receiving the right amounts through the systems. It is also important to be clear

so that people's expectations are managed effectively.

Colin Beattie: Paragraph 12 of your report states:

"the SPPA's Chief Executive wrote to the Scottish Government with a progress update and a request for additional funds over the medium-term period to deliver Remedy."

In the bullet points that follow, you deal with different scenarios and you note that, in the worst case, it could be 2030 before this is resolved. What amount of additional funds did the SPPA request from the Scottish Government in September 2025 and what amount did it get? What was approved? Was the full amount received?

Stephen Boyle: Michael Oliphant can answer that.

Michael Oliphant: In that request, the agency was looking for about £1.8 million, given the budget pressure. I believe that that was found through offsetting savings within the corporate portfolio.

Colin Beattie: So the SPPA received the full amount.

Michael Oliphant: That is my understanding—it received what it had asked for.

Colin Beattie: You know that for sure.

Michael Oliphant: Yes.

11:45

Colin Beattie: Your report says that the SPPA wrote to the Pensions Regulator in October 2025 to advise it of further delays and that, at the time of the audit, the regulator

"had not provided a view on the SPPA's actions or deadline extensions."

Do you know whether it has now provided a view? If not, is there an expected timescale?

Michael Oliphant: We have not heard the Pensions Regulator's view. We have asked for that. I ask Stuart Nugent to comment on the recent dialogue that we have had with it.

Stuart Nugent (Audit Scotland): We wrote to the Pensions Regulator several months ago, and we have been in on-going dialogue about the legal background to our query, given that we are dealing with a Scottish situation and that the regulator exists outside Scotland. We are considering the latest communication that we have received from the regulator, but we have not yet had a view from it on the action that the SPPA has taken.

Colin Beattie: From what you have said, should I understand that the Pensions Regulator has a problem in dealing with you as a Scottish entity?

Stuart Nugent: I would not say that. The Pensions Regulator is trying to clarify the basis of our information request, and we have not yet reached a point at which it is satisfied with what we have provided to it.

Stephen Boyle: There are fairly well-established arrangements for external auditors of pension schemes or pension authorities to communicate with the Pensions Regulator, so I would not read in any concern on our part. I think that we are just waiting for clarification on our query.

The Convener: I turn to Joe FitzPatrick to put some questions.

Joe FitzPatrick: Some of my specific questions have been answered in responses to others, but I will follow on from Colin Beattie's questions about the implications for individual members. Can you give us an idea of the scale of the impact that being on the wrong benefit could have on an individual, so that we can understand how that could impact on someone's life—whether they are already retired and have been given the wrong pension, or are looking to retire but have been given the wrong estimates?

Michael Oliphant: I do not think that we have that information at specific case level, so we would not know to what extent people are not getting what they are entitled to—or, indeed, in a small number of cases, whether they might have to pay money back.

We are looking at the application of a discriminatory period between 2015 and 2022. That is a smaller element over the course of someone's pension life, if you like, but, equally, it could be financially significant. We do not know the detail but, as I have said, there is stress for individuals in not knowing whether they are on the correct benefit, irrespective of whether they are entitled to additional funds.

Joe FitzPatrick: Do the individuals know that they are potentially impacted? Do they know that there is a question mark over whether they are getting the right amount?

Michael Oliphant: Yes, they should know. Back in the latter part of 2023, the agency wrote to all affected members to say that their calculations would be reviewed as part of the process.

Joe FitzPatrick: Are you confident that that part of the transparency of the process has been successful?

Stephen Boyle: Of course it matters that people are informed, but I guess that people then want to know what that means for them personally and whether they are being underpaid. People may then think, having worked however many years in

public service, that they are not getting paid what they are entitled to and should be receiving the pension that they are due—or, perhaps more distressingly, as Michael Oliphant mentioned, that they may have been overpaid a pension and are sat with a liability.

In the report, we try to convey the point that this is a complex process, and the SPPA is not alone in working through it, but it must be clearer in order to manage people's expectations. As I mentioned to the convener earlier, there is good progress on police pensions, but considerable work remains on the firefighters, teachers and NHS schemes.

Joe FitzPatrick: You said that, if someone was underpaid, they would be compensated by 8 per cent, which seems fair. However, I am slightly concerned about the opposite situation. If someone has been overpaid, will they have to pay that back? If so, would they have to pay it back with interest? What would happen for someone in that situation?

Michael Oliphant: Whether interest had to be applied would depend on the individual circumstances and the time period involved. I am not entirely sure. There is a small number of cases in which an individual has been overpaid. I do not know whether Stuart Nugent has anything to add.

Stuart Nugent: That was discussed at the Finance and Public Administration Committee. It was to do with a tapered relief, and the SPPA thought that a very small number of people might have been overpaid—I think that the number quoted was 30. We do not have full sight on that, and that is as much as we know.

Joe FitzPatrick: Would those people be expected to pay that back?

Stuart Nugent: I do not know.

Michael Oliphant: My understanding is that they would be expected to pay it back, but I do not know the terms on which they would have to pay it back. It might be over an extended period, as opposed to in a lump sum.

Joe FitzPatrick: The UK Government has set the 8 per cent rate for someone who has been underpaid. Has it also set a percentage for someone who has been overpaid?

Michael Oliphant: I am not too sure whether that would apply in such a situation. We can check and come back to the committee.

Joe FitzPatrick: That would be helpful. Thank you.

The Convener: I turn to Graham Simpson to put some questions.

Graham Simpson: As with Joe FitzPatrick, a lot of what I was going to ask has been covered, but I will pick up on the point about people being overpaid, because it is a serious point. Even though it might affect only a small number of people, they might have been overpaid significant amounts. Throughout this period, a number of people will have passed away who were not getting enough or who were getting too much. What is happening in those cases?

Michael Oliphant: In those cases, it is the beneficiaries of their payment who will make a choice based on the remedial service statement that they get. In the case of a deceased member, it passes on to the beneficiary.

Graham Simpson: Do we know whether that has been going on? Just imagine that you are a widow or a widower and, unbeknown to you, your partner has not been getting enough pension or has been getting too much. Suddenly, you get either a letter saying, "We owe you this" or one that says, "You owe us that." Has that been happening?

Michael Oliphant: Yes. It is one of the priority categories that the agency has been given. Ill-health assessment is one priority category, and beneficiaries of deceased members are another. There are various complexities with the calculations that have to be made.

Graham Simpson: Do you have any idea of the numbers that are involved?

Michael Oliphant: No.

Stephen Boyle: We can certainly check our records, but I think that the scale of the numbers might have been something that the chief executive of the SPPA covered in his evidence to the Finance and Public Administration Committee.

This illustrates the importance of safe progress. As Graham Simpson points out, especially given the nature of the schemes that the SPPA administers, it will want to be satisfied that it can progress as quickly as possible and reassure retired scheme members and families that they are providing members or their beneficiaries with the correct level of pension.

Graham Simpson: I think that it was Michael Oliphant who mentioned the reliance on manual processes, which seems a bit bizarre in this day and age. In the pension sector, it used to be normal practice for someone to sit down and work things out manually but I would not imagine that that is the case nowadays—although it appears to be the case with the SPPA. Why has it got to the stage of people having to sit down with a pen and paper and a calculator to work things out, rather than hitting a button to get a figure?

Stephen Boyle: Historically, there has been underinvestment in the Scottish Public Pensions

Agency's IT systems. My predecessor produced a section 22 report and a section 23 report in 2017 or so that set out the circumstances surrounding what was, ultimately, the unsuccessful implementation of an IT system for pensions administration. Some of the legacy of that is still felt today within the SPPA. It does not have an effective IT system that allows it to do what you would expect. It is not unreasonable for you to expect that there would be some system automation in order not just to produce remedy statements, but to handle some of the day-to-day business as usual. As Michael Oliphant mentioned, there has been significant investment in additional staffing resources within the agency so that it can free up some of the longer-standing members of staff to do some of the manual interventions and calculations that are necessary for individual records.

The agency recognises that it needs to do more to invest in IT and data management. Both those processes need to be improved so that the agency can function as the committee would expect, with a level of automation in the regular, timely provision of annual benefit statements and in other service standards being met for deferred members and active members of the pension schemes, which will require investment. You are right that there is a reliance on manual interventions in the system by expert pension administrators. As we have already touched on, there are long lead-in times to train people to equip them with the level of expertise to do those things. There is no easy fix, but it requires considerable focus on IT to transform the service into what you would expect of a modern pension administration provider.

Graham Simpson: That is really concerning. Do you know whether SPPA has ever looked at bringing in some help from the private sector to get it through this period?

Stephen Boyle: The SPPA uses private sector systems and has an arrangement with Altair, which provides pension administration systems. The previous statutory reports that I referred to were about planned engagement with private sector providers. The SPPA has relevant expertise on its audit and risk committee and its management advisory boards. It is not that there is a lack of diagnosis of where it might improve its arrangements, but the organisation's current focus is on addressing the challenges that are presenting in resolving remedy. In due course, the focus will have to be on equipping the SPPA for what it needs to be in the future, while addressing its current issues. I will pause and turn to colleagues, who may want to say more.

Michael Oliphant: It is worth saying that, as the SPPA works through the complexities with remedy calculations, there are a number of different categories that an individual case could fall into. Those categories could relate to marital status, pension-sharing arrangements following divorce, job changes, working pattern changes, ill-health assessments, and transfers into and out of the scheme over the period. The more categories a member is involved in, the more complex the calculation becomes, particularly if someone has already retired and retrospective adjustments need to be made.

The agency gave priority to the police scheme, which involved developing 27 different software calculators that can be used to quicken the pace when it comes to the other schemes. It can use those software calculators not only for remedy but for its business-as-usual activities. It means that its investment in developing the calculators is not immediately lost when working on business-as-usual activities.

12:00

Graham Simpson: Okay. Committee members have probably not had the chance to read the letter that was written to the convener of the Finance and Public Administration committee and forwarded to this committee. Interestingly, the letter says that a meeting is scheduled today between

"the SPPA Chief Executive and Minister for Parliamentary Business … with an agenda focused on a 'deep dive' of McCloud Remedy delivery in the police pensions immediate choice cohort"—

whatever that is—

"member communications and engagement, and SPPA resources."

I do not have a question for the Auditor General about that, but I wanted to highlight that there is a meeting today and that it would be good for us to hear about its outcome.

The Convener: We will follow that up.

The deputy convener will now put some final questions to the witnesses and wrap up the session.

Jamie Greene: A lot of ground has been covered, so I will keep it brief. Auditor General, have you had a chance to review the letter from the SPPA to Kenneth Gibson, which Mr Simpson just referred to, and the letter from Ivan McKee, the minister, to Kenneth Gibson? I appreciate that both are dated as having been sent yesterday. Has Audit Scotland had a chance to briefly look at them before today's session?

Stephen Boyle: Yes, we have. The agency shared them with Michael Oliphant towards the end of yesterday. I am familiar with the letters, which I have in front of me.

Jamie Greene: Okay. What do you make of them?

Stephen Boyle: You will see from our report that one of the things that we comment on is the need for more transparency, which is important. The letters go some way to clarifying the scale of the issues that are in front of the agency and the need for it to communicate better. Other aspects are helpful because, as Mr Simpson indicated with his last point, there is a great deal of technical language. The SPPA's letter sets out what "immediate choice cohort" and "active cohort" mean, which comes off the back of the Finance and Public Administration Committee's questioning of the agency about those aspects.

However, the letters do not persuade me to deviate from my overall conclusions about the need for progress and for better transparency around that progress; the need for the agency to address the wider issues that are in front of it, which we set out in the report, around digital and data capabilities; and the need to transform its services for its scheme members in the future.

Jamie Greene: I am playing devil's advocate, because I do not have a view on the SPPA's efficacy or otherwise, but the body has a lot of money and people. It has hired 100 additional staff, which begs the question of how many staff it had in the first place. Yesterday's letter said that that is an increase of 30 per cent, so let us assume that it had 300 to 350 staff as a baseline. The addition of 100 staff means that it has around 400 to 450 staff, which is a massive jump for an agency in a single year.

Looking at SPPA's budget, I see that it has been given around £123 million, presumably of public money, by the Scottish Government over four years—that includes the coming financial year—just to administer the pension scheme before a single penny of pension is paid. Is that unusual? Is it proportionate?

Stephen Boyle: You are right about the numbers. There has been a significant increase in head count in order to deal with the issues that are set out in the report, which require significant manual intervention. It takes a long time to train people—I think that the chief executive said that it takes about a year to equip somebody with the expertise to support the calculations as part of the process.

Michael Oliphant mentioned the number of additional software calculators that have had to be developed to help the agency arrive at some of its judgments. I am also sure that there is a caseload of correspondence from people who are keen to understand the situation with their statements.

I think that the numbers reflect the lack of historical investment in digital capability. The work of the agency is still predominantly a manual-based enterprise of administering and then working out calculations. That is a policy choice for ministers, as advised by the chief executive, and it may be the model that they wish to pursue.

You are right that the situation reflects the balance between people skills, expertise and digital capability.

Jamie Greene: The agency alludes to automation in its response, and it seems to have made quite a lot of progress in that regard. We can ask these questions when its representatives come before us, of course, but there is one phrase that the agency used that I quite liked: it stated that it wants

"to get it right first time".

It will have to spend a bit of time on the calculators and on working out how to remedy. Once that is done, however, the automation of the process can allow the agency to rattle through the case backlog. I assume that that is what it is saying to us, reading between the lines. Is that not a good thing? Would you not want to spend a bit more time setting up those processes—presumably with some manual oversight and intervention—before then reaching the point at which you were comfortable that accurate figures were coming out the other end of the machine? I am sure that the last thing that the agency wants—given the context of Mr Beattie's line of questioning—is to get through the process quickly and produce wrong information, so that people get statements that are over, under or wildly different. It is hard to criticise the agency for its approach.

Stephen Boyle: That is very fair. The automation point is an interesting one. There is some inevitability to people's expectations, including scheme members' expectations. Broadly, people think that they will be able to log on to the website with the right user identification and password and get their statement, so that they can see what their benefits are. There should be calculators available for them, so that they can project and work things out for their individual circumstances.

In revisiting the evidence given by the agency's chief executive and his colleagues to the Finance and Public Administration Committee, we noted that automation was being developed with the Scottish Government's centre of excellence. In some cases, that was reducing tasks that had taken an hour to two hours down to five to 20 minutes. That is a good thing for organisational efficiency. However, although that would take the agency so far, it would not necessarily work for reviewing some highly complex cases.

On your overall point, deputy convener, I agree. I think that automation will be a feature of pensions administration, and it may increase organisational efficiency—but there need to be the right safeguards for complex cases, with some levels of appropriate human oversight.

Jamie Greene: Do you know whether the 100 additional staff are just temporary contractors who have been brought in to deal with the issue, or has the agency's base level of full-time-equivalent staff rocketed?

Stephen Boyle: I think Michael Oliphant mentioned that they were on temporary contracts, but you are right that that is an important aspect. There is a wider assessment of what the future holds for the agency in terms of workforce planning and the adoption of technology. Those will be key pillars of a baseline for the provision of service. In many ways, there will be complexity in doing that while the agency is dealing with remedy. As our report sets out, based on the agency's forecasts, we could be into 2028 before the agency is clearing the backlog of remedy. At that point, how its workforce interacts with technology and what the scenarios and forecasts are will shape what the new baseline will be.

Jamie Greene: Like other members, I would be concerned that somebody at a later stage in life who has retired with health issues, for instance, might have to wait two years to get a back payment in their bank account when they could be benefiting from it now. I know that some cases are complex and lengthy, but do you think that the process should be sped up? Should there be a target for getting through the backlog more quickly, so that people—presumably pensioners, for the most part—will get their money?

Stephen Boyle: That speaks to the heart of why I decided to do a section 22 report: I felt that there was a public interest, and individual pensioner interest, in supporting parliamentary scrutiny through this committee in order to support additional transparency and help the agency meet its new objective of setting realistic deadlines. It is not for me to suggest alternative deadlines, but deadlines should be set that are deemed to be realistic and that avoid being overly optimistic, as we describe early on in our report. Deadlines need to be realistic and appropriate, but also appropriately stretching. There are now 100 additional staff and the organisation is learning, as it works through complex cases, so it will be for the chief executive and his colleagues to take a view about whether 2028 is still the right deadline or whether there is a better date, and to communicate that appropriately to scheme members.

Jamie Greene: I have had a chance to read the other letter from the minister to the Finance and Public Administration Committee, which was, literally, thrust under our noses at the beginning of the meeting. It is quite short, and I was quite struck by the tone. It seems very different from and perhaps less contrite than the other letter. The first two pages are essentially a veritable "Why? This isn't my fault. It's not the Scottish Government's fault. This is the UK Government's fault." I have no interest in the politics of all of this, but the minister makes some points that I thought you might reflect on, Auditor General.

On the first page, the minister says that the whole issue extends from the fact that the UK Government

"did not understand the complexity of the remedy"

and had set an unrealistic timeframe.

Three specific accusations are made. First, the UK Government should not have made the changes in the first place, because they were not compliant with the European convention on human rights. Secondly, not enough work was done to identify what timeframes would be needed for the remedy, so the deadlines were completely unrealistic. Thirdly, the UK Government was supposed to issue guidance to various public agencies, but the guidance arrived after the deadlines had passed. Those are quite profound criticisms of the UK Government by another Government. Do you have any thoughts or reflections on that?

Stephen Boyle: I will cover those as appropriate. We touched on the third point in our report. Some of the guidance arrived after the deadline, so that was, inevitably, part of the narrative about why the deadline was not met.

There is a judicial judgment about the complexities involved. I will not take a position on that, other than to note that the McCloud/Sargeant case judgment identified that there had been age discrimination in the original intent to move scheme members from a final salary scheme to a career average scheme, but that the protections that were offered were deemed to be inconsistent with the law on age discrimination.

On that basis, we are content with what we set out in our report. There needs to be transparent communication and the remaining remedial service statement cases need to be addressed.

We know that the agency still has a lot of work to do, and in your earlier questions you touched on the additional investment of public money in the agency. The agency should do that remaining work as quickly as is realistic and, in due course, it should identify what that means for its future operating model.

Jamie Greene: I knew, before I asked the question, that I would not be able to drag you into that territory.

I note the letter, however. Both letters were issued on the same day but are markedly different in their description of how we got to where we are and whether things are looking better. I presume that more will come out in the wash when we speak to the agency.

The Convener: I thank Michael Oliphant, Stuart Nugent and the Auditor General for their evidence this morning on this important report.

We will convene a special meeting of the committee on Tuesday 17 March, when we will take evidence from the chief executive of the Scottish Public Pensions Agency, as well as from the Scottish Government's director general corporate, because there is some responsibility in that quarter, too. We look forward to that session, when we will be able to put some questions to them.

As I understand it, Auditor General, this is the final public session of the Public Audit Committee that you will attend. I say, on behalf of the committee, a great thanks to the staff at Audit Scotland, and especially to you, for your outstanding leadership of the organisation. The public service that you provide, the spotlight that you shine, in the public interest, and the quality and standard of the work that you produce are exceptional. It has allowed us, as a committee, to scrutinise public bodies in the way that we have been able to do over the past five years—at least, while I have been chairing the committee, because Colin Beattie goes back even further. The work that you do provides not just this committee and Parliament, but the public, with a hugely important public service. I wanted to put that on the record, on behalf of the committee.

12:15

Meeting continued in private until 12:47.

Official Report
Room T2.20
Scottish Parliament
Edinburgh
EH99 1SP

Email: official.report@parliament.scot
Telephone: 0131 348 5447

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

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

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

The Scottish Parliament
Pàrlamaid na h-Alba