OFFICIAL REPORT
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Public Audit Committee

Wednesday 4 March 2026

Session 6

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Pàrlamaid na h-Alba

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PUBLIC AUDIT COMMITTEE
9th 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:

Fiona Bennett (Scottish Government)
Caroline Lamb (Scottish Government)
Christine McLaughlin (Scottish Government)

CLERK TO THE COMMITTEE

Claire Menzies

LOCATION

The Alexander Fleming Room (CR3)

Scottish Parliament

Public Audit Committee

Wednesday 4 March 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 ninth meeting in 2026 of the Public Audit Committee.

Our first agenda item is a decision on whether to take agenda items 3, 4 and 5 in private. Do members agree to take those items in private?

Members *indicated agreement*.

"NHS in Scotland 2025: Finance and performance"

09:30

The Convener: Our principal agenda item is further consideration of the Auditor General's report, "NHS in Scotland 2025: Finance and performance", which is an annual audit report. We are pleased to welcome, to give evidence on the report, Caroline Lamb, accountable officer for the national health service and director general for health and social care; Fiona Bennett, chief finance officer, Scottish Government health and social care directorate; and Christine McLaughlin, chief operating officer and deputy chief executive, NHS Scotland.

We have quite a number of questions to put to you on the report. Before we get to those, I invite Caroline Lamb to make a short opening statement.

Caroline Lamb (Scottish Government): Good morning. I am grateful for the opportunity to be here to respond to questions on Audit Scotland's report, "NHS in Scotland 2025: Finance and performance", as well as any further questions that the committee may have about the audits of NHS Ayrshire and Arran and NHS Grampian.

We have given our full consideration to the recommendations in the NHS in Scotland report. We were pleased to see that Audit Scotland noted the progress made on our reform and renewal strategies through the publication of the operational performance improvement plan, the population health framework and the service renewal framework. The operational performance improvement plan has driven the progress that we have seen this year. The latest statistics show improvements in new out-patient, in-patient day-case and diagnostic waiting lists and activity. Over the 12 months to January 2026, in-patient and day-case activity was more than 270,000, which was 5.6 per cent more than in the previous 12 months. Waiting lists continue to fall in Scotland, with waits of more than 52 weeks having reduced for eight months in a row.

Of course, while we acknowledge those improvements, we know that there is a lot more work to be done. We will continue to work with NHS boards to drive change and improvement as we work towards the aim of our guiding reform frameworks. We are committed to publishing reports on delivery against the key actions in the operational performance improvement plan and against the actions set out within our reform frameworks.

The Audit Scotland report is always an audit of a snapshot in time. Since its publication, time and work have moved on. As the committee will be

aware, since the publication of the Audit Scotland report, the Scottish Government's budget for 2026-27 has been passed. In providing almost £22.5 billion of investment in health and social care services, that budget exceeds consequentials and provides a real-terms uplift to enable more sustainable and resilient services. The provision of more than £17.6 billion for health boards represents a real-terms uplift of 1.8 per cent, while spending across the NHS will have risen by nearly £5 billion by the end of this session of Parliament. The £2.4 billion for primary care includes support for recruitment, retention and capacity building. More than £98 million of additional funding is being provided in 2026-27, and a further £36 million is being provided to establish new high street walk-in general practitioner services, the first of which we are now seeing opening.

We also note Audit Scotland's findings in its 2024-25 audits and subsequent section 22 reports on NHS Ayrshire and Arran and NHS Grampian. Those boards both recently moved to stage 4 of the NHS Scotland support and intervention framework, which indicates that the Scottish Government is providing an enhanced level of support and oversight to deliver a sustained improvement in those boards' financial positions.

As always, we will be very happy to answer the committee's questions on any of the audit reports.

The Convener: Thank you. For the record, do you accept the findings and recommendations of the Audit Scotland report?

Caroline Lamb: Yes, and we will be working towards addressing the recommendations.

The Convener: I want to ask about an item that you touched on towards the end of your opening statement: the support and intervention framework that you operate. You are right that we had NHS Grampian and NHS Ayrshire and Arran before us, because they were both the subject of section 22 reports. Section 22 reports are produced when things are not going terribly well.

One thing that stood out to us was that NHS Ayrshire and Arran, for example, has been in deficit for, I think, seven years and has been at a high level of escalation for a long time. Our working assumption would be that, if a board is escalated, that is in order for it to be turned around and de-escalated. Some of us have experience with boards where that has happened—it happened with NHS Forth Valley, for example. Why has NHS Ayrshire and Arran been allowed to sit at a high level of escalation for as long as seven years?

Caroline Lamb: As you rightly say, NHS Ayrshire and Arran has been in escalation at level 3 for a number of years. That has meant that the Scottish Government has been supporting the board. There were questions and commentary about the input from Viridian Associates, which is just one example of the way in which the Scottish Government has been supporting the board. The increased level of escalation reflects the fact that, despite those efforts, we have not seen the improvement that we would have expected to see in NHS Ayrshire and Arran's financial performance.

The stage 4 escalation moves NHS Ayrshire and Arran to a level at which we will continue to provide extra support but we also put in place oversight and assurance board arrangements. You heard from NHS Grampian how helpful it has found those assurance and oversight arrangements. We are looking for improvement to be delivered through a combination of support. We have a new interim director of finance coming in, and we are also putting in place the oversight and assurance processes.

The Convener: What is the point of a support and intervention framework and the Scottish Government supporting and intervening if that makes no difference to a health board's performance or financial position? Is not the purpose of escalation to bring about an improvement in performance and financial management?

Caroline Lamb: Yes, of course—the purpose of the support and intervention framework is to support boards to improve.

The Convener: But it has not happened in this case, has it?

Caroline Lamb: It has not happened in this case, which is why the board has been escalated to a further level. We have a number of boards that are escalated, and we monitor those. As you noted, boards move up and down the escalation framework. Our aim is always to see boards moving down. We were not seeing that movement at NHS Ayrshire and Arran at level 3, so it has been escalated to level 4.

The Convener: That has come after a considerable period of time in which there has been an escalated level that has not led to any change in performance.

Caroline Lamb: Yes, and that has not been without our providing additional support in an effort to change that. We recognise that the issues at NHS Ayrshire and Arran are long-standing ones. Some of them are around the need to look at redesign of services and how the board can provide its services differently. The level of support that we are providing will enable the board to get into those considerations. Just last week, you heard from Gordon James about the work that the

board is doing in that respect, and the Scottish Government will be looking to support it with that.

The Convener: We acknowledge that there has been a change in the leadership of the board. To an extent, that leads me to one of the overall points that is made in the audit report and that was articulated by the Auditor General when he gave evidence to us on the issue. He said:

> "It is important for … boards to be absolutely clear about what happens in different scenarios."—[*Official Report, Public Audit Committee*, 7 January 2026; c 48.]

Clearly, NHS Ayrshire and Arran has not understood what is supposed to happen and has not been absolutely clear about what it is supposed to do when it is escalated.

Caroline Lamb: I do not think that that is strictly the case. I think that NHS Ayrshire and Arran has understood that it was escalated at level 3. When the previous chief executive at NHS Ayrshire and Arran announced that she was moving on from the board, I had a conversation with her and the chair about the board's level of escalation. The Scottish Government also has a national performance oversight group, which keeps an eye on all issues across NHS boards. NHS Ayrshire and Arran has been pretty clear about the need to manage its financial balance.

Having new leadership, with Gordon James having joined the board, has been a positive move. As part of the level 4 escalation, we have ensured that Gordon can be supported. That is why Gordon welcomed the escalation. It means that he can be supported to make the changes that need to be made to allow NHS Ayrshire and Arran to get back to financial balance.

The Convener: Can I take you to the other side of the argument? A number of health boards have never gone into financial deficit and have never needed to be escalated. They might not have met all the performance targets but, nonetheless, they have not found themselves requiring brokerage or financial bailouts or loans. What do you say to them?

Caroline Lamb: It is clear that there are different challenges and issues that need to be addressed across Scotland. You are right. As well as responding to financial balance issues, our escalation process and support and intervention framework respond to other issues. The challenges that NHS boards face vary across the country and across time.

The financial challenges at NHS Grampian developed relatively recently, but they developed pretty swiftly and were of a magnitude that led to its level of escalation.

We accept that having boards that are struggling to balance causes pressure on the whole system. It means that we are not able to invest in the ways that we would wish to. That is why, through the financial delivery unit and other measures, we are focused as much on supporting boards that are not in financial escalation, so that they do not get into that position, as we are on supporting boards that are in a challenging financial position.

Fiona, do you want to add to that?

Fiona Bennett (Scottish Government): I will just briefly add that we have moved away from the old brokerage system to the deficit support funding system to make it a more equitable process. All territorial boards get an NHS Scotland resource allocation committee share of sustainability funding, whereas before that did not exist.

Those boards that are above stage 2 in the framework will also get a share of deficit support funding, in recognition of the challenges that those boards face. Through the move to stage 4, NHS Ayrshire and Arran has received an increase in deficit support funding to help it on its recovery journey. The new system is more equitable than would have been the case under the old brokerage system that we had in place.

The Convener: Other members of the committee will ask about the allocation formula and so on.

An issue that we have raised previously in evidence is that it would be one thing if it was the case that the health boards that are in financial deficit and that regularly require brokerage were in that position because they were exceeding targets, outperforming other health boards and going above and beyond in meeting the needs of their population, but we discovered that those health boards are not only in financial difficulty but underperforming on targets compared with similar health board areas. What are your reflections on that?

Caroline Lamb: I agree. NHS Grampian was escalated not only because of financial performance but because it was an outlier in relation to performance in a number of areas, especially unscheduled care.

The escalation process in NHS Grampian has involved support not only to achieve financial balance but in relation to how it can improve its performance against other metrics, especially on unscheduled care, as well as planned care.

The Convener: I suppose that that begs a question about why it is necessary to rely on unannounced inspections by Healthcare Improvement Scotland to bring about the necessary changes, interventions and supports. Should we not have a better system of communication that lets you understand what is going on out there? Such a system could, for

example, let you know that there are regularly six beds in a four-bed ward, or whatever the issues are. We heard about the issues at Dr Gray's hospital, for example, that came up in the NHS Grampian escalation. Do you need to wait until there is a swoop by the HIS team to understand that activities are not being conducted to a level that we would expect and that there are public health issues in relation to how patients are being treated?

09:45

Caroline Lamb: I will ask Christine McLaughlin to give you a bit more detail. However, to be clear, within my directorate, through our national performance oversight group, we have a process that looks at bringing together data around the performance of our NHS boards. We look at financial data, performance data and soft intelligence, which includes intelligence that we get through, for example, HIS reviews and the survey of doctors in training that NHS Education for Scotland conducts. We bring together all that information so that we can think about where boards are and which boards need more support and might need to be supported through the support and intervention framework.

Christine McLaughlin (Scottish Government): I agree with the point that you are making, convener. Often, when a system goes out of balance, that manifests itself through the financial position, but it does not start there. Through the group that Caroline mentioned, which I chair, we bring together data and intelligence across the system. It is probably also worth saying that, in order to keep focus, we look at one system relative to another. Personally, I do not think that having everybody escalated to a heightened level helps us, because we try to differentiate and decide where we need to put the support.

You mentioned NHS Forth Valley. The process is very intensive for everybody who is involved. We want to intervene on the basis that that will lead to an improvement, so we look across the whole system in order to get a balance.

The work of Healthcare Improvement Scotland is an important component of that. We now have specific escalations in relation to mental health and maternity services. That is part of the picture. You are right—there will sometimes be an inspection that leads us to go faster on some things, because we have evidence in front of us that merits action. However, what we really want is to get a sense of what is ahead of us and to think about the work that we need to do.

We can also use that process to take steps before escalating. In that regard, it is really important for us to look at how we see the signs and how we can learn from the work at NHS Forth Valley and NHS Grampian, so that we can take steps before escalation. It is designed to be a supportive process, but it is a very intensive process. There is probably more that we can do to look at how we can learn from other systems and take steps before reaching the point of escalation—certainly before reaching a level 4 escalation.

The Convener: That leads me on to my final question for this part of the discussion, which is about governance arrangements. It is not simply a question of you, from the centre, stepping in, escalating and providing extra resource, such as consultants or people from other health boards to work with the affected health board. It is also about the territorial arrangements at board level, is it not?

Do you think that there is sufficient support, training and understanding at the level of territorial health boards when it comes to their role in overseeing the financial management of the health board and ensuring that it is performing to the level that we would expect and is not breaking the rules that Healthcare Improvement Scotland would come down hard on? Do you think that that system is working well?

Caroline Lamb: You are absolutely right. The responsibility lies with territorial boards. The relationship between the non-executives and the executive team is particularly important. The non-executives need to get the right information to be able to hold their executive team to account. That is a really important part of our system. Even when a board has been escalated to level 4, it is still the board that is responsible for delivering the improvements that we expect to see.

In order to support that, as you will be aware, we have "The Blueprint for Good Governance in NHS Scotland", which is in its second edition. Boards have relatively recently been through a process of self-assessment against that, and they all have action plans that they are delivering. They are supported by a team in NHS Education for Scotland, which acts as a critical friend and looks across the range of self-assessment results that come back from boards, so that we are able to identify where themes are coming through and boards can learn from one another.

We provide a number of supportive mechanisms to boards. In our recruitment, especially of chairs of NHS boards but also of non-exec members, we focus on being really clear about those roles and responsibilities and ensuring that board members take up training in relation to their roles.

You are right that that responsibility is a really important part of our structures. We provide a lot of support to boards to help them to discharge that, but it is also something that we monitor through our performance management arrangements and the

soft intelligence that we receive about how board meetings are functioning.

Fiona Bennett: There is also really good evidence of a level of collaboration across the boards, and I have seen that grow over the past year or so. There is a peer support network not just at chief executive or chair level, but in the professional group. For example, with regard to the most recent escalations, both Gordon James and Laura Skaife-Knight could speak about the extent to which they have sought and received support from other boards, and not just for them in their roles; there are also quite a lot of examples of mutual aid, whereby boards are supporting one another much more.

There is a difference between a competitive environment and a supportive one, and I see movement towards a much more supportive network, which is something that we definitely want to see more of.

The Convener: You mentioned evidence; do you have evidence to support claims that new board members are being trained and that existing board members are being offered refresher training? Do you collect data on that?

Caroline Lamb: That would be part of the assessment against the blueprint for good governance, but I will come back to you as to whether we have any data. I should add that there is now a process of appointing a buddy for each new board chair who is appointed. A brand-new chair will be buddied up with a more experienced chair, so that they have a definite point of contact to go to. In fact, it is a bit more proactive than that—they will meet regularly to ensure that the new chair is being supported in their role.

The Convener: Good. Thank you very much. I now invite Colin Beattie to put some questions to you.

Colin Beattie (Midlothian North and Musselburgh) (SNP): At our meeting on 7 January, the Auditor General highlighted the fact that we are now entering a cycle in which private finance initiative—PFI—contracts are starting to fall due. Obviously, they are very complex. I have read through one of the contracts for the Edinburgh royal infirmary, and the financial options that are woven into the end of the contract are quite complex when it comes to what the outcomes might be and what the best option is to take. According to the Auditor General, it is not unusual for each PFI contract to have many different terms at the end, as to how the handover takes place and so on. There is no template. It is a bit surprising that they are not more similar, but, clearly, they were all negotiated individually. What financial risks arise from PFI contracts that are now reaching maturity? How are the boards preparing for the potential handover costs and the long-term liabilities that might go with that?

Caroline Lamb: I will turn to Fiona Bennett on this one. Obviously, we have been making sure that there is a lot of support for boards that are in that position so that they understand what those options are and very clearly understand what the financial impacts of those choices are.

Fiona Bennett: We have seven PFI contracts expiring between now and 2030, so we are very much doing that horizon scanning to understand what is coming up. Contracts are ending for the Edinburgh royal infirmary in 2027 and University hospital Wishaw in 2028. We work very closely with the Scottish Futures Trust and NHS Scotland Assure with regard to that finance, legal and estates expertise. There has to be quite a holistic approach to the end of those contracts to understand what the best options are, but we absolutely build that into our medium to long-term financial planning for both the cost and opportunity of those contracts ending, to understand what the future service model needs to look like.

Colin Beattie: Are the local boards not involved in that?

Fiona Bennett: They are. They will work directly with the Scottish Futures Trust and NHS Assure and our team will have part of that conversation so that we can have national oversight, but the local boards will have the expertise for their contracts.

Colin Beattie: Do the local boards have that expertise? I am basing this on the one contract that I have read, but the options are complicated and the outcomes are a bit uncertain—a bit back of the envelope. How do the boards get the skills that you say they have to take this through? You have talked about the Scottish Futures Trust, but there are also difficult legal aspects to deal with.

Fiona Bennett: There are, yes. Some of that expertise will come from the boards but, as you say, each contract is unique and it is not a regular process. People in a board area are not going to be doing this day in and day out, because it will happen only every so often. NHS Assure and the Scottish Futures Trust will provide some of that support but, when a contract is particularly complex, we will seek further external support—Deloitte has been providing the Edinburgh royal infirmary with some expertise on that—that will look at these things on a UK-wide and global basis. We will supplement local expertise within the public sector, but also within the private sector when it is needed.

Colin Beattie: The PFI contracts are about the management of the estate, which is quite a complex business. There must be few companies that can take that on, unless the NHS takes it in-

house, which is an administrative issue for the NHS. How is the NHS approaching that?

Fiona Bennett: Those options will be looked at to see what is optimal and whether there is the right sort of company that could provide that service or whether we need to look at it in-house. However, that happens months if not years before the end of a contract to ensure that we have done that forward planning and options appraisal to ensure value for money as well as continuity of service.

Colin Beattie: If that has been done years in advance of the end of a contract, some of them should already have been decided.

Fiona Bennett: Yes, and they are all at different stages. As I said, a couple of contracts are ending in 2027 and the University hospital Wishaw contract is ending in 2028, so they are already starting to go through the process of looking at those options. They are, however, at different stages, based on the individual contracts.

Colin Beattie: My concern is that, having looked at the different options, one of which is taking the management in-house, there are so few companies out there that we would end up continuing the existing arrangements under another name by default.

Fiona Bennett: Again, that will form part of the consideration, but it is vital that we base our decisions on value for money as well as ensuring that the service can continue to be delivered in the hospital without affecting safety and the quality of service for patients. It has to be about a value-for-money contract but also about the reality of the service.

Colin Beattie: Are you satisfied that we have a grip of that? The potential downside is huge, given the size of these contracts.

Fiona Bennett: It is extremely complicated, but I am confident that the boards that are coming to the end of their contracts have appropriate support and, if they do not feel that they have that support, they will come to us to request it.

Colin Beattie: That is good to hear. There are also backlog maintenance issues with the estate. I have a figure here of £1.3 billion, which is an awful lot of money, and £59 million of that is high risk in one way or another. What actions are being taken to address the high-risk maintenance issues that pose a direct threat to patient safety or operational continuity?

Caroline Lamb: Fiona Bennett can talk you through the work that we have done with boards on their business continuity planning and the extent to which we have funded those outcomes.

Fiona Bennett: One of the key steps that we have taken is to start the business continuity process so that we can see those high-risk areas across the country. Rather than boards having to bid individually for that support, they let us know what areas need the most urgent support. We have used red-amber-green ratings to understand those high-risk areas, and we have funded 100 per cent of those that are in red for 2025-26.

With regard to business continuity, it is important, as we move more into whole-system working from an infrastructure and capital perspective, that, through subnational planning, we review our estate to understand where it might be appropriate to rationalise it. That involves thinking about our older properties and whether they are still fit for purpose, and ensuring that we are sharing our estate across the public sector as much as possible.

10:00

However, the business continuity plan is focused on the backlog of maintenance in high-risk areas. As I said, we have fully funded the red-category projects within that.

Colin Beattie: You say that the high-risk areas are 100 per cent covered. Does that relate to the £59 million, or is it a different figure?

Fiona Bennett: It is the same part of it.

Colin Beattie: So that has been 100 per cent covered.

Fiona Bennett: Yes. We have invested £100 million in the business continuity plan in 2025-26.

Colin Beattie: Okay—thank you.

Delayed discharges and waiting times are an on-going issue. How are delayed discharges and wider system-flow pressures being addressed to support reductions in waiting times and reduce pressure on acute care?

Caroline Lamb: You will be aware that Audit Scotland published a report on delayed discharges; Derek Grieve and I were at the committee talking about that a few weeks ago. There is no doubt that the level of delays in our hospitals is a huge issue for the individuals who are delayed. We have all the evidence on how much it leads to deconditioning and deterioration; it is not good for people to be in an environment that is not their own home or a homely environment when they are clinically fit to be discharged. It also means that people are occupying a significant number of beds that would otherwise be available to improve our flow through hospitals and our ability to provide planned care on a more timely basis. It is, therefore, a significant issue for us all.

We are addressing the issue in a number of ways; Christine McLaughlin can say a bit more about that. We have been looking very much at how we keep people out of hospital in the first place, for example through not admitting them, and providing treatment in other ways. We are also looking at how we discharge people as early as possible. We should bear in mind that 97 per cent of discharges are not delayed, but even with those discharges, if we can get those people out of the hospital early in the morning, that helps to relieve flow through the rest of the day. Marginal gains can be made at every step of the process.

We are working with the discharge without delay collaborative to look at a number of measures around discharging people earlier in the day and reducing the length of stay, and working through all that. In addition, each NHS board is engaging with their partners in local government and integration joint boards. I remind the committee that local government has the statutory responsibility for social care, and the ability to access social care is key to reducing the number of delays. There is a huge amount of work going on across the piece in every area, overseen by the collaborative response and assurance group, which is jointly chaired by the Cabinet Secretary for Health and Social Care and Councillor Kelly from the Convention of Scottish Local Authorities.

Christine, do you want to say a bit more about the NHS actions?

Christine McLaughlin: Yes—let me know if I am on the right track with what you are looking for.

We often focus on individual components of the system, but if we step back from it, we can focus on two components. The first is being able to plan for the level of capacity that we need for planned care in order to meet demand across the system. Our target is to be in balance in that regard, and then to ensure that the backlog consistently comes down. The second component—they are both clearly linked—is how we manage flow through the whole system. Caroline Lamb gave some examples of that.

Sometimes focusing on one part of the system, whether it is delayed discharges or admissions through emergency departments, does not give us a sense of how we keep the whole system in balance. The work that we are doing on flow is designed to enable us to understand the coherence of all those components. As Caroline Lamb said, it is about keeping people out of hospital in the first place and making sure that, if people are admitted to hospital, they are treated on time and there is a flow through the system that allows them to go to the right place. It is about doing the work in advance of discharge so that they can be discharged.

We will get significant improvement in that respect through focusing on the totality and taking a more consistent approach to learning about the things that are making a difference across the country. I could speak for the rest of the session about good examples of various parts of the country.

What we have got to do, and I think that this is the role of Government in particular, is to understand what things are actually making a difference—and we can see that through outcomes—and have those things consistently applied across the country. I am not saying that that is an easy thing to do, but we have got to get people to approach it in that way so that we get sustained improvement across the system—within financial balance, as we talked about earlier. There are enough really good examples out there for us to be able to understand what "good" looks like and the things that we need to do to be able to move towards it.

To answer your question, that is really what we have got to be able to do. We need to set our sights on understanding what a system that works in balance in both unscheduled care and planned care will look like in the future, the extent to which we have got that in place, and where we need to invest more than we do at the moment in those areas.

Colin Beattie: From my perspective, looking in, the big issue seems to be the availability of care in the community that you can discharge into—you can improve efficiencies and so on within the NHS, but that is still the fundamental problem. The councils, certainly in my area, seem to have a big deficit every year on their social care side, running into millions of pounds over budget every year, yet the availability of social care is very restricted and they have difficulty recruiting people into that service, even when the money is there. You are working on this with local authorities and so on. Do you feel that it is improving? Are we heading in the right direction with it?

Caroline Lamb: One of the challenges here is that the picture is very mixed across Scotland. There is a lot of variability between the local authority and IJB areas, with a significant spread between the areas with the lowest number of delays per thousand of population and those with the highest. As Christine McLaughlin says, we can point to good examples across the country, but the challenge is to ensure that those examples get picked up and implemented. We know that there are challenges because local circumstances are different and you cannot always just lift and shift one way of working to another bit of the country, but there are some really good examples. Where systems have come together—the NHS, IJBs and local government—to focus on this, we can see

shifts happening. However, it requires constant attention.

Your point about the workforce is well made. We know that there are challenges in recruiting to social care posts—and, again, those challenges are not consistently spread across Scotland. We see far more of a challenge in remote and rural areas; that is sometimes linked to the availability of housing. However, we also know that there are things that we need to do to address some of the challenges around levels of pay and other terms and conditions in the social care sector, which is not a single, homogeneous employer in the same way as the NHS is, so terms and conditions vary quite significantly across different employers, and that, again, is a challenge.

In relation to the workforce—and Christine might want to say a bit more about where we see areas of improvement—the whole issue around international recruitment has been a challenge for the social care sector. The constraints on international recruitment have had and continue to have an impact. That is why we put £0.5 million, I think, into supporting folk who already have a visa and are able to work in the UK but are finding it more difficult to get jobs in other parts of the UK.

Christine McLaughlin: There is no doubt that there are pressures in the system in relation to social care capacities; there are pressures in some areas on acute beds within hospital environments, as well.

I was out talking to the team at NHS Forth Valley recently and what was clear there—it was great to see, given that the board had been in escalation—was the constructive and close working relationship between the local authorities and the health and social care partnerships with the Forth Valley chief executive and senior team in looking to find joint solutions to these problems.

We see the best progress when there are good working relationships and everyone contributes to finding a way through a problem. We try to avoid silos and people blaming one another for such issues. We consider the main pressures and how people can best provide support. There are good examples in the Falkirk area, and we want to spread them across the rest of the country.

The simple answer to the question is that there is no one solution.

Colin Beattie: Clearly, more work needs to be done in that regard.

I will move on to emergency and unscheduled care. In our evidence session on 7 January, the Auditor General said:

"The presenting symptom is that hospitals are unable to receive ambulances and people are not being handed over within 15 minutes. If ambulances are hovering for about an hour, it is because there is a backlog."—[*Official Report, Public Audit Committee*, 7 January 2026; c 58.]

There has been talk about some progress having been made in that regard. What actions are under way to address backlogs in the system that result in ambulances being delayed in their turnarounds?

Christine McLaughlin: At some sites, there are no ambulances queueing; at other sites, multiple ambulances are queueing. The answer is not to try to solve the ambulance issue by building a larger area for ambulances to wait but to improve flow within the system.

The Royal infirmary of Edinburgh was one of the sites that used to have one of the highest rates of delays, with ambulance crews waiting. It ensured that there were fast turnaround times in its acute receiving wards in order to avoid backlogs that result in ambulances having to stack.

There are other basic things that can be done. For example, over the winter, we invested about £1 million in hospital ambulance liaison officers. That is a practical step to ensure that the issue that you have talked about does not build up and that there is co-ordination between teams to allow ambulances to bring patients into emergency departments and then get back on the road. About £1 million has been provided for targeted liaison officers at sites where the largest numbers of ambulances are waiting.

Helping to have fewer ambulances waiting is about ensuring that there is flow through emergency departments in the way that there should be. Staff on the ground tell us that that starts early in the morning. If things really build up in the morning, it is hard to recover through the day. Therefore, ensuring that there are fewer people from the previous day still in the hospital setting is part of ensuring that there is better flow throughout the system.

The Centre for Sustainable Delivery, which leads on a lot of our improvement work in unscheduled care, has a number of components of work under way across all systems to allow for improvement and learning across all our key sites. As a result of that work, we have seen significant improvements this winter.

Caroline Lamb: Another aspect is ensuring that our systems result in ambulances having to convey people to our hospitals only when that is essential. Through flow navigation centres and ambulance crews being able to speak to senior clinicians, more than 50 per cent of calls to the Scottish Ambulance Service do not now result in people being conveyed to hospital.

All those things help. However, as Christine McLaughlin said, there is always more work to be done.

Christine McLaughlin: The Ambulance Service has a big focus on trying to treat people in their own homes, rather than having to convey them to hospital, as Caroline Lamb said. We see improvement in that area. Overall, fewer people are being conveyed to hospital, but alternative options need to be available so that only people who really need to be in hospital are conveyed to hospital. That is a big component of the work that we need to do.

10:15

Colin Beattie: Audit Scotland spoke to us about planned improvements such as frailty units and alternative pathways, but it also stated that those have been rolled out too slowly to ease the pressure. What progress has been made on those planned improvements?

Caroline Lamb: Christine McLaughlin might want to come in on the detail, but first I will say that we have been very focused on those improvements happening across the system. They are all about ensuring that people who do not need to be in hospital are not in hospital—whether that is achieved through the hospital at home service, which is the top-end system; virtual wards, where people's health conditions are monitored; or frailty units.

Frailty units provide an option for keeping our frail and elderly people out of accident and emergency settings and managing them in an environment where there is good communication with support networks, social care services and other forms of support in the community so that we can get them home as soon as possible. All the evidence shows that we are reducing the lengths of stays for frail and elderly people through the use of such units. I think that they are now operational in all acute hospital sites.

Christine McLaughlin: All mainland territorial boards and emergency departments have a frailty service in place. The improvement that we seek is to ensure that a standard for such services is achieved in all areas where there is a seven-day service. Having it in place is not enough. A board could tick a box to say that it has such a service, but we really need to have them all operating at the highest level that they can achieve. That is the work that we have in place, and we are on track to meet the commitment on frailty services by the end of the year.

Colin Beattie: Let me clarify my understanding on that. You said that there is a frailty unit in each area.

Christine McLaughlin: All mainland territorial boards have a frailty service.

Colin Beattie: But there is not one in each A and E department, of course.

Christine McLaughlin: There is a defined thing that is a frailty unit. Some sites will have a component for frailty in the emergency department; for others, it will be a service with designated staff. The benefit of such a service is that it involves a multidisciplinary team dealing with those patients to ensure that they get the best care, and its work is really targeted. It is key that we have a frailty service, and I reiterate that we have that in all our mainland territorial board areas.

The Convener: I will go to the deputy convener shortly, but, before I do that, Joe FitzPatrick wants to come in on one of the areas that Colin Beattie covered.

Joe FitzPatrick (Dundee City West) (SNP): I have a quick supplementary to Colin Beattie's questions about PFI contracts. The Government has moved away from the use of such contracts, some of which could now be regarded as historical or legacy contracts. For example, the Wishaw hospital project that you talked about predates this Parliament, yet we are still paying for it every year. Do we have a handle on how much the NHS has to pay for PFI and public-private partnership contracts every year?

Fiona Bennett: We collect the data that each board spends on PFI contracts. In some cases, that data is commercially sensitive, particularly in relation to the negotiations that come towards the end of the contract. We understand that, and we work with boards on both their value for money and their spend.

Joe FitzPatrick: Do you have a ballpark figure for that?

Fiona Bennett: I could provide that in writing, if that would be okay.

Joe FitzPatrick: That would be helpful, because then we would know the significant amount that the NHS has to spend. Colin Beattie's questions showed how badly written some of those contracts were in terms of value for money for our NHS, although they are historic and predate this Parliament.

The Convener: Thank you. We may return to PFI at some point later on, but Jamie Greene has some questions now.

Jamie Greene (West Scotland) (LD): I want to take us back to the bigger picture and to the premise of the Audit Scotland report. I draw your attention to page 3 of the report, which sets out the key messages that sum up where we are at. These are not trick questions; I genuinely want to try to get underneath the skin of some of this.

In key message 1, the sentence that jumps out at me the most is the second one, which says:

"Even with increased funding, the NHS in Scotland is not in a financially sustainable position."

Surely that must be a point of concern, given that you said that you accept the content of the report and its recommendations. Caroline Lamb, why, in your view, is the NHS not in a financially sustainable position?

Caroline Lamb: You are absolutely right, and that is a point of concern for me as the accountable officer for the portfolio. That said, I welcome Audit Scotland's recognition that boards have achieved unprecedented levels of savings. Sustainability remains a challenge, although, as we noted earlier in our conversation, that is not the position across all the boards: some manage to break even, but others are struggling to get to that position.

The underlying issues relate to demographics—our ageing population, more people living with multiple conditions, and everything that goes alongside those. There has also been significant growth in the medicines bill. New medicines are being developed every year, which is great, but they all come at a cost.

We need to support people to live longer, healthier lives. That is good for them and it is also good for the financial sustainability of the health service. We are doing that through the population health framework, and that is where we are also focused on our service renewal framework and our reform propositions. Through the service renewal framework, we need to consider how we can redesign services to achieve financial sustainability.

We are doing lots of things in the short term. You will have heard about the 15-box grid that we use to support boards in identifying areas where we expect them all to make improvements. It is through the work of the finance delivery unit, and through a focus on that grid, that we have supported boards to deliver those unprecedented levels of savings.

However, in order to get to financial sustainability, we need to look more fundamentally at how we can better spend the money that we have. Some of that goes back to the conversation that we have just had about delayed discharges. You will be aware that Audit Scotland pinpointed the cost of such delays as being £440 million. We need to find ways to support people where they need to be supported, which is not in hospital—that is at the most expensive end of the places where they can be supported.

There is lots that we need to do. Christine McLaughlin can talk about the work that we have been doing on improving collaboration across health boards. For example, we are making best use of our resources in planned care. We also need to think about how we can leverage digital and innovation opportunities to support population health and deliver services in an improved and more efficient way.

I could talk about business systems and subnational planning as well, but I am sure that we will come on to those aspects in other questions.

Jamie Greene: Thank you. I appreciate that comprehensive answer. I am glad that you mentioned some of the improvement plans that you have in place. There is the operational improvement plan, the health and social care service renewal framework and the population health framework—there is lots of jargony stuff there.

I am glad that you pre-empted my next question. In point 3 of its key messages, Audit Scotland identified that the ambitions are "long-standing" and many have "yet to be delivered". However, the key point is the

"persistent implementation gap … between policy ambitions and delivery on the ground".

That seems to be the sticking point. You can have all the frameworks and plans in the world—and do so with great ambition, which we share—but, as Audit Scotland has identified in its key messages, if the delivery on the ground does not match that ambition there will be a problem.

Caroline Lamb: We accept that the ambitions and the actions that are set out in our population health framework and the service renewal framework are not revolutionary. They are about areas of activity such as shifting the balance of care, which Audit Scotland particularly alighted on. We now have an increased number of tools to be able to do that. The committee has heard a bit about virtual wards and the hospital at home approach. Some of those services rely on technology that probably was not available 10 years ago, when people first started talking about shifting the balance of care.

However, I accept that there is a job of work for us to do to demonstrate that the frameworks are not just documents but very much about how we shift the way in which we deliver services. We can point to early examples of success in those areas. I will ask Christine McLaughlin to say a little more about what we have been doing through collaboration with boards on reducing waits for planned care, and how that is developing into our approach through subnational planning.

As confirmed in the recent budget, we are increasing our investment in general practice. That is absolutely focused on increasing workforce and so increasing capacity, and therefore having a

stronger and more robust primary care offer that can take some of that additional shift. We also have the general practitioner walk-in centres. Many of the things that we have already talked about are about shifting activity away from the acute hospital setting into the community, whether that is about ambulance paramedics treating people in their homes, or patients using hospital at home or virtual wards. Then there are the digital developments through the digital front door programme and the MyCare app for Scotland.

There are things that we can point to. I have probably focused on that shift because that is the issue that the Auditor General highlighted, but we have been working hard on delivering other things. Within the service renewal framework, we have announced the establishment of what was then to be known as NHS delivery and is now to be called public services delivery Scotland. That will come into being on 1 April, so it has almost been delivered.

I accept the criticism that we have struggled with implementation, but I believe that we have a track record already. As I said in my opening statement, we plan to publish what we have achieved against that. What we have done so far provides the foundations to build on and to accelerate the progress.

Would it help to hear a little bit more from—

Jamie Greene: Yes—I would like to interrogate some of the operational areas where you are making changes. Some of them are quite visible in the health service and people are already seeing new ways of being treated or dealt with. However, before I do that, I want to cover some of the financial issues, because that is an important area. We have taken quite a lot of evidence on it, and we have heard from two boards that are in a perilous financial position.

The issue of brokerage has come up quite a lot in our sessions, and the Auditor General spoke at great length about it when he gave evidence. There is cumulative brokerage—and when we talk about brokerage, we are talking about loans to health boards from Government—of £0.5 billion. That is a lot of money. If that money was ever to be repaid, surely it could be reinvested in the health service. However, let us be honest. Do you expect any of the money ever to be repaid? Which health board is in a financial position to pay back the loans?

Caroline Lamb: Our financial assumptions are not dependent on that funding being repaid. I will ask Fiona Bennett to come in on the difference between brokerage and financial sustainability funding. We have made the move away from brokerage, and it is now important for us to work with boards, at individual board level and, importantly, through our subnational planning arrangements, and to focus on getting to a place where we can step back from financial sustainability payments.

Fiona Bennett: Brokerage worked quite differently before the Covid pandemic. NHS Tayside and NHS 24 repaid brokerage, and that was how the system was designed to work. After the pandemic, more boards fell into financial difficulty and we recognised that the system was not working as it should.

You mentioned the outstanding £500 million, and that is not a number that we want to continue to increase. However, in terms of equity across the system, it is important that it remains repayable. As has been noted, some boards have never required brokerage and do not have an outstanding balance. From an audit perspective and for transparency in the annual accounts, it is important that the figure continues to be recognised.

However, as has also been noted, we have now moved to a different system of deficit support funding, with the main difference being that that is not repayable. It is agreed with a board before financial plans are submitted, so that the board knows what it is working towards. We also give a three-year trajectory of those figures, so that the board can do its medium-term financial planning in a robust way, instead of having to wait until, say, month 12 to know what its brokerage figure will be. It is all about proactively trying to manage its position.

10:30

Jamie Greene: Would it not be better just to say, “We’ll just write that off”, in the way that many other Government debts have been written off in recent years where the Government has stepped in to support specific sectors and there is just no expectation that it will get that money back? After all, the money has gone; it is off your balance sheet, and it has been spent by the health board. Let us not pretend that you are going to get it back.

Fiona Bennett: Just for the sake of transparency, I do not think that would be the right thing to do—I am thinking of readers of annual accounts and statements and non-executive directors being able to hold boards to account. What you have suggested happened before the pandemic in 2018, but, at the moment, we think it important for transparency that the balance is held.

Jamie Greene: The new model is not a loan—it is just a cash intervention. How is that different? Is it more limited, or more limiting?

Fiona Bennett: It is different because it is non-repayable, because it is agreed at the start rather

than at the end of the financial year and because it has a three-year trajectory. Previously, the brokerage figure would be known only at month 12; now, boards know their deficit support funding for 2028-29 and can plan on that basis.

Jamie Greene: The problem with agreeing the funding at the beginning of the year is that it still leaves health boards short. For example, NHS Ayrshire and Arran made it clear in evidence to us the other week that what it expected to get in deficit support funding was still less than its deficit.

Fiona Bennett: That is correct. NHS Ayrshire and Arran is the only board at the moment that cannot live within its deficit support funding. The gap is £4.7 million, or about 0.3 per cent of its overall budget.

Of course, given that the financial year has not yet ended, that is not to say that Ayrshire and Arran will not be able to meet the £25 million limit in period 13 when that comes into play. I would also note that the total deficit support funding is £166 million for 2025-26 and, at month 10, our NHS Scotland deficit is £170 million, so the £4 million difference rests only with Ayrshire and Arran.

Jamie Greene: That brings me to the key point. What obligations are put on the health board so that it can get the money? You agree the figure at the beginning of the year, but what does it have to do to qualify for the cash?

Fiona Bennett: There is no qualification process. The health board will be allocated funding up to that financial envelope. If it can deliver below that—as Grampian has, for example—that is even better, but it is a maximum allowable deficit.

Jamie Greene: But the board does not have to make non-recurring savings in year in order to get the cash.

Fiona Bennett: No. Of course, we would strongly encourage boards to make 3 per cent recurrent savings, but they do not have to do that to get the cash.

Jamie Greene: Okay. That is helpful to know.

Is there a wider issue with the funding model? We also heard from NHS Ayrshire and Arran how health boards get allocated their percentage of the pot. I accept that it is a big pot of cash, and that record levels of funding are going into health and social care, but, despite the record funding, waiting lists are still long, as other members will explore, and there are all the other operational issues that we all know about in the health service. Are we comfortable that the current model—the NRAC funding formula—works, and that it is proportionate and fair to health boards such as NHS Ayrshire and Arran, where higher levels of deprivation, an ageing demographic and a reducing population will negatively affect the NRAC funding that it gets?

Fiona Bennett: The NRAC formula is complex. It takes into account a number of the factors that you mentioned such as population increases or decreases and the demographic within the population and whether it is ageing. It also takes into account things such as rurality and the fact that, for patients on Arran, the costs of travel are higher.

We review and update the formula annually, but it is something that we continue to consider. I would also point out that the operational improvement plan was funded in a slightly different way, because we understand that there will be variances and pressures in individual boards' areas. Moreover—this is linked to the point about deficit support funding—we have increased the amount that is available to NHS Ayrshire and Arran in 2026-27, with the move to stage 4. We have recognised the challenges that the board is facing and have increased its deficit support funding as a result.

Jamie Greene: I guess that the premise of my question is this: is it worth rethinking how we support and fund boards? If many of them can make ends meet but many cannot, does that show that their governance arrangements are lacking? Do they have specifically difficult areas to manage when it comes to patient care, or does the model just not work for them, given the nature of the services that they are required to provide?

Fiona Bennett: Changing the formula will not change the overall pot of money that is available. I do not want to call it a distraction, but it is important to make it clear that that will not change the overall picture for NHS Scotland.

It brings me back to the point about governance and understanding which boards are struggling the most. That would come through the NHS Scotland support and intervention framework and the sorts of changes that we have seen in Grampian and Ayrshire.

Jamie Greene: Ms Lamb, if the Scottish Fiscal Commission's forecasts are accurate, the level of spend on health and social care will rise to 40 per cent of Government spending in the coming years and up to 55 per cent not that far down the line. It could hit 50 per cent-plus during the next parliamentary cycle. That is half of all devolved spending. Surely that is unsustainable.

Caroline Lamb: I agree that our focus needs to be on ensuring that we are not set on that otherwise inevitable trajectory, which is why the publication of the population health framework—and the work to support it—is so important. As we

touched on the last time I was here, the contribution of the health and social care system to the health of the population is important. However, as Michael Marmot would argue, 80 per cent of the determinants of people's health are shaped by poverty, the economy, housing, education and a whole load of other factors. From this Government's perspective, the key focus is on child poverty and ensuring that young people get the best possible start in life, so that the country can start to move away from a cycle of deprivation and from the health inequalities that deprivation produces.

Jamie Greene: The problem with that is—

Caroline Lamb: That is long term.

Jamie Greene: It is, but it is also a chicken-and-egg situation. If half of your budget is spent on treating people who are unhealthy, there is less money to spend on, for example, the preventative work to make people's homes safe and warm, on education, and on treating drug and alcohol problems, mental ill-health and homelessness. There will be less money to go round every other portfolio when half of all Government cash goes to yours.

Caroline Lamb: I absolutely accept that, which is why our service renewal framework is so important. That is about how we start to make the changes that we know we need to make so that we can live within our means. I sometimes describe the NHS as a repair shop. We need to move away from being a repair shop towards much more preventative and proactive work.

We can point to moves that we have already made. In the operational performance improvement framework, there are a couple of innovative actions for the treatment of stroke patients. For the one-third of people who do not respond to the commonly prescribed drug, we can now use genome testing to ensure that they receive the right medicine to prevent strokes or, in the case of young babies, to prevent them from developing hearing issues.

There is much that we can do that is relatively simple, but there is also the big societal issue of addressing the underlying problems that drive health inequalities in our population.

Jamie Greene: I am sure that my good friend Mr Simpson will come on to talk about technology.

Caroline Lamb: I am sure that he will.

Jamie Greene: It has huge potential in healthcare.

Before I finish, I must talk about general practitioner walk-in centres, which have been in the news for the past few weeks since the committee last met. I have no political view on them, but we have to note the concerns that have been raised about them. I would say that the British Medical Association in Scotland and the Royal College of General Practitioners have been unusually critical of the plans. We are talking about a lot of money. They claim that the approach was tried and tested in England, but that it failed, and that no lessons will have been learned from it.

I can see the benefit of walk-in GP or nurse appointments, particularly if they are open until 8 o'clock in the evening; it makes complete sense for most of the working-age population. However, those services have been heavily criticised by the very people who will be tasked with delivering them. What is your response to that?

Caroline Lamb: The GP walk-in clinics have been established as a pilot programme, so they will have evaluation wrapped around them from the outset. The pilot is very much about understanding the population that uses those walk-ins and the reasons why. It is not just about convenience; it is about the sorts of conditions that people are presenting with. It is very much a pilot programme and it is designed to complement the investment that we are making in general practice.

I have spoken at length with the RCGP about the issue. It and the BMA are concerned about the potential loss of continuity of care and the value of that continuity of care to patients. As part of the evaluation, we will be looking at ensuring that, when people attend those clinics, the record of the interaction is available to their general practitioner as well.

However, we also have to accept that people are looking to access those types of services, as you said, over a longer timeframe and in locations that may be more convenient—for example, because they are closer to where someone works rather than where they live. It is good to test that, and we are doing so with all the evaluation work wrapped around it.

Jamie Greene: Okay—I will leave it there.

The Convener: Thank you. I turn to Joe FitzPatrick, who has some more questions for you.

Joe FitzPatrick: As you know, I sit on the Health, Social Care and Sport Committee, and there are a few times when that committee has found it difficult to obtain witnesses from health boards. This is the Public Audit Committee, but the audit function is for the whole Parliament to undertake. The issue is not just with the NHS—other committees have had challenges in getting witnesses. However, you are here today, so I ask for some assurance that you can ensure that, in the next session of Parliament, board chief executives and chairs understand the importance of engaging with the committees of the Parliament.

Audit and scrutiny are good for everyone, and we should be encouraging health boards to engage with the Health, Social Care and Sport Committee, because that is helpful overall. I would like some assurance on that.

Caroline Lamb: Absolutely. I completely agree: it is really important that, as public services, we engage with all the committees in the Parliament and are accountable for the work that we are doing.

I was not aware that that committee was having any issues in that regard. I will take that away and pick it up with the committee clerks. If that is a feature, we would certainly want to sort it for the next session of Parliament. If the matter was escalated to me and my office, we could probably provide some help.

Joe FitzPatrick: There have been a couple of times when more senior people were invited to give evidence, and they should have been there because they are the right people, but they have not been available. It might save your time, for instance, as you are obviously really busy. Thank you very much for that, because it is an issue for the Parliament going forward.

That is the main question that I had just now, convener; I might have some supplementaries to other folks' questions later.

The Convener: Okay—that is fine, Joe. In that case, I invite Graham Simpson to put some questions.

Graham Simpson (Central Scotland) (Reform): I have a few questions to cover, but I will start with a press release that the BMA has just put out. You will not have seen it, because it has just been issued.

The BMA is talking about the number of consultant vacancies. The information is based on the freedom of information requests it made to health boards—it appears to request the information every year—which shows that there are more than 1,100 whole-time equivalent consultant vacancies in Scotland. However, the BMA says that official figures show that there are only 447 vacancies. That is a big discrepancy. In its press release, the BMA argues that, based on those figures, which are quite stark, it is little wonder that people are waiting so long for health treatment.

I will highlight some of the figures. For example, NHS Lanarkshire—I live in Lanarkshire; it is my health board—has 180 consultant vacancies; NHS Lothian has 144; and NHS Dumfries and Galloway has 119. The BMA says that vacancies have gone up since its previous FOI requests. That is concerning, is it not? Those levels are really worrying.

The official vacancy figure, according to the BMA, is 447, but the figure that it has uncovered from its FOI requests is 1,100 vacancies across Scotland. Which is right? I know that you have not seen the press release.

Caroline Lamb: I am sure that you will agree that you are slightly springing that one on us. The data that I have in front of me in relation to consultant vacancies, which is expressed in percentages, would indicate that the vacancy rate for 2024—which seems to be the latest figure that I have—was 6.2 per cent. That can be compared with 6.4 per cent in 2015. We probably need to look at where the BMA is sourcing its data, and I will do my best to respond to the committee on that.

10:45

Graham Simpson: It is saying that the rate is 14.4 per cent. That is quite a difference.

Caroline Lamb: It is quite a difference, yes.

Graham Simpson: It is a big difference. The information comes from responses to FOI requests, which show that more than 1,000 posts are unfilled. I accept that your figures are different, but we have those FOI responses. There is a difference somewhere. Perhaps the way in which you collate your figures should be reviewed. We need to know the true picture.

Caroline Lamb: NHS Education for Scotland is responsible for collating workforce statistics, which are subject to the usual checks and balances for any published statistics. We would need to consider where the BMA has drawn its detail from. I am happy to come back to the committee on that.

Graham Simpson: The chair of the BMA, Dr Joanna Bredski, says that the BMA has

"consistently warned of the urgent need to deliver a comprehensive and forward-thinking workforce plan for the NHS which looks at level of patient need and the doctors required for the future."

You presumably agree with that. Dr Bredski also says that, given that level of vacancies, it is little wonder that waiting lists are what they are. It is also little wonder that people turn to private healthcare.

Caroline Lamb: Could I clarify that? Is that from the UK BMA or from a BMA Scotland report?

Graham Simpson: That is from BMA Scotland. That came out just this morning, and I appreciate that you have not seen it, but it raises issues that very much relate to what the Auditor General has written about.

I was struck, after reading that quote, to find that the Private Healthcare Information Network issued a report this week—you might have seen it. It says

that private hospital admissions are now hitting "record levels". People are increasingly turning to paying for their own treatment. It was reported that

"Cataracts were the most common reason for admission"

and were

"up by 5 per cent."

That is followed by hip replacements and upper gastrointestinal endoscopy. Interestingly, there are

"more consultants … active in private practice in Scotland than ever before."

At the same time as we have those vacancies in the NHS, consultants are increasingly turning to work in private practice. That is not right, is it?

Caroline Lamb: The report that you are referring to came out yesterday, I think.

Graham Simpson: Yes.

Caroline Lamb: We are looking at it at the moment, and we are trying to understand the data in it. However, I would point you to my opening remarks about the increase in the levels of activity across NHS Scotland. I am sure that Christine McLaughlin will be happy to provide you with more details around the impact that that has had on our waiting lists.

Graham Simpson: I am sure that we have previously raised the issue of the number of people turning to private healthcare. I have not done it myself, but I know people who have—and they are not wealthy people: they are dipping into their savings and spending thousands of pounds on things that really ought to be provided through the NHS.

Caroline Lamb: That is why we have been so focused on the operational performance improvement plan and on using all the capacity that we have in Scotland in the best way possible. Christine McLaughlin can say more about how we have been working on boards supporting one another. One issue has been that there are much longer waits in some board areas than in others. The work that we have been doing through collaboration—and now increasingly moving into subnational planning—is about addressing that.

Christine McLaughlin: Your example of cataracts, Mr Simpson, illustrates why we are all focused on reducing the longest waits. The national treatment centres are doing a lot of the high-volume cataract surgeries. There are 30,000 appointments going through the national treatment centres this year; indeed, the figure will exceed 30,000 by the end of the year.

That is where the answer to the issue that you raise lies. There will always be a private market in Scotland, although, as you will know, it is relatively small compared to that in England, for example. However, our aim is to get to a position in which, when people are making a choice, the wait times in the NHS support them remaining on a waiting list and being seen and treated within the timeframes that we have set as our targets. That is what the plan is focused on.

Graham Simpson: I do not know whether the number is relatively small, but it is clear that an increasing number of people are turning to private healthcare. That is out of desperation, really, because they feel that they are not getting the treatment that they need in the NHS. That is the reality.

Christine McLaughlin: The data that you refer to is from an independent report, and there will be a range of private services in there. However, you are right that cataracts are one of the areas of growth. We are aware of that, but the national treatment centres are our sustainable model for that going forward.

Graham Simpson: We have spoken previously about the national review of procedures, which is about looking at procedures and medicines that might be of limited clinical value, doing things better and not doing things that we do not need to do. In our evidence session with NHS Ayrshire and Arran and NHS Grampian, they said that they have submitted their thoughts on that—to you, I presume. Where are we with the national review? Are we in a position to make some decisions?

Caroline Lamb: The national referral protocol was issued by the chief medical officer at the end of September last year, accompanied by evidence reviews covering a range of procedures. To be clear, that is not about rationing or restricting access to procedures for people who need them; it is about being clear about the clinical criteria for people requiring those procedures and ensuring that people do not get procedures that will not necessarily be helpful or are not clinically required.

The protocol requires boards to set up vetting panels to monitor adherence and to consider appeals against decisions that are made about access to procedures. We recently wrote to boards to ask for confirmation that those processes are in place. I suspect that that is the feedback loop that was referred to. We asked for that information at the beginning of February—I think that we have had responses from all but two boards, and they are being chased up—with a view to establishing that boards have put in place processes so that they can ensure that the evidence and clinical guidelines are being followed and to identify and highlight any issues that are emerging as a result.

Graham Simpson: Do we now have a list of procedures that we are either not doing or doing less of?

Caroline Lamb: The guidance is all online, and it gives a list of all the procedures. It is probably more difficult to understand than the PFI contract for the ERI if you are not a clinician but, if you go into the individual evidence summaries, you can see some of the presenting issues that mean that perhaps somebody should be treated, as opposed to when they should not be treated.

Graham Simpson: Where would we find that information?

Caroline Lamb: I looked at it last night. If you google "national referral protocol Scotland", you will find the site, where you can click on the different procedures. It includes things such as tattoo removal, varicose vein surgery and aesthetic facial surgery. There will be circumstances in which all those procedures are absolutely appropriate but, equally, we need to be assured that those are the circumstances in which the procedures are being provided.

Graham Simpson: Okay. You told us about varicose veins previously, so we will add tattoo removal to the list.

What about medicines? The Auditor General's report shows that the cost of prescribing is going up year on year, which I know that you have been looking at. At some point, we need to get a grip of that. What can you tell us about it?

Caroline Lamb: Prescribing practices and medicines that are of low clinical value are picked up in the 15-box grid that I referred to earlier. Fiona Bennett can say a bit more about what that covers and the support that we provide on that.

Fiona Bennett: Around £30 million is spent nationally on medicines of lower or limited clinical value. A published list is available on the internet that sets out what those medicines are. There may be some cases in which those medicines should be prescribed but, in many cases, they are shown to have limited clinical effectiveness for the patient. We could potentially drive savings into the system if we do not prescribe medicines that are not driving the outcomes that we would look for. Of course, there are other things that we look at, such as switching to biosimilar medications where it is clinically safe to do so, as well as looking at things such as polypharmacy reviews. People may be on eight-plus medications, which may not be the best treatment for them. We are looking at numerous initiatives to try to manage the spend on prescribing.

Graham Simpson: If you have a list of medicines that are of lower clinical value, are you preventing any of them from being prescribed?

Fiona Bennett: No, they will not be removed from the list as such, unless there is evidence to say that a medicine is clinically harmful. Similar to the approach that we take to procedures, they would be prescribed only in specific circumstances. In the main, they have been shown not to be as clinically effective as other medicines.

Graham Simpson: Have you looked at medicines that are prescribed that could easily be bought over the counter for possibly less money than it would cost the NHS?

Fiona Bennett: Pharmacy first is a good example of what we are looking at in terms of prescribing in different ways when people need medication. As noted, our policy is not to charge for prescriptions and for medicine to be available at the point of need for everyone.

Graham Simpson: If I go into a pharmacy, rather than a GP, and the pharmacist prescribes me something, what would the pharmacy be paid for that?

Fiona Bennett: There is a tariff system for different medicines, so it varies by medicine across the country. There is quite a complex rebate system for pharmacy payments.

Graham Simpson: Let me give you a personal example. Recently, I had an allergic reaction to something and I came out in a rash that was quite itchy. I was in Edinburgh—I was not at home—so I went into a pharmacy. They were very good and gave me some antihistamines and some cream to deal with the itch. I could have bought those things myself and I wanted to pay for them, but they were given to me for nothing and I have never used the cream. I did not go to get free stuff; I just wanted some assistance, but I was given the medication for free. What did the pharmacy make from that? Would it have earned less if I had bought it from them?

Fiona Bennett: The way that those rebates and costs are set up should not be driving prescribing behaviour in pharmacies, and we are not means testing it. The pharmacy would not be privy to information about your ability to pay and it is important that people get the medicines that they need. Where possible, we would encourage people to buy things over the counter, if that is an option. However, it is important that we do not discriminate and that people's ability to pay or not does not prevent them from getting the treatment that they need.

Graham Simpson: I guess that it is a difficult area, but I will not be unique in going into a pharmacy and thinking "I want to buy some stuff—just tell me what to buy." I was given the medication for nothing, which cost the taxpayer money that did not need to be spent. Have you looked at such examples?

Fiona Bennett: The pharmacy first model and the way that some of these initiatives work is part

of our wider thinking about the prescribing model. It goes back to the point that it is important that people are able to access medicines when they need to.

Graham Simpson: Before I move on, I think that Joe FitzPatrick wants to ask something about this.

Joe FitzPatrick: I understand where Graham Simpson is coming from. Obviously, he was not overly concerned about his allergic reaction, but other folk might have been, and their first instinct might have been to go to the GP. My assumption is that going to the GP would be far more expensive for the system overall, would put pressure on the GP and would prevent someone else from getting an appointment. Have you looked at the savings from pharmacy first and how much pressure it relieves in the system?

11:00

Caroline Lamb: That is a really important point about the value of the pharmacy first approach, which is about ensuring that people can access the care and advice that they need in the community and recognising that pharmacists are very skilled in understanding the nature of medicines that will help people. As you said, if we can deal with people through pharmacies, rather than people presenting at general practice, that will free up more appointments in general practice for people who genuinely require that sort of input. That is why the pharmacy first approach has become such an important aspect of the overall package of services.

I do not have in front of me information about the volume of activity under the pharmacy first approach, but we can provide the committee with that.

Graham Simpson: It would be interesting to know, so it would be good if you could get that information for us.

On preventative health measures, in the chamber, I raised with the Cabinet Secretary for Health and Social Care the issue of screening for certain types of cancers, such as lung cancer. In many areas of England—perhaps throughout England—there is a system in which people who are deemed to be at risk of lung cancer, such as anyone over a certain age who has ever smoked, can be called in and given a routine screening.

I know someone in that position who lives just over the border. In that case, cancer was picked up, so the individual is now waiting for an operation. Had that screening not happened, they might not have found out that they had cancer until it was too late. That would obviously have been terrible for that individual, but it would also not have been good for the NHS, because it is better and cheaper if we pick things up earlier. We do not have such a national system in Scotland. The health secretary said that the Government is looking at the idea, but it seems to me that it ought to be a priority.

Caroline Lamb: In Scotland, we take a national approach to all the conditions that we screen for. I do not have in front of me any details on where we are with lung cancer screening, but we can come back to you on that.

It is worth acknowledging the success and impact of our rapid cancer diagnostic service, but I accept that that is for people who might have undifferentiated symptoms. Christine McLaughlin might be able to say more about that.

Christine McLaughlin: All UK nations are working through evaluation and implementation in relation to lung screening. We have six rapid cancer diagnostic services, which, as Caroline Lamb said, can pick up cancers that result in some symptoms presenting but for which there is no clear pathway. The evaluation of those six services has been positive. The median referral time to diagnosis is 15 days. Dedicated lung screening programmes are one way to detect issues, but people having a way in that cuts down the important time at the beginning is also really important.

As well as the rapid cancer diagnostic centres, we have developed a single point of contact within diagnostic services. The key point is ensuring that we reduce the time that it takes to get a diagnosis and a referral as part of our overall cancer pathway.

You make an important point, but being able to capture people through the overall pathway is also important. Lung cancer is one example, but capturing all the other cancers is equally important. We need to learn from the rapid cancer diagnostic centres and understand the extent to which there are further opportunities to roll out such services across the country as part of our cancer improvement plan.

Graham Simpson: To do the learning, you just need to go to Carlisle.

Fiona Bennett: We might do that.

Graham Simpson: Please do, because you will see a very good service in operation, which we could use here.

Fiona Bennett: As part of our cancer improvement plan, we are considering a range of areas. We will write to you and give a bit more detail, specifically on the lung screening programme.

Graham Simpson: You have discovered that I like to be bang up to date. I read the recent report from the Tony Blair Institute for Global Change. I do not know whether you saw that. [*Interruption*.] You have not read it? You should read it.

I am not a big Tony Blair fan but I am afraid that the NHS in Scotland has come on to his institute's radar and it has produced a report called "From Ambition to Delivery: How the Next Scottish Government Can Transform Health". I recommend it. It is detailed and has some good recommendations. I will not go through all of it but, funnily enough, it mentions my favourite thing: the app—or the lack of an app.

Interestingly, the report tells us that Denmark has

"a single national digital platform … through which every citizen can access their medical record, test results, prescriptions, referrals and vaccination history".

They can also

"book appointments and communicate with clinicians. The system connects general practice, hospitals and other local services".

In Finland, more than 5 million people have access to digital care pathways.

As I pointed out, England—again, I suggest you go to Carlisle if you want—has an app. England has had it since 2018 and it has been downloaded by three quarters of adults, which is a really high number. More than 5 million prescriptions a month are ordered through it. It provides users with access to their GP health records and you can book appointments and communicate with healthcare providers through it. In Scotland, all we have so far is a limited trial in Lanarkshire and it is only for dermatology patients. Come on—when will we get a national app?

Caroline Lamb: As you acknowledged, we have been trialling it in Lanarkshire. That is going well. I ask Christine McLaughlin to talk about the plans for roll-out.

Christine McLaughlin: I have read the Tony Blair institute report. We all need to learn from what is happening in other nations. I will focus on where we are today.

We cannot go back the way but, as my technology team tells me, an app is not everything. We have mechanisms to do a lot of the things that you mentioned, Mr Simpson, but they are not single national systems, which is the aspiration. The system in Denmark is internationally recognised best practice that nations are looking to move to.

The trial in Lanarkshire was successful, I am glad to say. That gives us the foundation on which to build, but that success comes from the systems' ability to interface with that digital front door. The fact that we have the emergency care summary gives us the ability to move now to national roll-out, which is on target for April this year for population-level access to a limited amount of information. That will enable people to access their personal information and, from that, the emergency care summary and a service access finder.

You will know that the roll-out in England started off with limited data and was built from there. People having web-based access from April is the minimum first step, and having access through a downloadable app will allow us to build other services from there across the country and get to the point at which we have a fully integrated digital front door across health and care. You will know that the work in England is focused on the NHS but our focus is health and care. People will be able to get their "What matters to you?" information through social care as part of that development.

Having access to screening, vaccinations and self-management is all part of a plan, but we need to build that up. I do not think that we will find many nations where everything went live on the same day. We need to build it in a way that we know is going to work, with the data that people can access being the right data and the system being clinically safe. The approach that we will take in April is therefore to make sure that we can access the data from our core systems and build a roll-out plan from there.

Graham Simpson: So, from April we will have something that is very limited and nothing like the all-singing, all-dancing system that they have in England, Denmark and Finland. As a patient, that is something that I want to see. We need to make it easier for people to access the health service, and that is what this is about.

Christine McLaughlin: I do not think that anyone will disagree with you on that, but you will know that, although the picture varies across the country, mechanisms are available for people to book appointments with GPs, order repeat prescriptions and so on. Although it is not a single national system, it is not as if we have absolutely nothing. As you have outlined, and as the Audit Scotland report says, it is our ambition for Scotland to move in that direction.

Graham Simpson: The question is when. When will that happen?

Christine McLaughlin: April—

Graham Simpson: No, not April—that is a very limited thing and it is not what I am talking about.

Christine McLaughlin: We will agree with the system and with users about the right level of prioritisation as we roll it out. You will know that the trial on dermatology in Lanarkshire included two-

way booking, which will be important to some people, but not everyone uses hospital services all the time. For some people, prevention and self-management will be more important. We will work through the roll-out plan next, after the population-level roll-out.

Graham Simpson: Right. I do not know what the problem is or where the sticking point is. What needs to happen is quite obvious, but it needs to happen at pace and it is not happening at pace. It is a frustration.

The Convener: I see your frustration, Mr Simpson. I want to follow up on some of Mr Simpson's questions. Lanarkshire has been mentioned, and we have been talking about prescription drugs. There is a shortage of co-codamol at the moment, is there not? People are unable to get it prescribed through their GPs—certainly, people in Lanarkshire have been coming to me to say that. Do you know what the latest position is, how long it is likely to last and what the alternative solutions are?

Caroline Lamb: I am sorry, but I do not have an up-to-date position on that. I will get back to you on it.

The Convener: That is fine. Jamie Greene has a final question.

Jamie Greene: It is a really important question about technology. I was on a waiting list for 18 months for elective surgery. I then got a letter about an appointment at short notice, which was great because it was a result of the new initiative of sending people to other health boards at the weekend. That is a great way of getting through the backlog, although I am sure that it is costing a fortune because you will be having to pay consultants overtime to work on a Sunday. Nonetheless, I was grateful for it.

The problem is that it was a letter. I do not know when Royal Mail last got a letter through the post on time, so I missed it and I went back on the waiting list after waiting a year and a half while my condition got worse. That is why it is important that we get this right. I had no app, no portal, no email, no text message—nothing. It was just a letter in the post; thankfully the right address was on the system.

Caroline Lamb: I am sorry that that happened to you. Rapidity of communications is one of the many reasons why we are also keen to progress this work at pace. Audit Scotland has been clear in pointing it out to us, but we recognise that we need to maintain other channels so that people who do not want to use digital means or are digitally excluded can also access services.

Jamie Greene: I know, but I am just asking for people to be sent a text message.

Caroline Lamb: Absolutely.

Jamie Greene: It is not difficult. It does not require a lot of capital investment in infrastructure. It just means that there will be a little bit of joining up in how you inform people about things such as appointments. I am pleased to say that I was able to speak to the right people and, luckily, I got a last-minute cancellation for the following week, but how many people are out there waiting on those letters?

I have one final proper question about the national treatment centres. We have spoken a lot about reform and about innovative new ways of doing things to get through the backlogs. However, the NHS capital budget has been cut by 22 per cent in the past five years and my understanding is that five of the national treatment centres are on pause. The Royal College of Surgeons thinks that four of them have been canned completely and are never going to happen.

We have talked a little bit about NHS Ayrshire and Arran and some of the problems that it is having, and its national treatment centre is one of those that have been paused. That does not make sense.

11:15

Caroline Lamb: You have set out correctly the fact that, because of capital constraints, we have paused the national treatment centre programme. However, that does not mean that we have not been doing anything. We have focused on maximising the use of existing national treatment centres and on looking at areas within our existing estate that, although not badged as national treatment centres, have theatres that can be brought into use. We have brought additional capacity into use in the Queen Margaret hospital in Dunfermline, at Gartnavel and in a number of other areas within the existing estate. Our focus will remain on what more we can do within the existing estate, because we can do that much more quickly and at lower cost.

Jamie Greene: I imagine that those NTCs would be quite expensive projects to build, but they would be new build and so would take time, and we know that everything costs more and takes forever. If there is capacity in the existing estate that can be used to get through the backlog, I understand why that would be a priority.

The Convener: I have had an indication that Joe FitzPatrick is going to try our patience and ask a final question.

Joe FitzPatrick: It is more of a point of information related to Graham Simpson's question on the national referral protocol. I did not do a Google search; I did a DuckDuckGo search and

the information is there. All the conditions are listed and there is an app.

Caroline Lamb: We have a number of apps.

The Convener: On that note of harmony, I will bring this morning's session to a close. I thank Caroline Lamb, Christine McLaughlin and Fiona Bennett for their evidence this morning. I note that you are going to get back to us with more information about some things.

As this is our final session together, Caroline, and you have been one of our most regular witnesses, I am bound to say that I am reminded of Nye Bevan saying in 1948 that, as the health secretary, he would be responsible for every single dropped bedpan. I should think that there are times when you have felt as though you have been held responsible for that level of detail—we even got to tattoo removal this morning.

I thank you very much for your co-operation with the committee and, to reflect the point that Joe FitzPatrick made earlier, we appreciate your willingness to sit before us, answer our questions and respond to our requests for further information to help us scrutinise what we have reminded everybody is a huge part of public expenditure in Scotland and a treasured institution—the national health service.

As previously agreed by the committee, I move the meeting into private.

11:18

Meeting continued in private until 11:36.

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