OFFICIAL REPORT
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DRAFT

Public Audit Committee

Thursday 25 January 2024

Session 6

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Thursday 25 January 2024

CONTENTS

Col.
DECISION ON TAKING BUSINESS IN PRIVATE 1
SECTION 22 REPORT: "THE 2022/23 AUDIT OF NHS FORTH VALLEY" 2

PUBLIC AUDIT COMMITTEE
3rd Meeting 2024, Session 6

CONVENER

*Richard Leonard (Central Scotland) (Lab)

DEPUTY CONVENER

*Sharon Dowey (South Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Graham Simpson (Central Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Stephen Boyle (Auditor General for Scotland)
Leigh Johnston (Audit Scotland)
Pat Kenny (Deloitte LLP)
Rebbecca McConnachie (Deloitte LLP)

CLERK TO THE COMMITTEE

Lynn Russell

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit Committee

Thursday 25 January 2024

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Richard Leonard): Good morning, and welcome to the third meeting in 2024 of the Public Audit Committee. The first item for consideration is whether to take agenda items 3 and 4 in private. Are we agreed?

Members *indicated agreement.*

Section 22 Report: "The 2022/23 audit of NHS Forth Valley"

09:00

The Convener: The substantive item on our agenda is consideration of a section 22 report, "The 2022-23 audit of NHS Forth Valley". I welcome our four witnesses: Stephen Boyle, Auditor General for Scotland; Pat Kenny, associate partner, audit and assurance, at Deloitte; Rebbecca McConnachie, senior manager at Deloitte; and Leigh Johnston, senior manager at Audit Scotland.

We have a number of questions to put to you, based on the report that was produced into the performance of NHS Forth Valley but, before we get to those, I invite the Auditor General to give a short opening statement.

Stephen Boyle (Auditor General for Scotland): Good morning. I am bringing this report to the committee to highlight matters of public interest in NHS Forth Valley. I prepared the report under section 22 of the Public Finance and Accountability (Scotland) Act 2000.

The external auditor issued an unmodified audit opinion on NHS Forth Valley's 2022-23 financial statements. It also highlighted that the board met its financial targets in 2022-23, achieving a small surplus of £229,000. It goes on to report that the board needs to make £40.6 million of savings in the 2023-24 financial year. Financial challenges, however, are not unique to NHS Forth Valley, and to varying degrees they are being felt by NHS boards across Scotland. We will be reporting to the committee in a few weeks on our NHS overview report, which will go into that in more detail.

Today's report highlights concerns that were raised by a range of review bodies during 2022-23 in relation to the governance, leadership and culture of NHS Forth Valley and the subsequent progress that the health board is making to address those issues.

On 23 November 2022, NHS Forth Valley was escalated to stage 4 of the NHS Scotland performance escalation framework due to those concerns about governance, leadership and culture. Concerns had been raised first by Healthcare Improvement Scotland, in relation to patient safety at Forth Valley royal hospital, and then by the national planning and performance oversight group on a range of performance-related issues in respect of general practitioner and primary care, out-of-hours services, unscheduled care, mental health services and progress on integration. In January 2023, NHS Education for

Scotland reported further concerns about clinical supervision arrangements. Stage 4 escalation brings direct formal oversight and co-ordinated engagement from the Scottish Government in the form of an assurance board.

An escalation improvement plan was developed by NHS Forth Valley and agreed by its assurance board in December 2022, with the aim of strengthening its leadership, supported by effective governance, and improving its culture. A HIS action plan is also in place to address the requirements arising from its unannounced safe delivery of care inspections. Regular monitoring and updates have been provided on the actions in both plans.

The mid-year review by the Scottish Government reported to the board in May last year that it confirmed that it had received assurance that the board's leadership remained committed to delivering the required change. It also highlighted the importance of achieving changes within the timeframe that was set out in the escalation improvement plan and keeping staff, local people and their elected representatives informed of progress.

The chief executive announced her intention to retire from the board in September last year, and an interim chief executive is in place; the board will soon be recruiting for a permanent replacement.

NHS Forth Valley is responding positively to the escalation framework. It has put in place appropriate governance arrangements and has made progress in the months since agreeing the escalation improvement plan. It is critical that sustained progress is made, especially under the new leadership, with sufficient resources put in place to drive forward the changes that are required.

As you mentioned, convener, I am joined by colleagues from Deloitte and Audit Scotland. We look forward to answering the committee's questions.

The Convener: Thank you very much, Auditor General.

I invite the deputy convener, Sharon Dowey, to ask the first series of questions.

Sharon Dowey (South Scotland) (Con): Good morning, Auditor General. Paragraph 4, on page 4, which is the start of the summary, states:

> "This report highlights concerns raised by a range of review bodies in 2022/23, in relation to the governance, leadership and culture of NHS Forth Valley and the progress the board is making in addressing these issues."

Can you give us more detail on the nature of those concerns?

Stephen Boyle: We can. I draw the committee's attention to exhibit 1 in the section 22 report, which sets out a timeline of events, tracking from April 2022 through to January 2023, arising from a range of independent external bodies that apply regulation and inspection processes on the NHS.

I will bring in Leigh Johnston in a minute to set out a bit more detail on the nature of the work of the inspection bodies, but I will kick off on this. Right at the start of that timeline at exhibit 1, we draw attention to the work of Healthcare Improvement Scotland, which inspected quality of care on an unannounced visit. As part of its arrangements, representatives will arrive at a health facility to form an assessment of how well patient care is being delivered and how safely it is being done. It will also engage with staff on their views, and so forth.

The inspection report raised concerns about the quality of care in relation to a couple of examples. Healthcare Improvement Scotland found that, in respect of a patient's ability to consent to care, there was a lack of documentation and risk assessments in respect of an adult with incapacity. HIS also highlighted concerns about capacity and the use of an extra bed in a ward facility at Forth Valley royal hospital. HIS went on to report the frustrations that staff who engaged with the inspectors conveyed about the extent to which they were being listened to and supported by management.

As HIS regularly does when it finds concerns, it followed them up quickly. It carried out a further inspection later in the same month—April 2022—and found that the concerns that it had raised a couple of weeks previously had not been addressed. That brought about a report and escalation arrangements.

I could go on. As I conveyed in my introductory remarks, that was followed up with work on further matters identified by the Scottish Government's national planning performance oversight group regarding arrangements for unscheduled care, progress on meeting requirements for out-of-hours services, the four-hour wait time in accident and emergency, mental health services, progress on integration, and aspects of governance, leadership and culture.

A range of issues have been highlighted by inspection bodies and accepted by the board, with associated action plans and a need for progress, which drew my judgment that the matter was worthy of public comment and scrutiny through a section 22 report, which we are considering today.

I will pause for a moment; I am happy to broaden out the discussion to colleagues if they wish to explore the matter further.

Leigh Johnston (Audit Scotland): I do not have much to add to what the Auditor General has said. On service performance, accident and emergency in NHS Forth Valley and meeting the four-hour waiting time target, performance has been poor for an extended period, alongside performance on access to child and adolescent mental health services, for which NHS Forth Valley was one of the poorest-performing NHS boards in Scotland.

The only other thing that I will mention is some of the concerns that NHS Education for Scotland raised on clinical supervision, a lack of consultant oversight of doctors in training and doctors in training being expected to work beyond their competence. NHS Education for Scotland will monitor that situation and look for improvement.

Sharon Dowey: My colleagues will ask further questions on governance later. Paragraph 5 of the report says:

> "In 2022/23, NHS Forth Valley delivered a break-even position, achieving an underspend of £0.229 million against its Revenue Resource Limit … However, the board experienced significant financial challenges, during the course of the year, due to ongoing capacity and staffing pressures, increases in medicine costs, ongoing Covid-19 legacy expenditure"

and

> "delays in delivering recurring savings plans".

Why have there been delays in delivering the recurring savings plans?

Stephen Boyle: I will invite colleagues from Deloitte to update the committee on the extent of financial progress that was made to deliver a break-even position. I appreciate that the committee is well sighted on the issue, but perhaps it is worth stating that NHS boards are required to break even every year in their revenue and capital positions. They have to deliver a programme of activity within the financial limits that are set by the Scottish Government.

Paragraph 17 of the report notes that NHS boards face a wide range of financial challenges. I reasonably mentioned in my opening remarks that those challenges are not unique to NHS Forth Valley. Every year, NHS boards start with a requirement to deliver savings programmes to support the efficient and effective use of public money while delivering their services and meeting their financial targets. Pat Kenny and Rebbecca McConnachie can say more about this, but in order to move to a more sustainable position, boards are expected to deliver recurring savings, which involves an element of transformation. Rather than making one-off or opportunistic savings, which are known as non-recurring, boards are expected to deliver their services in a financially sustainable way while achieving operational ambitions.

In NHS Forth Valley and elsewhere, there is an on-going reliance on non-recurring savings. That means that you might hit the target in the year in question, but you will be back to square 1 for the following year. I will pause for a moment and invite Pat Kenny to set out for the committee the nature of some of the non-recurring savings and what steps the board is taking on the more transformational activity that will be recurring in nature.

Pat Kenny (Deloitte LLP): Rebbecca McConnachie has that detail, so I will pass that question on.

Rebbecca McConnachie (Deloitte LLP): The non-recurring savings in 2022-23 were approximately 60 per cent of the total savings programme. NHS Forth Valley achieved the full savings programme that it required in 2022-23, but there is still an issue with the majority of savings being non-recurring. It expects that, in 2023-24, 60 per cent of savings will again be non-recurring. Although it is working towards more recurring savings on a transformational change basis, in line with other boards in the sector, it is still heavily reliant on non-recurring savings.

Sharon Dowey: Is there a lack of pace? Every business needs transformation to keep it viable. You mentioned a lack of communication with staff, Auditor General. Is there a lack of pace in the board and the NHS more widely on transformation to ensure that recurring savings are made?

Stephen Boyle: We will be able to speak further with the committee to give you a rounded picture of the financial position of NHS Scotland and how recurring and non-recurring savings are progressing when we publish the NHS overview report in the next few weeks.

09:15

NHS Forth Valley's financial position is not the root cause of concern as it relates to the board's operation. To draw that distinction, it was not escalated by the Scottish Government in respect of its financial position in the way that some health boards have been, although nothing is in isolation.

As Leigh Johnston mentioned, NHS Forth Valley's performance on accident and emergency, CAMHS and aspects of its psychological therapy arrangements are in the lower quartile of performance. Although its financial position is healthier than that of other boards, its service performance is not. How it delivers improvements in its performance while managing its financial position needs to be looked at in the round. There

are examples of non-recurring savings such as slippage on development and recruitment.

One factor that can be seen through our audit and in Pat Kenny's and Rebbecca McConnachie's work is that there has been slippage in recruitment to key posts. Leigh mentioned a lack of clinical oversight, and those factors are all connected. As the board moves to progressing all the action in its actions plan and addressing the findings of inspectors and regulators, it is reasonable to assume that that will have a bearing on its financial position. It will have to manage all those factors in the round as it transforms its services and still meets the Scottish Government's requirements to deliver financial balance in the years to come.

There is work to be done, but it is fair to say that the nature of the escalation was not based on its financial position at the time.

Sharon Dowey: You mentioned that NHS Forth Valley will face the same challenges that all other NHS boards across the country will face. Does NHS Forth Valley face any unique challenges, and if so, can you tell us a bit about them?

Stephen Boyle: There are very clear challenges for NHS Forth Valley. I will bring in colleagues from Deloitte to say a bit more about the financial position. I know that other members will want to come in on the nature of the challenges that led to the concerns of regulators.

Leadership, governance and culture were the key factors that led the Scottish Government, through its escalation framework, to bring in enhanced monitoring and supervision of NHS Forth Valley. Those are the factors that it needs to address satisfactorily, together with the evidence base, to show progress. I will perhaps speak further to the committee about that. In addressing those factors, we will allow NHS Forth Valley to give assurance to the Scottish Government, patients in NHS Forth Valley and the wider public that the board is making the necessary progress.

Pat Kenny might want to say a bit more, but we set out in paragraph 20 some of the range of challenges that NHS Forth Valley faces in setting a balanced budget. It still has progress to make in 2023-24. We are coming towards the end of January, with the end of the financial year just over a couple of months away. There is a gap to fill in delivering financial balance, but we know that the Scottish Government is working with Forth Valley to identify solutions to fill that gap.

Pat Kenny: To go back to Sharon Dowey's point about the specific challenges that NHS Forth Valley faces, the key challenges were summarised in the recent "NHS Forth Valley Corporate Governance Review" by the chair of NHS Greater Glasgow. On performance, the two main challenges were that the integration model—the business model—had not been clearly defined in terms of roles and responsibilities and the lack of a high-performing executive management team. The review concluded that those two core challenges were the main root causes of the board's governance, leadership and cultural issues. As the Auditor General mentioned, there is a clear linkage between governance, leadership and the board's financial performance—those obviously go hand in hand.

Those were the two root causes: the integration model not being fully defined, and issues with the executive management team.

Sharon Dowey: I come to my last question. We are always talking about sharing best practice. Are there any models of good practice in other boards that are facing similar challenges, from which NHS Forth Valley could learn?

Stephen Boyle: Pat Kenny is right to draw attention to the work of John Brown, who undertook a governance review of NHS Forth Valley that referenced "The Blueprint for Good Governance in NHS Scotland". There are benchmarks that NHS Forth Valley is being tracked against. Again, there is much more to say about that, but it provides an opportunity for NHS Forth Valley to say, "Here's the expected standard, and here are the steps that we want to take to get to that."

Somewhat helpfully, Mr Brown's report contains more than 50 recommendations to NHS Forth Valley on its governance arrangements. Progress undoubtedly needs to be made against those. Nevertheless, as a framework, that provides NHS Forth Valley with the steps that it needs to take to assure itself, and to demonstrate clear and effective scrutiny, of the progress that the executive leadership team is making, and—as Pat Kenny said—the necessary progress with its partners to deliver a sustainable health and social care integration model.

I appreciate that the committee will be sighted on this, but the findings in that report were very similar to Audit Scotland's findings back in 2018, when we produced an update report on health and social care integration. That, again, drew attention to the need for clarity, consistency and effective application of health and social care integration. NHS Forth Valley has steps to take against those benchmarks.

The Convener: Thank you. Graham Simpson wants to come in with a question in that area.

Graham Simpson (Central Scotland) (Con): I will leave it until later, convener; the question that occurred to me may be covered by other members.

The Convener: Okay—that is fine. I will take us back to current financial year performance. Colin Beattie will talk about the deficit issue, which is a major feature of the report, but I will look at the current year.

You mention in the report that there has been

“An overspend of £3.2 ... million in acute services”,

but

“An underspend of £1.3 ... million in corporate functions”

and

“An underspend of £2.245 million in ringfenced and contingent budgets.”

Could you explain a little bit more the detail that lies behind those figures, please?

Stephen Boyle: I will quickly pass that over to colleagues in Deloitte, who will have the detail that underpins what appears to be a range of overspends and underspends that leads to a small surplus. That is always a feature of financial management in NHS boards at the year end. Ultimately, boards are multimillion-pound organisations and, as a feature of public sector accounting, they have to deliver financial balance, so it is not uncommon to see that level of in-year management.

On what is behind that, I hand over to Rebbecca McConnachie, who can share that detail with the committee.

Rebbecca McConnachie: The key elements in acute services in particular relate to contingency bed and temporary staffing arrangements that the board has had to put in place. That spend has been recovered via underspend on corporate functions; in general, it is due to delays in certain organisation-wide projects that the board has undertaken. There was an underspend in the ring-fenced and contingence budget, but that is offset by delegated functions and, within that, operational services. The main concern there relates to prescribing: the increased cost and volume of prescribing medicines under that budget. Those were the key elements that drove the underspends and overspends in those different categories.

The Convener: I want to ask about one of those in particular: the spend on agency and bank staff. In his opening statement, the Auditor General mentioned elected representatives being briefed by the health board. I speak as one of the elected representatives who have had those briefings. One of the features of them, which I have been trying to interrogate, is the extent to which there has been a ballooning in spend by NHS Forth Valley on bank and agency staff.

Back in May 2023, it was reported that there had been an increase in spend, year on year, in the region of 70 or 71 per cent. By December 2023, at the last briefing that I attended, the figure that was being cited was a 46 per cent annual increase in spend on agency and bank staff. Could you give us your understanding of the reasons for such a big escalation in costs in that area on a year-on-year basis? What lies behind it? Do you have any sense of how that compares with the reliance of other health boards of a similar size on agency and bank staff?

Stephen Boyle: That is such an important factor. Both through our overview reporting and in our engagement with the current and previous committees, we have discussed the need for sustainability of services. Vacancies arise primarily in nursing in respect of bank and agency services. The health board has an obligation to respond to that, and it usually covers its need for resource, where it is not available on its roster, through the use of bank and agency staff. Bank is preferable, as that much more commonly comes at hourly rates that are aligned with those of permanent staff. The use of agency staff, however, always comes at a premium.

On the specifics, I turn to colleagues from Deloitte on whether we have any detail that sits behind the movement from one year to the next. If we do not have that, we may need to check our records and come back to the committee in writing. That is something that we are considering carefully on a Scotland-wide basis for our reporting of the overall financial position, which we will set out in the NHS overview report in the next few weeks.

I will pause to check whether there is anything that colleagues can add. We may need to come back to you in writing.

The Convener: That is fine. I do not know whether I am asking you to break an embargo, but could you give us an early insight into how 70 per cent and 46 per cent increases in spend compare with the figures that you have been unearthing in your preparation of the overall NHS report?

Leigh Johnston: They are very similar across Scotland. You will see that in our NHS in Scotland report when we bring it to the committee. I do not think that that situation is specific to NHS Forth Valley; I think that the picture is similar across the NHS in Scotland.

The Convener: So it is not a function of, for example, the level of vacancies or of a particular sickness absence rate in NHS Forth Valley.

Leigh Johnston: The level of vacancies and the sickness absence rates across NHS Scotland are reflected in the high costs of agency and bank staff across the NHS in Scotland.

The Convener: One of the inferences of what came out of the Healthcare Improvement Scotland report is that, because of things such as poor leadership, there might be higher-than-average levels of absenteeism, and the figure for bank and agency expenditure might be a function of that, but we are being told this morning that that is not the case. I want to try to clarify that.

Stephen Boyle: I am not sure that we would be able to draw a definitive conclusion that those things are not related. The report from the other inspectors clearly draws attention to the fact that there were staff concerns about not being listened to, about engagement with senior leadership in the organisation and about the implications of that for the wider culture of the organisation. I am sure that there will be many factors around why a person is unable to go to their work. It is undeniable that there were specific concerns over and above the wider factors affecting NHS Scotland that would lead to somebody not being at their work, which NHS Forth Valley must address in relation to its leadership and culture.

The accompanying action plan will have to be delivered, so that NHS Forth Valley and the Scottish Government assurance board can be satisfied that the culture and leadership issues are not exacerbating the wider national challenges that are causing people to be off their work.

The Convener: I think that Healthcare Improvement Scotland's initial report identified an excessive reliance on bank and agency staff as one concern. I think that it used the description of "serious concerns" in its report, and that was one of its serious concerns.

We now turn to Colin Beattie, who has some more questions to put, and perhaps an initial observation to start us off.

09:30

Colin Beattie (Midlothian North and Musselburgh) (SNP): Auditor General, before I come to questions, from my perspective, this report has a different feel to it from other reports that you have produced. Some of the detail that is normally in your reports is not there. You talk about issues around governance, leadership and culture, and there is some explanation of that, but the report does not seem to go into the depth that is normally there. I am still sitting here thinking, "What has happened with leadership? Where is that demonstrably failing?" It is possible to infer a little from some of the things that are in the report, but there is nothing specific.

Stephen Boyle: Good morning, Mr Beattie. I am grateful for your observations and your feedback. I recognise that this report is slightly different from other section 22 reports that we produce. As you know, many of our section 22 reports draw on the work of the external auditor through the annual audit process. The most significant departure from the usual situation is that this report draws not just on the work of the external auditor but on a wider range of reporting from other external organisations, such as HIS and NES, which have produced reports that set out more detail on the accompaniment of the findings that have led them to arrive at those judgments.

For similar style reporting in the future, we can think about the extent of the detail that we go into in our section 22 report, which perhaps needs to be accompanied with the detail of other reports. We can reflect on how accessible all the associated judgments are alongside what is, in many respects, a summation through the section 22 report.

Colin Beattie: From the committee's point of view, I am sure that every member simply wants to get a full understanding of the detail behind the comments that are made, so that we can make our own judgments.

I turn to financial sustainability. Paragraph 19 of the report says that, despite the savings of £25 million in 2023-24, there is a £15.6 million residual deficit. Can you tell us more about that deficit and what the short and long-term impacts will be if it is not addressed properly?

Stephen Boyle: Yes, certainly. I will then ask Pat Kenny to share with the committee what we understand to be the most up-to-date position, recognising that we are now closer to the end of the financial year than we were when we finalised the drafting of the report.

It is significant that the board started the year needing to make nearly £41 million of savings to ensure financial balance. Through the work that NHS Forth Valley and other boards do each year, the board identified £25 million of savings, with only £10 million of those expected to be recurring. Therefore, there is further work to do in order to find £15.6 million of savings. We understand that progress has been made, but there is still a way to go, because savings of in the region of £10 million still need to be found in the final two and a half months of the financial year. That is significant. Rightly, you would have questions about whether NHS Forth Valley can bridge that gap on its own, without a significant impact on its ability to deliver services as planned.

We know that NHS Forth Valley is engaging with the Scottish Government. Pat can say a bit more about what steps are being taken to fill that gap and, then more widely, about what will happen if the board does not fill it. The committee will be

familiar with some of the support mechanisms that the Scottish Government is able to offer.

Colin Beattie: Indeed. Has it been escalated?

Stephen Boyle: The board and the Government are in that process. I will hand over to Pat Kenny to update you on where they are in the process and what, potentially, will come next.

Pat Kenny: As the Auditor General says, the latest position, with about two and a half months to go, is that the board is looking at a deficit of around £10 million. I recently spoke to the finance director, and he is hoping that that might come down a bit. The board is in discussions with the Scottish Government on how that deficit can be financed. There could be implications for the revenue programme or the capital programme, possibly on the timing of capital receipts. There are various options currently at play.

The big issue, however, is that there is obviously an underlying deficit in the board's finances, which, if not addressed, will simply carry on into later years. The big challenge for the board—again, it is not unique in this sense—is that it needs the transformational resource and capacity to address that structural deficit through innovation and change, new technology, new ways of working and so on.

There are challenges at NHS Forth Valley in that respect. I understand that internal auditors recently did a review of the transformation resources available to the board and raised some serious challenges in that respect. A key consideration was that the internal auditors asked NHS Forth Valley to satisfy itself as to whether it had sufficient resources to adequately address the transformational change that was required.

There are definitely question marks for me in that respect, and that is the key challenge going forward: the transformational capacity and resource that are in place to address that underlying structural deficit.

Colin Beattie: In the report, you clearly talk about

"the lead-in time needed"

to bring in those savings, and the lack of staffing capacity, which you touched on just now.

How did we get to a position in which, two and a half months before the end of the financial year, we are still £10 million out?

Stephen Boyle: I will start by raising a couple of points. While I mentioned earlier that NHS Forth Valley has not been escalated for its financial position in the way that some boards have, the scale of the financial challenge facing the NHS across the piece in Scotland is significant. As we set out in paragraph 20 of the report, there are multiple challenges facing NHS Forth Valley, and many of those could be read across as challenges that the NHS in Scotland needs to address across the piece. Those include recruitment challenges; bank and agency staff factors, which the convener mentioned; the need for recurring savings; the need for the health and social care integration model to be sorted; and the inflationary pressures that are affecting all individuals and businesses. There are also some local factors. For example, NHS Forth Valley accommodates, through health services, a significantly higher percentage of Scotland's prison population: 23 per cent of that population resides in the NHS Forth Valley service area.

Those are all factors that, in most years, NHS Forth Valley has been able to keep a lid on, so it is not in the escalation category for finance, but it is becoming more challenging for the board to deliver financial balance. To move on to my second point, which Pat Kenny rightly led us on to, transformation must, therefore, be at the heart of service delivery in order to secure effective services and financial balance.

Colleagues might want to elaborate on that. It rang a bell for me, when I was reading about it, in respect of some evidence that the committee took on NHS Highland a couple of years ago, which members may recall, on the central function of the programme management office that that board brought about as part of its attempt to transform its services and deliver financial balance. We are seeing similar patterns in NHS Forth Valley. There is learning from other places that can be drawn on, but there is work to do.

As I said, as paragraph 20 sets out, there are many challenges to overcome. There is some doubt, as Pat Kenny mentioned, as to whether the board will be able to turn all that round within the short space of the remaining months of the current financial year.

Colin Beattie: The issues that NHS Forth Valley faces are not dissimilar to those that are faced by other NHS boards, with regard to the difficulty in identifying recurring cost savings.

However, the level of non-recurring savings is very high, at 69 per cent, as a proportion of the £29.3 million in efficiency savings in 2022-23. That is a huge chunk, which means that the board has to identify that amount again the following year. What steps is the board taking to address that problem? It is currently only rolling up the problem into the future—it is not resolving it.

Stephen Boyle: That is the classic conundrum that health boards need to tackle. They get to the finish line on financial balance one year with non-recurring savings, but the clock resets for the start

of the following year if they do not transform and deliver recurring savings.

That becomes harder and harder, especially given, as we set out in paragraph 20, the scale and range of the issues that health boards are facing. If boards cannot do that on a sustained basis, even boards such as NHS Forth Valley, which have not been experiencing financial pressures as significant as those experienced by some other boards, are now in the frame of being at significant risk—although we cannot be definitive about it yet, because there are a number of months to go—of not being able to deliver financial balance in the year in question.

Transformation, effective partnership working, deploying technologies and looking at the base funding arrangements all have to be part of the decision making for NHS Forth Valley, in conjunction with its assurance board and wider discussions with the Scottish Government.

Colin Beattie: There is a target for all NHS boards to deliver 3 per cent recurring savings. Is that being addressed as a separate specific item, or is it just part of the whole in terms of meeting the deficit?

Stephen Boyle: I will bring in colleagues—Rebbecca McConnachie will cover that one with regard to NHS Forth Valley's wider approach to savings and how integrated that is.

Rebbecca McConnachie: The board looks at the 3 per cent Scottish Government target, but the savings requirement that it has will be over and above that amount. It is forecasting that, in 2024-25, it will need to reach a savings threshold of approximately 8 per cent as a target in order to achieve financial balance in that year.

Colin Beattie: I suppose that I have to ask: is that achievable?

Rebbecca McConnachie: We cannot say at the moment—the board is going through its budgeting process, and that is not finalised, so we do not currently know. However, I would suspect that, as we have reported in the section 22 report, there is "a significant risk" to financial balance in the short term and onwards in terms of sustainability.

Colin Beattie: That sounds a bit gloomy.

Stephen Boyle: Rebbecca is right—it is probably not possible for us, as the auditors, to say whether the board will be able to get there or not. What we can say is that there are significant risks around its ability to do that. At the risk of repeating myself, I highlight that, while a board can get over the line in one year with non-recurring savings, it becomes harder and harder for it to sustain that position if it is relying on such savings.

I would not underestimate the challenge. We need to recognise that there is not a lot of flexibility in overall NHS spending. So much of it is demand led, whether that is the cost of prescribing, some of which will be in the control of the board while other elements will not, staffing cost pressures or demand requirements overall. The board has to take a longer-term view of how it can, over time, move to a sustainable model.

Health and social care integration plays such a fundamental part in that. For many years, the committee has heard about the need to shift the balance of care and take a preventative approach to the delivery of health and social care services. NHS Forth Valley is not as far forward at this point as other boards. As Pat Kenny mentioned, the John Brown report refers to that. That approach is at the heart of moving to a healthy population and sustainable health and social care models, and it will, over time, assist in the delivery of savings to support financial balance, too.

Colin Beattie: I will highlight an issue that comes up fairly regularly. Is NHS Forth Valley using or managing vacancies to help to address the deficit?

Stephen Boyle: All health boards do that. They all attribute slippage in recruitment or vacancy management arrangements to support the delivery of financial balance. Deloitte might want to say a bit more about that, if Rebbecca McConnachie has any further detail on the quantification.

Although you might win on one hand with vacancies, you lose on the other, especially if you have to backfill with bank and agency services with higher costs. Even worse, if you cannot backfill the vacancy, your financial saving might be to the serious detriment of service performance and have an impact on patient care.

09:45

Colin Beattie: Do you have a percentage for those vacancies?

Stephen Boyle: I do not have that to hand. We can check our records.

Colin Beattie: It would be interesting to see whether it is in the same ball park as the percentage for other organisations.

Stephen Boyle: We need to check that. Indeed, the board will have more detail if it has a planning assumption on vacancy management that informs its budget setting, as, I think, you suggest.

Colin Beattie: The report says:

> "The recurring funding gap associated with the ... implementation of the Primary Care Improvement Plan"

will be a risk

"if not addressed by the Scottish Government."

What is the funding gap in monetary terms? What does the Government need to do to address that gap?

Stephen Boyle: That is a factor for the health board and the assurance board to discuss. Unfortunately, I am not sure that we have the detail of the scale of that gap in our records. I apologise.

Colin Beattie: Would you be able to provide that information?

Stephen Boyle: Of course. We can come back to the committee on that. As you will see, it is one of a number of financial challenges that the board needs to address to secure financial balance in the current year and, potentially, for next year.

The Convener: Rebbecca McConnachie, did you say that NHS Forth Valley would be required to make savings of the order of 28 per cent?

Rebbecca McConnachie: No. To clarify, it is 8 per cent.

The Convener: Did you say 8 per cent?

Rebbecca McConnachie: Yes—8 per cent.

The Convener: That will be a bit of a relief for my constituents in the Forth Valley health board area. Nonetheless, although we are talking about recovery from Covid and the backlog in treatments because of Covid, an already ageing population and, probably, a climate of rising demand, health boards are expected to produce savings of 3 per cent across the board and, as you described, NHS Forth Valley will have to come up with at least twice that amount. Will you explain how that works? It strikes me that that might be unsustainable financially and in terms of outcomes.

Stephen Boyle: That is exactly the comment that I was going to make, convener, and it reiterates judgments that I have made in previous years about there being real doubts about the sustainability of the way in which NHS Scotland currently delivers services.

NHS Forth Valley, as you have heard, has to make recurring savings in the current year, and more next year, while needing to improve aspects of its performance—A and E department wait times, out-of-hours services and mental health services. At risk of being really glib, I note that squaring off financial balance on one hand and service improvement on the other is an incredibly difficult challenge to pull off. You can see that it requires transformation within NHS Forth Valley and the wider model so that we can get to a healthier, sustainable position, with the finances to support it.

The Convener: Thank you. I invite Willie Coffey to put some questions to you.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): Your report mentions that Forth Valley's high prison population has an impact on the health board's ability to deliver financial savings. Why would the prison population have such a significant impact?

Stephen Boyle: By coincidence, we will be briefing the committee next week on a further section 22 report, on the Scottish Prison Service's 2022-23 audit, which will go into some of this in a bit more detail. At the higher level, the demands of the prison population—which is an ageing population—bring a call on the services that the NHS provides.

The scale is significant: 23 per cent of Scotland's prison population is within the NHS Forth Valley area, with those in Glenochil, Stirling and Polmont all residing within its boundaries. That population will vary—I am keen to talk to the committee in more detail regarding our report on the SPS—but the nature of the prison population in Scotland is changing. It is ageing, and that brings further demands on not just the Prison Service but NHS providers.

Willie Coffey: The responsibility to deliver healthcare services for the prison population falls to that health board, rather than being flattened out across Scotland.

Stephen Boyle: Yes—that is correct. That is one of the factors that NHS Forth Valley has identified as exacerbating the scale of the financial and service challenges that it faces.

Willie Coffey: My other questions are about performance, the escalation measures and so on. You have mentioned several reports and a variety of recommendations from different people. Initially, in April 2022, HIS produced a set of nine requirements for the Forth Valley royal hospital. That was followed up, in the same year, by a further 11 requirements. Could you give us a little flavour of what those requirements are about? Why are they not being actioned, or are they being actioned now?

Stephen Boyle: I will pass over to Leigh Johnston on that. It would be helpful for the committee to hear about the various reports and the associated action plans, about how they are being tracked and monitored and about the progress that is being made. Exhibit 1 of our report helps, I hope, to set out the timeline of the reporting. Even since the cut-off date, however, there have been more reports. We have mentioned John Brown's report on governance arrangements, which has also produced a number of recommendations. Leigh Johnston can perhaps set out what has been reported, the progress that

the health board is tracking, together with the Scottish Government, and how they are being assured.

Leigh Johnston: Following the HIS inspections, a Healthcare Improvement Scotland action plan—which was different from the escalation improvement plan—addressed the different recommendations that HIS had made. As, I think, the Auditor General has already outlined, HIS was concerned about a range of areas, such as contingency beds, particularly in non-standard areas, dignity for patients, emergency evacuation procedures in very crowded areas in the hospital and a range of cultural issues, with staff not feeling that there was an appropriate level of staffing or the right mix of skills and not feeling that their concerns were being listened to.

Healthcare Improvement Scotland will have been monitoring progress through different actions. We know that new procedures have been put in place to monitor staffing levels on the hospital wards. More support staff and leadership have been provided on a 24/7 basis to support staff. There are also new mechanisms in place to encourage staff and patients to speak up if they have concerns about their experience or the safety of care.

Willie Coffey: On the 11 requirements and the nine other requirements—the 20 requirements in total—that have been placed on the health board, are you in a position to say whether it is now making good progress on them? Has it completed any of them, or is it still in the middle of the process? Where are we with the 20 specific requirements that HIS gave the board?

Leigh Johnston: I would need to come back to you with the specific details. We know that the health board has made progress in some areas. Healthcare Improvement Scotland will obviously be monitoring progress, but I would need to come back to you with the specifics.

Willie Coffey: We have HIS reports, we have the oversight group, we have the 12 recommendations in Professor Ritchie's review of October 2022, we have the 50 recommendations in John Brown's report, we have the escalation improvement plan and we have the measurement framework. Is the health board awash with report on top of report? Is that a factor?

Stephen Boyle: There is a lot to get through, but it is probably fair to say that those are not competing findings. Some of the HIS findings are about specific arrangements in Forth Valley royal hospital, other findings from the oversight group are about specific service delivery arrangements for out-of-hours care or unscheduled care, for example, and the Brown report includes many recommendations on wider governance arrangements.

Whether the health board is making progress or has work to do, it is about having the right measurement framework in place that sets out very clearly what the recommendation is and what steps have been taken. There is then governance and scrutiny of that through the Scottish Government assurance board, which considers whether the board has done what it needed to do. Satisfying the Scottish Government assurance board and the health board's committees that the health board is taking all the necessary steps is still a work in progress.

I accept the principle of your point, which is that there is a risk of not being able to see the wood for the trees because there are so many recommendations and reports, but perhaps that just illustrates that there is so much interest in getting the health board to a sustainable position in which it can deliver safe and effective patient care. Through the escalation process, the board and the Government have to be satisfied that steps have been taken and that the board can, in effect, score off those recommendations and move to a sustainable platform.

Willie Coffey: For many years, you and your predecessors have talked about service redesign and transformation, but here we are talking about those issues again. Do you get the sense that the recommendations that are made to health boards are about service redesign and transformation? Is that understood by health boards? Are they able to deliver the service redesign and transformation that we are talking about? Are you confident that they are making progress on that journey?

Stephen Boyle: As we have said, there is a range of recommendations. Some of them are very detailed and specific to a particular aspect of healthcare in a hospital setting, and others are much more wide ranging, such as those on governance and culture. It takes a lot of effort to sustain a culture and even more effort to transform it.

I will spend a moment on that example by referring to NHS Highland. The committee will be familiar with some of the cultural challenges that that health board has faced in recent years. Those went on for a number of years. It has taken time to move to an even keel with the reconciliation process. There are references in the report that show that NHS Forth Valley is thinking along those lines. That is about resetting rather than redesign. Mr Brown's report rightly picked up on the redesign element of health and social care integration. That is the redesign and transformation component of how healthcare will be delivered in Scotland. NHS Forth Valley is further behind its peers, and there is a clear signal

that there is work to do to transform that aspect of service.

There is a spectrum of issues here. Some are about getting back to where the board needs to be, and others such as the out-of-hours service are perhaps in the middle. Up until the report, the out-of-hours service was run by the acute service provision in NHS Forth Valley, which is at odds with what we see elsewhere. Typically, an out-of-hours service is run by GPs and primary care practitioners, and NHS Forth Valley has now moved to that model. Some might say that that is just a step forward, while others might say that it is transformative.

At the other end of the scale, there are wider pieces of work on transforming culture and on health and social care integration. There is a fairly wide range, but the most important thing is that the health board and the Scottish Government assurance board have clear oversight of the progress that is made on all those fronts.

10:00

Willie Coffey: I presume that it is still at stage 4. That has not changed, has it?

Stephen Boyle: You are right. The board is still escalated to stage 4 of the escalation framework. It is for the Government to decide when it is satisfied that the board can move to de-escalation.

Willie Coffey: In the section 22 report, you say that a report of

“an independent review of the board and Assurance Committee governance arrangements”

was

“due to be considered by the ... Board”

last November. Have you had sight of that report and its recommendations and conclusions?

Stephen Boyle: Pat Kenny will cover that.

Pat Kenny: That is the report of the governance review by the chair of NHS Greater Glasgow and Clyde. He made 51 recommendations, which we referred to earlier. Of those, 46 are still outstanding and have been incorporated into the escalation improvement plan. There is a clear measurement framework in place with key performance indicators, outcomes to deliver, evidence and so on. As part of this year’s audit, we will look at how the board is delivering against that in terms of progress made.

Willie Coffey: Do those recommendations all relate to governance?

Pat Kenny: Yes.

Willie Coffey: November was mentioned. Was that not a bit late in the day to arrive at the governance issues? Over the years, that has usually been the first port of call for the committee and members—that seems to be the starting point for a lot of these issues. How come that was brought so late to the table?

Pat Kenny: The NHS Forth Valley board commissioned the report once it had been put into the escalation framework, as it wanted an external view. The board must be commended for that. It reached out and commissioned the review, and it agreed the terms of reference. The delivery of the final report was a wee bit late—we were expecting it a bit earlier. Nevertheless, the board has taken that on, and, as I said, the recommendations have been captured in the overall improvement plan.

Stephen Boyle: I will offer a thought on that, Mr Coffey. Pat Kenny is right, but we might have reasonably expected the report to have been commissioned at an earlier stage, given how central governance was, together with leadership and culture, to the basis of the original findings. That is perhaps supported by the volume of recommendations that Mr Brown has made—there are more than 50 recommendations on the need to improve governance in NHS Forth Valley.

There are undoubtedly some mitigating factors. As we reported in previous NHS overview reports, NHS Scotland deployed, during the pandemic, a governance-light model in order to focus on patient care and safe protection of the population and staff during the pandemic. However, it is probably true to say that whether that model was switched back to the more traditional governance settings early enough, as we came out of the pandemic, is a question for NHS Forth Valley.

The timing of the review suggests that the pace and centrality of effective governance was not quite what it needed to be, as was borne out by Mr Brown’s report and by the scale of the recommendations that we made. We need to see progress against those recommendations now.

Willie Coffey: I have a final question. I think that you said that 47 of the 51 recommendations have not yet been actioned. Is it reasonable to ask when we could expect the board to get through them? That is a huge number of recommendations on governance. What are we looking at—six months, or a year?

Pat Kenny: When we conduct this year’s audit, we will, as part of our work on the wider scope, look at the progress, and I will ask questions such as, “Is the board making reasonable progress? Is the pace sufficient enough?” It will take the board a bit of time to get through the recommendations, given their scale. Some of the recommendations are wide ranging—there are cultural and leadership recommendations. One of the major recommendations is for a complete review of the

integration schemes, which, again, will take a bit of time. As I said, however, we will, during this year's audit, assess progress and report back.

Stephen Boyle: There has also been some change in the board of NHS Forth Valley that has led to the board looking at Mr Brown's recommendations. That has given him more confidence and assurance that effective governance is in place to address the recommendations and support the wider stabilisation and changes that are required in the health board.

Willie Coffey: Thank you very much for those responses.

The Convener: Picking up on some of the themes that were developing there, Graham Simpson has some questions on the assurance board, leadership and culture.

Graham Simpson: I am looking at the timeline in exhibit 1 of the report. It starts in April 2022 with a visit by Healthcare Improvement Scotland. Was that the first that anyone knew that there were problems in the health board, or would issues have been raised before that, which might have spurred HIS to pay its visit?

Stephen Boyle: I do not have a clear view on the motivations for HIS to carry out its unannounced visit to Forth Valley royal hospital. It is fair to recognise that healthcare regulators and inspectors exist for a reason: to provide assurance to the population, to elected representatives and to the boards of health boards that effective patient care is being provided. As to whether HIS had a RAG—red, amber and green—rating model to lead it to Forth Valley royal hospital, I am not sighted on the individual motivations.

We can probably take from that some assurance that, through organisations such as HIS, together with the oversight that the Scottish Government employs and the engagement that regulators and inspectors routinely have with one another, the model is working. If escalation is needed, that can happen, and it did. Healthcare Improvement Scotland carried out its work, it was not satisfied and it escalated the issue. That feels like a process that worked as intended.

Graham Simpson: HIS went in and found quite serious problems there. It strikes me, however, that if there were such serious problems, why did no one know about them? Why did it take a spot check to discover them?

Stephen Boyle: That is an interesting question. There is meant to be a range of avenues for members of staff and patients to raise concerns. We summarise in our report some of the HIS findings. As you can see, those focus in particular on staff concerns about not being listened to and on whether some of the well-established arrangements were working as intended.

I would not want to infer aspects that do not exist. Moving away from that example, we know that there are well-established whistleblowing arrangements in the NHS, such as whistleblowing champions and so on, to give members of staff the opportunity to highlight concerns if they need to do so. As HIS clearly set out, something was not quite right, as staff felt that they were not being listened to by the leadership.

However, it is, to some extent, reassuring that, rather than focusing solely on getting individual arrangements right in the hospital itself, HIS drew the much wider conclusion that there were governance, leadership and cultural aspects to be addressed in the board. It did not focus simply on arrangements for the number of patients on a ward and so on. There were various strands to its conclusions.

Graham Simpson: After that visit in April 2022, there was a period of months before, in November that year, the board was escalated to stage 4. Obviously it got to that stage because there was a lack of progress. Do we know why there was a lack of progress?

Stephen Boyle: In effect, the Scottish Government said, as it set out in the letter from the director general of NHS Scotland to the convener and me, that it was not satisfied that the leadership in the board was taking sufficient steps to address the concerns that had been raised by HIS, the oversight group and, subsequently, a very short time later, NHS Education for Scotland.

As we set out in our report, and as we have discussed this morning to some extent, leadership, governance and cultural issues were significant, and the Scottish Government was not satisfied that the board was making progress against the findings and recommendations of the regulatory bodies.

Graham Simpson: So, ultimately, are we to pin the blame for those issues on the leadership problem? The chief exec has now gone. Were the chief exec and the board not doing their jobs properly?

Stephen Boyle: It is difficult to reach a very specific source on responsibility. Structurally, health boards have an executive leadership team—their wider boards of governance. They have very close relationships with the Scottish Government and with their regulatory bodies. There is, however, an accountable officer system in the Scottish public sector, which involves personal responsibility. As we set out in our report, there has been a change of executive leadership in the board, and we understand that it is due to

recruit permanently for a new postholder in the next month or so.

It is not just about effective executive leadership, although deficiencies in that were set out in John Brown's report; governance, too, was not operating as effectively as it needed to. The governance-light model, which we talked about in the context of Covid, was not moved away from at the pace that was needed, especially given the concerns that are evident in the report. There are elements of timing, culture and pace in putting the necessary arrangements in place.

Graham Simpson: Leadership comes from the chief exec and from the board. If the board got itself into the position where we had to escalate to stage 4, because of a whole series of problems—which I will come on to—we surely have to say that the chief exec was not doing their job and the board were not doing their job properly. Surely it is fair to say that.

Stephen Boyle: The facts are laid out in the various inspectors' reports. That there is a consistency of findings around governance and leadership suggests that there are issues to be addressed. It is pretty plain to see that there were concerns around the factors to which you are referring.

Graham Simpson: Yes, it is plain to see.

I want to ask you about something that is very concerning, which is covered on page 10 of the report, in the timeline. It says:

> "HIS's inspectors identified instances of unsafe practice around medicines governance which could result in serious harm to patients."

Do you have any more details of what that means or of what lay behind that?

Stephen Boyle: Those points are set out in aspects of our reporting and in more detail in the HIS report. Leigh Johnston might want to say a bit more about the circumstances.

We support your judgment on that, Mr Simpson. If we are in the realms of potential patient harm through unsafe use of medicines, with factors involving staff levels, the skill mix, the experience of the NHS workers applying medicines and concerns not being listened to, which is also set out in the report, as well as staff not being supported or listened to effectively by senior management, that paints a picture of real risk to patient safety. However, the fact that HIS identified that is evidence that the different parts of the system are working as intended. We have inspectors and regulators for a reason. They did their job, they raised concerns and they escalated it when they were not satisfied that appropriate steps were being taken. I will pause there, because Leigh Johnston might want to say a bit more.

10:15

Leigh Johnston: I do not have any more detail to give about the governance of medicines; that would be in the HIS report. However, what follows that gives an indication about the senior management oversight of staff; I am sure that that feeds into the process. However, for the specific detail, you would need to look at the full HIS report.

Graham Simpson: Presumably those unsafe practices have now ended—whatever they were.

Stephen Boyle: I hope that you will appreciate that I am not able to give you that assurance, Mr Simpson. NHS Forth Valley—validated by its inspectors—would be able to give assurance to the committee on that.

Graham Simpson: You said that the board responded

> "positively to the escalation framework."

What do you mean by "positively"?

Stephen Boyle: It is fair to say that. There has been an acceptance by the health board of the various factors that caused it to be escalated and of the resultant steps that it has had to take. We are now on the third version of the escalation improvement plan. The plan is underpinned by the key priorities that we set out in paragraph 26 of the report on NHS Forth Valley, which are "Putting patients first", "Supporting staff" and "Working in partnership".

Referring back to the discussion with Mr Coffey about assurance arrangements and governance, those are in the right place overall.

The Scottish Government will want to see clearly—through the assurance board and the health board—that NHS Forth Valley has evidence to support that it has met a wide range of the recommendations and that it has made progress on others. Ultimately, that will lead to the health board being de-escalated by the Scottish Government.

Our judgment is one of acceptance of the progress and overall arrangements. However, the next step matters. The board has to have evidence to show that it is making progress, so there is a way to go yet.

Graham Simpson: How do we measure whether it has actually made progress? We will not just take the board's word for it, will we?

Stephen Boyle: Some bits of it will be harder to measure than others. In the example that you asked about—safe prescribing—HIS will be able

to satisfy itself through its procedures that the board has addressed that recommendation.

Other bits will be harder. Issues with culture, for example, will not be resolved overnight. That will require a programme of activity and, perhaps, reconciliation between members of staff and leadership in NHS Forth Valley. Governance will also take investment, as will effective working across the executive leadership team.

Pat Kenny mentioned that he and his colleagues will track progress through the annual audit. As I conclude in my report, I will take a view during 2024 on the extent to which further public reporting will take place on NHS Forth Valley. However, there are a range of aspects to that.

Evidence matters. That is the principle of the measurement framework by which the assurance board of the Scottish Government is clear when it says that work on one recommendation has been done and that it has more work to do on another.

Graham Simpson: Your report mentions that NHS Forth Valley is about to embark on a culture change and compassionate leadership programme, which is apparently used elsewhere. I have no idea what that means. Can you explain what it is?

Stephen Boyle: Probably not to any great degree, Mr Simpson. We can draw on NHS Highland, for example, which although not a perfect analogy, shows that models exist and have been used elsewhere in the NHS—not just in Scotland but across the UK—to reset relationships between staff, leaders and governance within an organisation.

We should not underestimate the scale of the challenge that requires to be addressed. As many management clichés set out, culture can dominate an organisation. Once a change of culture has been made, it will require considerable investment to reset.

That supports NHS Forth Valley's mission. As I mentioned a moment or two ago, it is important to point out that the priorities of the health board, through the escalation improvement plan, are about putting patients first, supporting its staff and working in partnership. Culture will be at the heart of that programme. The detail of how the board intends to address that is multifaceted. I am sure that NHS Forth Valley will be able to provide the committee with information on the range of steps that it is taking.

Graham Simpson: I guess that we will have to ask the board about that, because I do not know what is wrong with the culture and what needs to change.

Stephen Boyle: I will highlight a couple of points from various inspectors' reports. Staff felt that they were not being listened to, which is a hugely significant aspect of culture. In any organisation, staff need to feel that they are respected, that their voices are heard and that management listens to them. It is clear that some members of NHS Forth Valley felt that the culture was not effective enough for that to happen.

Graham Simpson: I have a final question on a topic that has been covered before. We talked about financial sustainability, and you say in your report that there is a

"risk that the board is not financially sustainable in the short term."

Rebbecca McConnachie talked about that as well. I want to understand what happens if that continues. If the board remains financially unsustainable, do we escalate it even further?

Stephen Boyle: I will ask Leigh Johnston to set out for the committee what happens. Arrangements have changed a couple of times over a number of years. The committee may recall that we previously had brokerage arrangements under which, if a board did not meet its financial target it got what was in effect a loan from the Scottish Government that was called brokerage. Those arrangements changed. Just before Covid, previous debts were written off, there was a reset and we then moved into a slightly longer-term planning horizon and medium-term financial plans.

Bear in mind that this is a real-life example. As Pat Kenny set out, there is a £10 million or so gap. That might or might not be bridged but, if it is not, the Scottish Government offers support, and Leigh can take us through that.

Leigh Johnston: During the pandemic, boards were fully funded. Now that we have moved out of the pandemic, we have gone back to arrangements that were introduced in 2018. Boards have a 1 per cent flexibility, so they can be in deficit by 1 per cent, but they have to break even within three years. Other than that, they would seek additional financial support from the Scottish Government, which is in essence a return to receiving brokerage.

Graham Simpson: What would happen if the Government turned round and said, "No, you're not getting the support"?

Stephen Boyle: In such a hypothetical situation, an NHS board would report an in-year deficit. I will not speak for Pat Kenny but, from an audit perspective, he would have to give consideration to the regularity of that spending, because there is no budget cover or approval for the board to produce an unbalanced budget. That would therefore bring my attention, and potentially a statutory report. Services would continue, and it would be the Scottish Government's call on what it

wanted to do next and how it would support the board. Escalation frameworks exist. The Government could also review the board's service provision arrangements and consider how it would help the board to return to financial balance.

A range of tools would be available, primarily for the Scottish Government, but there would undoubtedly be decisions for the board to make.

Graham Simpson: That is interesting. It reminds me of the work that the committee has been doing on colleges. As we have heard, a number of colleges are in a similar position and may have to be bailed out, which sounds like it could be the case here.

Stephen Boyle: Again, through the audit of NHS Forth Valley, we are closely tracking—as are Pat Kenny and his colleagues—the situation across the piece. As we have said a number of times today, the financial challenges for NHS boards in Scotland are clear in respect of delivering financial balance in-year and into the future, for all the reasons that we try to cover in the report. Those include the extent of demand, cost pressures, inflationary pressures and enacting the routes to transformative change that will deliver sustainable health services in Scotland.

The Convener: We are drawing towards a close, but I have just a couple of quick questions. Auditor General, you mentioned the importance of staff being listened to, and you referred, for example, to whistleblowing. However, is it not the case that staff being listened to is not just about individual whistleblowers using public interest disclosure, but that it is also about routine collective listening—for example, listening to trade unions and their health and safety forums—as well as partnership working?

Stephen Boyle: Very much so, convener. The committee may be aware that a unique aspect of NHS governance is the presence of an employee director on the board of health boards, which underpins the importance of the relationship and of listening to staff.

The Convener: Okay—thank you.

My second quick question is one that we have addressed in relation to a number of other reports: the question of induction training for members of the health board. Do they get such training in NHS Forth Valley?

Stephen Boyle: I am not sure that we have covered that in our audit work, but I would be surprised if that were not the case. I think that it is almost certain that there is a programme of support and induction for all public appointees in Scotland—in fact, to correct myself, I know that there is, as Audit Scotland has played a role in providing induction materials. We have given presentations to public appointees, including health board directors, as part of a wider programme of activity, so yes, there is a programme of induction.

The Convener: So that is not an issue that you have identified or that was identified by the John Brown inquiry.

Stephen Boyle: Looking at the specifics of John Brown's report, he has found that, regardless of the quality of induction, it is not an entirely sufficient safeguard to ensure that effective governance is in place. On any board, whether it is in the public or private sector, you can have all the effective governance induction arrangements that you like, but that does not guarantee that there will be effective decision making throughout the lifetime of somebody's presence on the board.

Pat Kenny might want to say a bit more about the specifics in NHS Forth Valley.

Pat Kenny: I know that John Brown raised in his report issues regarding board challenge and scrutiny, which is a key element of governance. That is another one of the recommendations, and I think that it will be reflected in the induction training for board members in future that that level of challenge and scrutiny is absolutely essential, because there were some deficiencies in that respect in the past.

Stephen Boyle: That is fine, but it will not in itself guarantee effective governance and a culture of effective leadership. That has to be worked at constantly. The examples that HIS and other regulators have found would all have been within the confines of effective governance, yet they still happened. The board has constantly to assure and check itself, as all health boards do, that governance is robust enough to deal with challenging scenarios.

The Convener: Yes. One of the lessons that we have learned is that culture change is one thing, but it is keeping the culture change going that is probably the harder task.

My final question—I think that you alluded to this in answering Graham Simpson's questions—is about how far there is to go through the assurance board process and so on. Again, when I had a briefing from the assurance board, which I think was as far back as May of last year, the expression that its members used was that they thought that there was a long way to go at that stage. We are now several months down the line, so that position might have been revised but, at that time, the assurance board was saying—I took a note of it—that there was no clear path to de-escalation. What is your assessment of that today?

10:30

Stephen Boyle: I am somewhat reluctant to speak for the assurance board, convener—its members will be better placed than I am to assess their intentions. I am sure that the assurance board will want to be satisfied that there is clear evidence of progress in meeting the significant range of recommendations. As we have heard a number of times, there are another 50 recommendations on governance from John Brown. It will take time to evidence progress on culture, too.

On progress, it is, for us, currently a question of wait-and-see, and close engagement through our audit activity. The timeline is probably for the assurance board to speak to.

The Convener: I wonder about that, though, based on your experience. I was quite taken aback when the assurance board said to me and other elected representatives who were taking part in that discussion that it could be years before de-escalation takes place. Is that the sense that you get? Is it the experience that we have had with other health boards that have been escalated to level 4?

Stephen Boyle: We have not seen that length of timeline, in terms of years.

That being the case, it probably illustrates to the committee and to those who are engaged in today's session that the scale of the issues is significant. They require careful attention and focus, with all the actions and evidence of progress. We know that the assurance board is focused on those aspects in order to be satisfied that the evidence framework is robust and that it can see that progress is being made. Again, however, I am probably not in a position to say whether it will be months or years.

The Convener: Okay. On that note, I draw the evidence session to a close. I thank you, Auditor General, for the evidence that you have given us, and I thank Pat Kenny and Rebbecca McConnachie from Deloitte and Leigh Johnston from Audit Scotland for the evidence that they have shared with us.

I now draw the public session to a close and move the committee into private session.

10:32

Meeting continued in private until 11:06.

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